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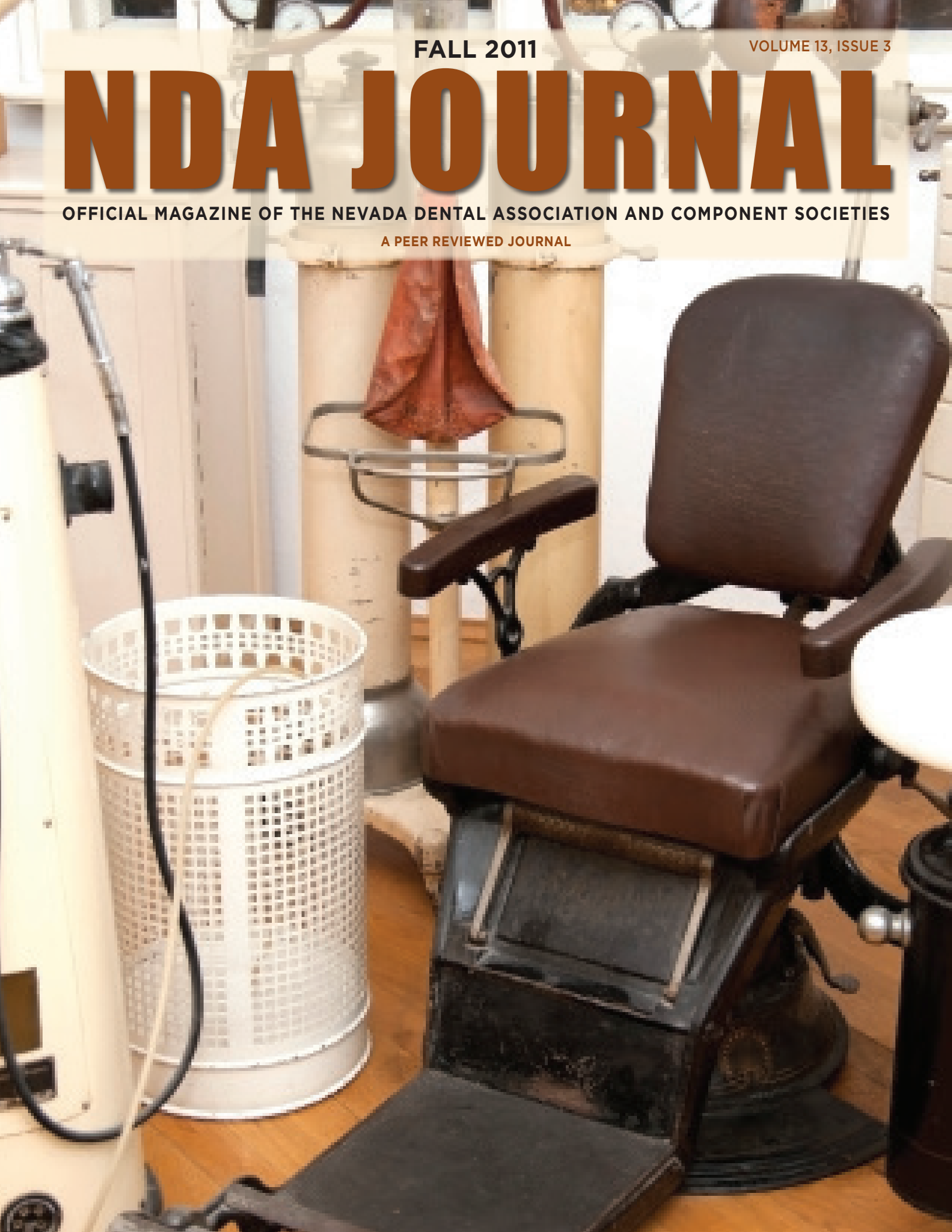

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The ~~$5,000 $10,000 $15,000 $20,000~~ $25,000 Toothache

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The Journal has previously opined about how fortunate those who chose to practice dentistry are.[1,2,3]

Dentistry is a relatively efficient service profession in part because the nearly 190,000 dentists in the United States deal more with patients and less with third parties (insurers, attorneys, politicians, governments, administrators, regulators, and others) than does our sister profession of medicine and its estimated 650,000 active practitioners. That organized dentistry has a grasp of how to facilitate continued patient access to quality care is evidenced by the fact that nearly 70% of all U.S. dentists are members of the ADA while the AMA claims less than 15% of the physician population.

Dentistry is relatively insulated from the regulatory machinations affecting medicine, but glimpses of potential issues involved if dentistry heads down the more servile road medicine has are available, such as the "$25,000 toothache" (the current fee estimate after years of increasing non-dental, non-functional, third-party odontalgia participation), a weekly phenomenon in Nevada for dentists who take hospital call.

First, a question: what does one do if a chronic mild toothache morphs to an acutely painful state on a Friday afternoon? Well, if the patient is a Medicaid participant in Northern Arizona, he or she is directed not to a dentist, but to the regional health center. The regional health center has no dentist, so the patient is evaluated by a physician. A physician is necessary because a transfer to another facility will be required for dental care. The physician decides to transfer the patient, not to a facility in Arizona, but in Nevada. Don't ask why an Arizona Medicaid patient would be transferred to Nevada, that is the subject for another editorial (but most entrepreneurial types will guess correctly in a nanosecond or two). Transportation has to be arranged from Arizona to Nevada. Because the system is activated, the choice for transportation is an ambulance, occasionally a helicopter, or fixed wing aircraft to a local airport (and an ambulance from there). Because toothache per se is not on the list of qualifying emergency diagnoses,[4] the physician writes emergent Ludwig's angina on the record, which is confirmed as "possible" by the radiologist interpreting the regional care center's CAT scan. A call is dutifully made to a Nevada facility where dental

Continues ➲

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care is available, an emergency transfer is arranged, and the patient begins ground and/or air transportation with the driver/pilot and two required attendant health care transport personnel.

The receiving facility in Nevada has confirmed that the airway is secure and immanent tracheostomy or intubation is not necessary. When the Arizona patient arrives at the Nevada ER hours later, he is fully evaluated by the ER physician who orders an MRI and admission via the hospitalist. The hospitalist, seeing a diagnosis of Ludwig's angina on the report, but having never seen one in real life, appropriately plays things safe and admits the patient to an intermediate care ward (IMC) (for some reason the patient just doesn't look ICU ready in spite of the diagnosis). There intravenous (IV) lines are placed and blood and urine lab testing, chest x-rays, and consultations from specialists in infectious disease (ID), internal medicine (IM), general surgery, otolaryngology (ENT), dietary, social work, and others, including the dentist on call, are ordered.

The ID specialist arrives first and immediately orders an exotic 5th generation IV antibiotic mixture to cover the latest resistant strains of bacteria. He orders blood cultures and tests for aerobic and anaerobic bacterial strains (all while considering tests for fungal and viral organisms too) and settles down to wait for lab work that may take weeks to grow out depending on the microscopic critter involved.

The IM physician spends nearly an hour doing an extensive history and physical exam, but is uncomfortable writing diet orders so just continues the hospitalist's IV fluid maintenance and makes the patient NPO. The IM doesn't know a lot about dental issues, so calls the general surgeons who may want to take the patient to the OR.

At this point in time the IM recommends a consult with an anesthesiologist. Since the preliminary diagnosis is Ludwig's angina, the anesthesiologist prepares for full high technology airway establishment and maintenance protocols in the OR in case surgery is scheduled.

The general surgeon now consults and, after treating multiple trauma patients for 24 hours, is somewhat confused about all the activity involved in this case. He determines emergent tracheostomy is not indicated and leaves a note to call him again only prn (*as needed*).

The ENT doctor arrives and after noting no tumescence over the neck actually looks in the patient's mouth and notes some tenderness near a molar, or maybe a bicuspid, he's not sure which, with because of extensive caries. He's reviewed an unimpressive MRI, but he does know Ludwig's can dissect superiorly into the cranium or inferiorly into the chest so he orders more MRIs with contrast media. He also recommends emergency consultation with an ophthalmologist as Ludwig's can spread to the orbits. He defers consulting a cardiologist or chest surgeon as the IM physician documented a nice heart and lung examination, all within normal limits.

The ophthalmologist then sees the patient and notes nothing unusual about the eyes, but is advised by the patient that he has a headache and wants something to eat. Deferring the request for food, the ophthalmologist continues the NPO orders and writes for STAT neurology and neurosurgical consultations because of the cephalgia.

The neurologist does a full cranial nerve examination and notes only a bit of hyperalgesia over a peripheral branch of the third division of the trigeminal nerve, apparently associated with teeth. He does a further bedside workup from head to toe, including Babinsky testing and has to think about what to say when the patient asks what all this has to do with his toothache? The patient also advises that his headache will go away if he could just get a beer (and he later calls a friend to arrange surreptitious delivery of the same).

The neurosurgeon consults with the neurologist, has looked at the MRI with contrast of the brain, read it as normal, and signs off on the case pending further developments.

Several non-physician personnel, including the dietician, psychologist, social worker, and the hospital's administrative cost-containment representative also see the patient and make their notes on the chart.

The dentist is called after shortly after midnight and is given a brief synopsis of the patient's course so far. He then orders a panoral radiograph.

The next morning the dentist visits the patient in the IMC and documents the toothache likely secondary to clinically evident caries in number 19. The patient reports he had a headache that morning, but it went away after a friend visited. The dentist writes an order to discontinue the IV morphine sulfate and replace it with topical eugenol, which he confirms is effective by administering it on a cotton swab at bedside. He also institutes a normal diet. The dentist then visits radiology to view the pan and finds his order was cancelled. No one admits to cancelling the order and he speaks with a radiologist to re-order the pan. The radiologist asks why the dentist needs a pan when they have a CAT scan and MRIs with and without contrast. The dentist says he needs to see what the teeth look like since the patient's chief complaint is a toothache. The radiologist offers to do a 3-D reconstruction of the CAT scan, but the dentist still requests a pan. He then asks the floor to send

the patient to his office Monday or Tuesday with the hospital's pan in hand for an extraction and leaves the hospital.

Saturday afternoon, the hospital calls the dentist to see if he'll take the patient to the operating room for the extraction. The dentist confirms this is not secondary to any health concern, but because the patient is from Arizona and doesn't have anywhere to stay in Nevada. The dentist can't justify the time or multiple cost factors in the OR with the attendant anesthesiologist, circulating, and scrub nurses for an extraction so repeats his instructions to have the patient follow up after the weekend. He further advises the hospital that as far as he is concerned the patient doesn't need to be admitted for the toothache and could probably get a pretty good room and meal for less than is being spent to keep him in the IMC. The hospital compromises by transferring the patient from the IMC to a regular care floor.

Monday morning the dentist's office manager calls the hospital to formalize an appointment for the patient and is told that the patient left against medical advice (AMA) when his friend picked him up Sunday. The hospital hadn't seen the patient since.

The cost of the dental treatment would have been in the neighborhood of a couple hundred dollars. The cost estimate for the care from non-dental third parties may have to be revised upwards once the patient returns with recurrent odontalgia, and perhaps even Ludwig's angina in part secondary to the resistant strains of bacteria developing after multiple non-curative antibiotic Rx's and other procedures. That is when the treatment is really expensive.

The scenario above is a representative example of common occurrences when non-dental third parties are involved in the care for odontalgia here in Nevada. Cases aren't always this complicated, but at times they are even more convoluted.

Dentistry is usually much better without third-party help. ◆

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UNLV SDM Oral and Maxillofacial Surgery Program awarded the 2011 Laskin Award at the AAOMS annual meeting in Philadelphia

Editor's note

Over the past three years, an average of over 10% of the graduating class has entered OMS training. In addition, one student from each of the past three years has been accepted into Dental Anesthesiology residency training. Pre-OMS and DA student co-authors have works in peer reviewed journals such as *JADA, JDE, JOMS, OOOOE*, the *NDA Journal*, and have won numerous research awards. Thanks to Dean Karen West, Clinical Dean Michael Sanders, OMS faculty Drs. Richard Hamilton, Lawrence Hundley, Jeff Moxley, Steven Saxe, generalists Tam Nguyen and Joe Hansen, OMS staff coordinator Valinder Addison and crew, and scores of UNLV SDM students beginning to understand the vision of serving others via the singularly great profession of dentistry.

About the OMS faculty

Dr. Richard Hamilton was featured on the front page of the *ADA News* in March 2010 for outstanding efforts with the UNLV SDM Ferrin Veteran's Clinic.

Dr. Lawrence Hundley commutes from Southern California as a half-time faculty member in OMS at UNLV SDM.

Dr. Jeff Moxley has the longest OMS tenure at UNLV SDM and was recently publicized nationally for his efforts in dealing with massive head trauma at UMC's Level I Trauma Center (www.lvrj.com/news/las-vegas-native-survives-pipe-through-head-thanks-to-doctors-121551849.html).

Dr. Steven Saxe is the current President of the NSSOMS.

Drs. Daniel Laskin and Daniel Orr

Dr. Richard Hamilton

Dr. Lawrence Hundley

Dr. Jeff Moxley

Dr. Steven Saxe

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After a two month process, I am happy to report the hiring of Mr. Chris Ferrari of Ferrari Public Affairs as our new Contract Lobbyist.

Chris brings to the association a bipartisan, well respected, long term relationship infrastructure built by the professional reputations of people who truly understand the legislative and regulatory process. The firm has successfully represented small and large companies, individuals and associations.

NDA legislative chair Dave White and I will accompany Chris to the ADA lobbyist conference in December and then start the process of developing a legislative plan for the upcoming elections and next legislative session in 2013.

Ferrari Public Affairs brings the Nevada Dental Association up to the next level in political advocacy at a time when our profession is venerable to attack on many different levels. In order to help defray the cost of such an endeavor, a dues increase was approved by the House of Delegates at the summer meeting.

Please take a look at an article in this issue written by one of our endorsed products, Best Card, about some changes coming to credit card processing. This is the processing service that the Association uses and has found them to be safe, economical, and very helpful in keeping us compliant. ◆

Photos from the 93rd Annual Summer Meeting

The Grand Wailea Resort • Maui, Hawaii • July 7–9, 2011

As the heat still sizzles in Vegas it is time to begin another year of transition for the Nevada Dental Association. Past president, Dr. John DiGrazia, served passionately and left the association in outstanding shape. It is my intention and goal to take the association to a new level and increase membership in the process.

The process of creating an effective association lies in the ability of its members to contribute time and energy. In working with the component societies we are encouraging new dentists to get involved. We know they will bring fresh ideas and can teach us old guys about the importance of using social media in our practices. They are the leaders of tomorrow and it is important that we show them that there is another integral part of dentistry besides just drilling and filling. All of us need to encourage them to go to dinner meetings, political rallies, health fairs and anything that supports our profession in a positive light.

For a long time the NDA has taken a back seat in the political arena and not attained its rightful place as the "Voice and Advocate for Oral Health Care in Nevada." The Legislative committee conducted multiple interviews with some of the top lobbyists in the state. They were chosen by their ability and reputation in the political arena. Thanks to Dr. David White and our executive director Dr. Robert Talley for their extreme diligence in helping the Legislative and Executive committees choose Mr. Chris Ferrari as our new lobbyist. I am sure he will represent our best interests and move any bills we may have forward!

I encourage you to contact Dr. Talley if you have any legislative issues; as that committee will begin its work for the next session right away. As you know, getting things accomplished is about relationships. Please let us know if you have a legislator as a patient! We want to build on that relationship. We are currently in a non legislative year but there is plenty to do with campaigns starting and developing our legislative agenda. We will be prepared for any issues that may threaten the viability of the private practice setting. This includes the mid level provider!

I encourage you to speak to our non-member dentists about the true value of membership. Peer review,

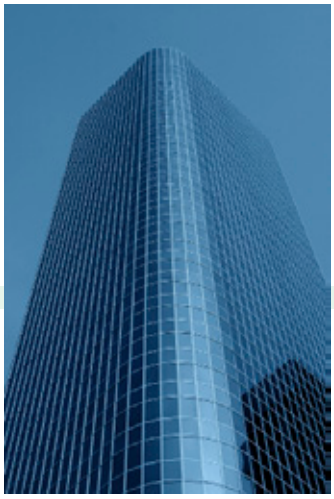
Michael Banks, DDS

advocacy for the profession, the wealth of information that the American Dental Association distributes, discounted insurance plans thru ADA and NDA, and retirement plans are just a few of the countless benefits of membership. But more importantly there is strength in numbers. We can set an agenda that will be unprecedented and move it forward if the members are willing and able.

As I enter into my presidential year I will strive to put dentistry in Nevada where it belongs! The leading "Voice and Advocate of Oral Health Care in Nevada"! ◆

Dentistry is Big Business

By Barry J. Taylor, DMD



It has become white noise from any news source—economic stimulus, job creation, skilled labor, new hiring reports, losing jobs to overseas companies, so on and so forth... I am curious what the response would be from a politician in Carson City if I were to discuss with them a new industry.

In this industry, 80% of businesses would be classified as small businesses. It would be a business model that could operate equally in both urban and rural areas. It would not require any special locations to operate or any special raw materials and it would not involve government subsidized investment. Its effect on the environment would be similar to any other small business and it would not be a large consumer of any raw material. While many segments of the business would be focused on the private sector, others would serve a portion of the population receiving public assistance.

This new industry would require laborers skilled in a variety of tasks. Jobs would be available to a wide range of educational levels—graduates of high schools; technical schools with short programs; community college; and university bachelor's, master's and doctorate programs.

There would be opportunities for employees to go back to school to advance to more skilled positions. Wages would be above what is considered the "living wage" for one adult in Nevada of $8.60 per hour. A high school graduate could attend a one-year program at a community college and could start a full-time job with benefits at $16 per hour. After a few years of post-high school education, the starting pay could be between $35 and $40 per hour with full benefits. With experience, it would be possible for a high school graduate with no further education to someday be managing a million dollar business and making $20 to $30 an hour. Few industries in Nevada could go to Carson City with these numbers.

It would maybe be a tough sell in Carson City because the new industry isn't classified as "green" or "high tech". I would tell the politician that these jobs cannot be outsourced to other countries. This industry would be a prolific consumer of computers, software and CAD equipment. Some high tech companies would exist for the sole purpose of providing services to this new industry.

In addition to the suppliers and manufacturers, some located in state, it would be difficult to know how many accountants, lawyers, consultants, etc. would be utilized by this industry. One would also have to include the economic impact of the education institutions involved and the insurance industry involved as well.

So what would the response be when the politician discovered that new business was dentistry? Would I be shunned for daring to suggest that dentistry is a business?

According to 2011 research from the University Center for Economic Development at the University of Nevada–Reno, there are almost 1,100 dental offices employing over 7,100 individuals. The direct effect of this labor income is $566 million dollars annually, add in the total number of individuals effected by the industry, 13,090, and the total labor income climbs to $816 million dollars annually. Total sales in the dental industry in Nevada were estimated to be $961 million, or about $356 for each Nevada resident. And these businesses also give back to the community by financially supporting non-profit organization and providing free services to those in needs.

If a bicycle manufacturer employing six people were to open in Reno, it would be on the front page of the *Gazette-Journal's* Business section. According to the ADA, the annual economic impact of a dental office is conservatively measured at $2 million. If an orthodontist were to build and open an office in Sparks, it would a page six footnote in the *Northern Nevada Business Weekly*.

The temptation is to put a wind turbine on my practice's rooftop to get some support for our industry. ◆

This editorial was first published in the June/July 2011 issue of the Oregon Dental Association's Membership Matters *magazine. It was modified for use for a Nevada audience by Dr. Barry Taylor.*

Dr. Taylor practices dentistry in Beaverton, Oregon, and is editor of Membership Matters. *He can be reached at beavertondentist@yahoo.com.*

CEBJA…Say what? PART 2

By Dwyte E. Brooks, DMD

As stated in Part I (*NDJ*, Sum. 2011), CEBJA is the acronym for the Council on Ethics, Bylaws and Judicial Affairs. At the ADA level, this is a very active council all year around. At the NDA level, not so much. Most of the time, NDA CEBJA consists of the Council Chair waiting for something to be referred from the NDA Executive Committee, House of Delegates or from one of the constituents.

Typically, the items referred from the NDA deal with interpretations and changes in the NDA Constitution or Bylaws and issues concerning removal of officers, delegates and members. The procedures for removal of officers and members are well outlined in the bylaws. Interpretations and changes in the constitution and bylaws require that the chair review these at least twice a year—before the two annual meetings of the NDA House of Delegates—and evaluate the need to propose changes. At each meeting of the NDA Executive Committee and NDA House of Delegates, CEBJA can introduce draft resolutions for consideration as can any NDA Council, the Executive Committee, the House of Delegates or any member. CEBJA can then assist in the drafting of the resolutions prior to review by the Executive Committee and submission to the House of Delegates.

At the state level, the definitions of dental ethics and conduct are essentially those from the ADA. Occasionally, a state may have slight variations which are acceptable as long as they are no less than the foundational ADA codes and principles. Normally, CEBJA at the state level becomes involved when a case has been appealed from the Ethics Committee of the constituent or some type of disciplinary action has occurred by the State Board of Dental Examiners or the court system. A critical point to remember is that the standards for ethical conduct are far more stringent than civil law and although the civil court system may exonerate someone, they still may have committed an ethical violation of great magnitude. The actions of CEBJA may be as simple as a denial of the appeal or a hearing to allow the introduction of new evidence or arguments by counsel. Although an attorney may be included in an appeal process, as a membership organization the decisions in these cases are not subject to review or modification by civil courts. Decisions at the state level can be appealed to the ADA CEBJA and their decision is final.

In Peer Review cases, NDA CEBJA handles appeals from the constituents according to ADA guidelines. The appeal process can proceed only if one or more of three situations have occurred: proper procedures were not followed, new information has become available or the committee decision appears contrary to the information. If the appeal is appropriate, the Chair acts as a mediator and prepares the paperwork for submission to a committee of three dentists. They review the documentation provided but no clinical examinations are performed. After the members have reviewed the material, the mediator conducts a conference to allow open

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Addicted to Government

By Alieta Eck, MD

It begins with an injury—a torn shoulder, a crushing back mishap, an abdominal operation. The miracle medications relieve the pain very well. However pain has an emotional component, and in some patients the need for narcotics far exceeds the time frame of any typical physical condition.

Calm, emotional peace and a feeling of well-being can only be temporarily relieved by taking a pill. Yet the addict becomes consumed with the desire for the feeling that narcotic pain pills bring. They can become an obsession and the patient will magnify his symptoms to secure more. Getting back to work is delayed and the addiction firmly takes root. Ambition diminishes as the addict's mind becomes consumed with conniving for the next prescription—or buying the next stash from the underground black market.

Doctors want to relieve pain and must carefully discern each case. But drug pushers just want to get rich and callously disregard the well-being of the patient.

Family members are recruited by the addict to corroborate his stories and help secure the drugs, but they often fall victim to the lying and stealing, and spend their own resources that they can ill afford. Addicts become self-absorbed and indifferent to the pain they cause others. Arguments escalate as the addict is moody and unproductive.

The kindest thing to do is help the addict come to grips with his dilemma, show him he is not alone, and have volunteers come along side to demonstrate a way out.

In the pain of the Great Depression, President Roosevelt wanted to relieve the suffering, so he nationalized retirement income with Social Security. Then in 1965 President Johnson initiated the "Great Society" with the Medicaid program designed to relieve the poor of the fear of not being able to gain access to medical care. But socializing any society causes new problems when it rewards inactivity and irresponsible behavior. Why save when the government promises cradle to grave care? Politicians become enablers, taking pride in their reputation of wanting to relieve the pain of the poor while actually exploiting them for votes.

Today one in seven US citizens—55 million—are on Medicaid. The government funds the program by extracting money from productive family members and other taxpayers. The poor can become addicted to the government program, doing nothing to extract themselves out of poverty until the program is cut or reformed. Again, ambition takes a back seat. As Rudyard Kipling once said of socialism, "All men are paid for existing and no man must pay for his sins."

Watching the rioting in Greece, Great Britain, and Philadelphia ought to cause us to re-evaluate the social welfare networks. Have we created a nation of people addicted to government payouts? Politicians, the poor and some government workers have become addicted to the culture of dependence on taxpayer largesse, lashing out at anyone who suggests cutbacks. When reasonable people suggest ways to lower overall Medicaid costs, anger is the knee-jerk response.

Now key Democrats, in the epitome of irony, have notified the Supreme Court that they are challenging President Obama for his plan to allow states to determine the way they want to run the Medicaid program. They claim that allowing states to balance their budgets by ratcheting down Medicaid payments to physicians will decrease access to the poor. State legislators fear losing the half of the Medicaid funding that is federal, so are slow to do the right thing.

The government currently spends $1.40 for every $1 it receives in tax revenue. The next generation is being saddled with a debt they will never be able to repay.

As with narcotic addiction, the kindest solution is to help the poor understand their dilemma, show them that the government programs have trapped them in poverty and work toward a complete withdrawal from government schemes that take from one person and give to another. The solution is a culture of independence, more personal responsibility and self-reliance.

Dr. Eck graduated from Rutgers College of Pharmacy and St. Louis School of Medicine. She has been involved in health care reform since residency and is convinced that the government is a poor provider. She testified before the Joint Economic Committee of Congress in 2004 about better ways to deliver health care. In 2003 she and her husband founded Zarephath Health Center, a free clinic that currently cares for 300–400 patients per month via the services of volunteers. She is on the board of the Association of American Physicians and Surgeons, which has given permission to republish this article.

The AMA claims that "judicial enforcement is the only viable means to remedy states' noncompliance with the Medicaid Act." (Pear R, NYT, 8 Aug 2011) The AMA believes in coercion.

The AAPS, on the other hand, recognizes the danger of allowing the poor to make demands on their caregivers. It endorses the dismantling of the huge government programs and replacing them with private interactions between physician and patient, privately owned insurance and finally real charity and real access to medical care for the poor. ◆

CEBJA, continued

discussion and once a consensus is obtained, the Chair drafts a letter to all parties concerned. If the appeal is denied, the Peer Review decision stands. If the appeal is allowed, the case is returned to the constituent to repeat the Peer Review process with a new mediator and reviewers.

During this discussion, little has been said about the members of CEBJA. The Chair is appointed by the NDA President with approval from the Executive Committee. As additional members are needed for specific tasks, the Chair and President recruit dentists to serve on the ad hoc committees. They are selected for the task based upon their experience, integrity and knowledge and serve only until the assigned tasks are completed. The Council on Ethics, Bylaws and Judicial Affairs spends most of the time quietly lurking in the background. Like your conscience, it exists to serve as an ethical and principled guide during your journey through our profession. ◆

Dwyte E. Brooks, DMD, is Chair of the NDA Council on Ethics, Bylaws and Judicial Affairs and a member of the ADA Council on Ethics, Bylaws and Judicial Affairs.

Letters to the Editor

Re: Dental Establishments in Nevada

I would like to express my confusion with the article "Dental Establishments in Nevada." *(NDJ, Summer 2011)*

What was the point of the article? Is it supposed to do something good for addressing the State's dental manpower needs? Is it evidence based?

I am unfamiliar with the term "dental establishment," as it is used in the article like some kind of standard for measuring the delivery of dental care. The term seems misleading to me to determine the number of providers present, and necessary to meet the needs of a community.

For example, the article says there were only three dental establishments in Churchill County in 2008 for a population to dental establishment ratio of 1/8,297. That would appear to be a very large shortage of providers. But there were more than three dentists in the county then. There were so many dentists that the Federal government doesn't even list Churchill County as a dental provider shortage area. So what use is this information in planning for future dental manpower needs?

I am concerned that because the NDA published it, the article will now have some creditability and be cited by others who do not understand what was presented. To show how this information could be misused—according to the article, the state added only 17 dental establishments in rural counties from 2000–2008. One of the main reasons the UNLV Dental School was established, was to increase the number of rural dentists. Even though the state spends $8 million a year on the school and graduated around 400 students during this time, only 17 new dental establishments were formed. This study seems to show that we haven't had a good return on our investment.

Using "dental establishments" as a measuring standard for dental manpower needs makes as much sense as using parking places to determine hotel occupancy on the Strip. Sure, there is some relation to the number of parking places to the size of the hotel and the number of rooms, but can one really tell how many people are inside from the size of the parking lot?

Sincerely, *Steve Sill*

Author's Response

In his letter, Dr. Sill asked why a review of dental establishments in Nevada was carried out, whether it was evidence-based and whether "it is supposed to do something good for addressing the state's dental manpower needs."

As was stated in the article, our intent was to consider the dramatic changing settings and arrangements of dental practices. We presented data developed by the Census Bureau (we would assume that would be "evidence-based") to review " (sic)…the need to ensure that the delivery arrangements for care meets the needs of the state's residents." Specifically, our aim was to present an overview of developments beyond the general perspective of individual practitioners. Thus we included a series of specific rankings.

The review from the standpoint of "dental establishments" was based on decades of annual data collected by the Census Bureau to compare County Business Patterns throughout individual states and the country. The difficulty arises in attempting to compare the multitude of practice arrangements (solo, partnerships, corporations, etc) as developed by the ADA's annual survey of practice arrangements. We therefore used a standard system used throughout the country.

We emphasized the fact that a dental establishment may include any number of dental health professionals. The attempt was to determine the number of sites for dental services in the various counties, not actual manpower. Thus with several dental professionals per dental establishment in Churchill County, it may not qualify as a dental provider shortage area. Using the writer's parking lot analogy, the fact that there is a parking lot would indicate that there is a hotel, or in our study, a dental establishment.

The provision of health establishments in rural sites is a difficulty faced, not just by dentistry, but many other health service professions throughout the country. It is essential to continue to seek solutions.

The use of "dental establishment" data provides a second approach (to the standard dentist-to-population ratio) to evaluate the efforts to meet the dental health needs of our communities.

H. Barry Waldman
Steven P. Perlman

Re: ADA annual meeting follow-up

Dan, we talked about the first ADA meeting in Las Vegas in 1965. Somehow I got into a position as a delegate to the ADA to promote Las Vegas.

It would take a vote of the 13 members of the Board of Trustees of the ADA plus a vote of the House of Delegates, some 400 members.

The meeting to decide was held in Los Angeles and it was a riotous one with support for and against a Las Vegas venue. The board of trustees met a week before the convention and meeting of the House of Delegates.

I had, at that time, a very rich contractor patient from Iowa who had made his fortune during WWII by building airports for the Army Air Corps. He continued after the war and he and his wife made frequent visits to Las Vegas. They became wonderful patients and friends. He had converted a WWII twin engine bomber, luxuriously furnished with his own pilot and copilot.

When I told him of our plans to get the ADA convention to Las Vegas he offered his plane and pilots to go to Los Angeles and bring back five of the Trustees' wives along with the wife of the President of the ADA who was Dean of the University of Michigan Dental School, my alma mater.

So we sent the plane and brought the ladies to the Tropicana where Bob Cannon, a patient of mine, was the manager. He and Des Kelly, manager of the Convention Center met them, wined and dined them, took them to strip shows and put them up in suites in the Tropicana. The next morning, Mr. Everist, my rich contractor patient, escorted them to his plane, put them aboard and offered them drinks and food for the trip back to Los Angeles.

The plan worked because word got back to us that these ladies, in no uncertain terms, told their husbands that they were to vote for Las Vegas; and they did.

It now went to the House of Delegates for discussion and vote. You can imagine the scathing words said before that house. "Sin City," "lack of dignity," "loose women," "no one will attend the lectures or exhibits," etc, etc.

One good friend of mine, a delegate from California, listened to all of this, took the microphone and said, "I have heard enough of this talk of sin in Las Vegas, so I want you all to know that some of my very best sins were committed right here in Los Angeles."

We won by a small margin and the 1965 convention of the ADA was a great success with greater attendance at clinics and lectures and exhibits than ever before. The bottom line was the largest financial success that the ADA ever had.

Sincerely,

Dr Bob Morrison

Re: Telephone scam

I wanted to warn NDA members about a phone scam called "cramming." I just talked to the FTC (877-382-4357, www.ftc.gov). Cramming occurs when third party providers tack usage charges on to phone bills. On our bill, it showed up as a $49.95 charge listed under "Usage Charges" notated by "Third Party Provider."

After speaking to CenturyLink, I was given a number for Payment One (5883 Rue Ferrari, San Jose CA 95183; 888-238-5118; www.paymentone.com). I spoke to Joseph (employee #6044) who gave me two company names which use their services for billing. They bill thru the telephone companies for over 500 businesses. The businesses claiming that we use their services were EZ Connect Services and First Call Tech Support. Both used the same phone number (866-922-6208). I called this number, but it went immediately to a fax. Payment One told me that they would credit my bill for three months charges of $49.95/month—no hesitation at all—which tells me that they are well aware of the scam. I was told it would take 1–2 billing cycles for the refund.

The FTC encourages consumers to file complaints, even if refunds are made, because they are anxious for legislation to pass to regulate cramming. Currently, there are no regulations, and the phone companies take the word of the third party provider that their services have been authorized. CenturyLink Fraud Division (877-783-7283) said this is happening so much that they do not have the manpower to investigate, so they refer everything to the FTC.

It was a fluke that I noticed this charge buried in our land line phone bill. I called the Nevada Attorney General's office, but they no longer deal with any complaints other than mortgage fraud. I did request the phone company to specifically block any third party providers from issuing charges to our bill. I added a block on our lines from long distance carrier slamming years ago, but this new issue requires a specific block. I urge everyone to do so.

Best wishes, *Karen Lasiter*

Editor's Note The NDA thanks Ms. Lasiter, spouse of Las Vegas Prosthodontist, Nelson Lasiter.

Editor's Note

The recently concluded 2011 ADA Convention in Las Vegas, the city's 8th overall, resulted in the all-time cumulative attendance record for any ADA venue. Las Vegas also holds the single meeting attendance record (1995). Thank you Dr. Morrison!

In 2008, the SNDS created the annual Fae T. Ahlstrom Award recognizing the leadership, example, and lifetime commitment to the dental profession, and to organized dentistry in Southern Nevada. The Ahlstrom Award has been presented to Drs. James Jones (2008), William Busch (2009), William D. Berry (2010), and now Robert L. Morrison (2011). Congratulations to Dr. Morrison and the others so honored.

Health Care Reform's Impact on Dental Practice

By Edward Leone, Jr., DMD, MBA, RFC

The media is full of information over the controversies surrounding the implementation of health care reform legislation. This legislation sets the framework to get health insurance coverage to an increased portion of the population. The rules and regulations will be written by the bureaucracy in the Department of Health and Human Services. The purpose of this article is to bring to light the issues which deserve vigilance as rules and regulations are promulgated along with known aspects of the legislation to which we must adjust. We as health care professionals, have an obligation to be knowledgeable on the evolution of this issue. The motive comes in the need to consume health care services for ourselves and our families, the provision of insurance coverage for our employees and the considerations which will affect the way our patients consume oral health services.

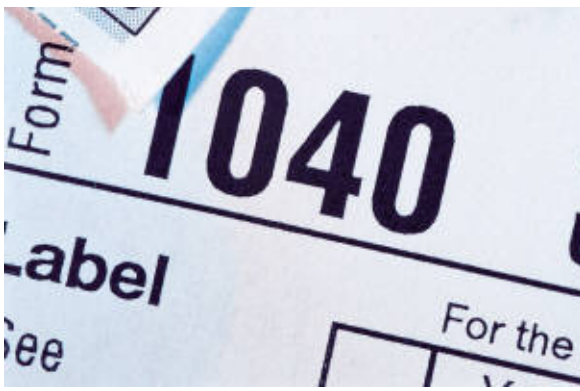
Current mandates

The issues which are of current interest revolve around the institution, in September of 2010, of mandates which dictate to health insurance providers that there be no limit on life time maximum benefits, no under writing criteria for pre-existing conditions and the continued coverage of dependents up to the age of 26 years in family plans. These mandates create upward pressure on health insurance premium structures since individuals with a likely higher claims incidence are included in the insured pool. It is possible that due to higher premiums for employers who offer health insurance to employees, adjustment in plan designs to shift costs to the insured along with a potential for reduction or elimination of adjunctive coverage such as vision and dental will occur.

Form 1040, FSAs, HSAs, Simple FSAs

There will be other changes as a result of heath care reform which will become visible in short order. The deductibility of health care expenses on schedule A of your 1040 will be subject to a threshold of 10% of adjusted gross income as opposed to the current 7.5% threshold. The contribution to FSAs will be capped at $2500 and not indexed for inflation. This is significant since many of us experience the scenario occurring near the end of a calendar year when a patient calls or visits the office with an inquiry as to how much they should commit to fund their FSA since they are considering that implant or fixed bridge you recommended as appropriate treatment for them. The FSA is a benefit to about 30% of the work force. It allows them to pay first dollar health service costs with pre-tax dollars while catastrophic health service needs are covered by high deductible lower cost health insurance. You may have an FSA for your employees. The effect of not indexing to inflation will be significant in future years as the purchasing power of that $2500 is reduced as a result of inflation pressures. It is evident that there will be a shift in these programs from the payment of first dollar costs with pre-tax dollars to after tax dollars. It should also be noted that as of the 2010 tax year, over the counter products cannot be paid for with FSA

Dr. Leone has been a clinical practicing dentist for 39 years and is a past President of the Metropolitan Denver Dental Society and a past President of the Colorado Dental Association. He is currently serving the profession of dentistry as the Treasurer of the American Dental Association. Dr. Leone is also an Associate with GHP Investment Advisors in Denver Colorado.



funds. The change to HSAs is also a matter of note. Distributions from an HSA prior to age 59 for a purpose other than health related costs will be taxed as ordinary income with a 20% penalty as opposed to the current 10% penalty. There is a provision in the legislation that provides an opportunity for small businesses to establish a Simple FSA. Much as is the pattern with a Simple IRA, there is no antidiscrimination standard in place here. It is possible for a business owner with a Simple FSA to fund employees at different levels.

Additional features

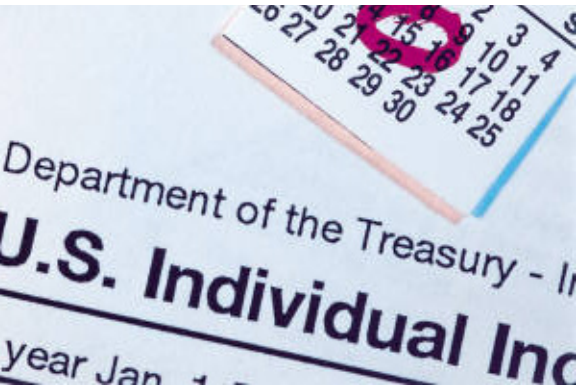
Other elements of this legislation which will unfold up through 2014 are:

- Closing the donut hole regarding prescription drug coverage under Medicare part D
- Provision for a National Long Term Care Program
- Health Care Insurance Exchanges sponsored by state government

The value which these enhancements will bring to the population is an unknown as are associated costs.

Penalties and credits

If you are not offering health insurance to your employees and you employ less than 50 individuals, your business will not be subject to any federal penalties. If you do offer health coverage to your employees, your business may be entitled to a tax credit. The rules for qualifying are as follows:



1. Your business employs ten people or less
2. Salaries must average $25,000 or less and phase out up to $50,000 average salary
3. Your businesses must cover 50% or more of insurance costs
4. This incentive will last for six years and then terminate

It is clear that this incentive is designed to get as many small businesses as possible to offer health care insurance to employees. Once the habit is established, the incentive goes away. You will need some help from your accountant to figure out the possibility for your business to take advantage of this credit. The variability rests with your ownership form (C corporation, S corporation, partnership or sole proprietor) and the salary structure for you employees and yourself. Your business will also be required to show insurance benefits costs on the employee's W-2. This is a great way to demonstrate to employees, the value of the benefit you are providing to them. Is this the first step in making this benefit taxable though?

Additional tax burdens

The final round of considerations addresses tax increases included in the legislation. A 2.3% tax will be placed on medical devices. Could dental devices such as a denture or an implant be defined as medical devices? Will the tax be imposed at the point of fabrication or at the point of placement? Will we have to collect this tax and transmit it to the Federal Government? None of these issues are clear to us at this point in time. If you earn $200,000 as an individual or $250,000 as a couple filing a joint tax return, an additional .9% payroll tax will be imposed and applied to Medicare funding. If your net investment income is $200,000 as an individual or $250,000 as a couple filing a joint return, a 3.8% tax will be placed on that income and dedicated to Medicare funding. This can reduce returns dramatically. You will need the help of your financial planner, accountant and estate attorney working as a team to navigate this particular tax issue.

It may very well be that some elements of this legislation prove to be unworkable and will require adjustment or deletion from the master plan. There will be much activity to monitor as the rules and regulations under which we function as consumers of health care services and providers of health care services are developed. ◆

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Reshaping Healthcare

By Quinn Dufurrena, DDS, JD

Health-care is one of the fastest growing costs for individuals, businesses and government. The United States healthcare system is unsustainable. Woodrow Wilson said, "If you want to make enemies, try to change something." So enemies we must make. When dealing with health care, we can longer afford the status quo. It is time to change the way we view health care and all its ramifications.

We need to change our basic philosophy. Not all nations' philosophies are the same. Let's compare a basic healthcare philosophy by looking at two individuals—François and Frank:

Both are 70 years old. Both are overweight: they enjoy their wine and rich foods. Both have bad knees. François is given a cane; complements of the French government. Frank has had both knees replaced to the tune of $35,000 per knee; indirectly paid for by the taxpayers of the United States in the form of Medicare.

So which healthcare system is better? I guess that depends on how you define "better." According to the World Health Organization (WHO) France is ranked as the number one health-care system in the world. The United States is ranked 37th—slightly better than Cuba and one notch above Slovenia. The United States spends 15.4% of its gross domestic product on health care. France, on the other hand, spends only 10.5% of its GDP on Health Care.

Why is health care so expensive in America? Americans regard health care as one of their top priorities and are willing to spend more not less on healthcare. Many have an illusion that there is an endless pool of money that will allow us to do everything medically desirable with no restraints. In the US, we have created more expertise and technology than we can afford to deliver to everyone.

In fact, many Americans have come to view health care as a "right." The problem with this is that they want someone else to pay for their "right." The problem with a right is that they are defined and interpreted by our judicial system. Language from our courts is developed in an adversarial process and, in this case, is counter-productive to our society's well-being. The judicial language of "rights" does not address how to allocate finite resources over infinite demands. Although prudent to provide basic health care to all our citizens, the allocation should be through the methodical process of the Legislature and not our courts.

It has been estimated that with the present growth of healthcare spending, by 2065, America will be spending 100% of its gross domestic product on healthcare (Princeton economist Rinehart). That means; no education, no defense, no money left over after funding healthcare. Such a system is inequitable and unsustainable.

Where is all this money going? You need only walk through a hospital and view into the rooms to realize where most of our health care resources are expended. They are expended on the elderly with chronic late life diseases.

Dr. Dufurrena is the Executive Director of the Colorado Dental Association

At present, America spends 27% of its health-care dollars on the sickest 1% of its people yet it spends only 3% of its healthcare dollars on the bottom 50% of its population. Treating chronic diseases causes the overwhelming majority of healthcare costs in United States.

It is time to change this debilitating ratio by looking from a society view, a broader panoramic perspective. We, as a society, must address the hard issues of allocating resources for healthcare. It comes down to basic mathematics; geometric growth cannot be sustained. There are not enough financial resources, doctors, nurses, technology, drugs etc. to give every person everything they want in healthcare. As such, I propose a different allocation of resources than presently exists.

We must re-allocate our resources toward prevention. I propose that medicine be structured, in one aspect, more closely to dentistry; with a greater amount of allocated resources going toward prevention and education.

In dentistry we know that early diagnosis, preventive treatments and early intervention can prevent most oral diseases that, when left untreated, have expensive and lasting health consequences.

Maybe France is ranked higher because they spend more on prevention and less on chronic diseases? France enjoys better cardiac health, than its neighbors, because it has a strong preventive cardiac program.

There will always be ten leading causes of death no matter the resources and technology used to eliminate them.

We have many choices, concerning health that we make along the road of life. One of our toughest decisions will be dealing with the issues of what aspect of beneficial medicine can we ethically avoid funding.

We need to learn from others and re-allocate our resources and instead of supplying Frank with two new knees he gets a cane like François. The money spent on Frank's knees could be reallocated to education in preventive medicine like obesity, smoking and all those other nasty habits we have. And while we're at it; let's give Frank some floss and show him how to use it.

Our present health care system is unsustainable. Now is the time to make difficult decisions. We need to be the master of change and not the victim of inaction. ◆

Universal Oral Health Care Possible Today

By Franson KS Tom, MS, DMD

Medical health insurance is totally different than dental insurance, but the solution to universal oral health care may be buried in the third party profit motivated medical model that replaced the Hippocratic Oath after World War II. Millions died, but millions more were injured, so each country had to address health care as they rebuilt. Everywhere except the United States, governments supported universal, socially oriented, managed care. By the 1960s, in the US, prepaid group health care plans for healthy employees had evolved. Fortunately, oral health often does not involve life and death decision making with the associated costs, so realistic oral health funding solutions are possible.

In the early 1970s, prepaid group health care plans as health maintenance organizations (HMOs) evolved with legislation that provided for federal endorsement, certification, and assistance. HMOs today are widely seen as agents of cost containment. The proportion of HMO members enrolled in for-profit plans increased from 12% in 1981 to about 62% in 1998. Nearly 75% of HMOs are now for-profit, shareholder-owned corporate run plans.[1] HMO physicians are now caught between patients anxious about the availability and reliability of care and investors demanding further cost control, in part through financial pressure on doctors. In the race to the bottom line in price, HMOs appear to embrace practice models physicians once abhorred.[1]

Meanwhile, the focus on finances by third parties has compromised the patient-doctor relationship of trust and respect. Doctors have not changed as a profession that maintains the time honored Hippocratic Oath of helping mankind with integrity, autonomy, non-maleficence, beneficence, justice, and veracity over personal gain. But, controlling third parties base health care decisions on profits.[1] Third parties have a model that makes it difficult to remain an ethical provider because of mandated profit margins. Profit motivated HMOs have not worked well for patients or doctors.

Third party insurers attempt to divert responsibility for geometric premium increases coupled with less and lower quality care by blaming doctors, hospitals, and demanding patients. Yet insurers legally price fix reimbursement and unilaterally deny patient services for profit motivated purposes. Busy employers don't realize they are paying more each year for less and lower quality care. Not surprisingly, the resultant profits disappear into administrative bonuses and other corporate expenses. Bonuses, reserves, and investments that could support health care in a more altruistic model benefit patients and doctors less and less.

HMOs require participating physicians to assume substantial financial risks with respect to the costs of the care they provide. Capitation, or an inadequate flat fee per member per month, encourages early non treatment, and guarantees more complicated future diagnoses, in order to achieve a reasonable profit and limit physician financial exposure. Withholding a large portion of income and paying bonuses based on meeting financial targets reinforced with "de-selecting" unprofitable physicians exacerbates the same results. Second, gatekeeper primary care physicians are inefficient for cases when specialists are needed. Third, low risk patient selection shifts high-cost, inefficient patients to other plans like Medicaid and Medicare. Fourth, "imperatives to reduce needless variation can translate into simple pressure to reduce utilization… by blocking specialist referrals and hospital admissions altogether." Fifth, external vendors for preapproval and utilization review stints services and increases suffering to patients, families, or physicians by "managing costs" versus "managing care."[1]

Dental insurance is different from health insurance in that at this time it is more economical, more efficient, and much better quality. A viable model involves prepayment to a dentist with a smaller amount than prepaid to the third parties that profit

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by delivering minimal services. Typically, dentally insured patients think everything is covered but the fact is the list of services is generally extremely limited. A proof is the patient authorization and claim form that professional staff has difficulty completing "correctly," per the latest annual requirements, even with a computer. Large patient co-pays required out-of-pocket are not covered. Also, only a very low maximum annual benefit exists that has not changed since the 1960s. Less than 5% of premium payers ever get the maximum annual benefit. The $1000 annual maximum hasn't kept up with inflation for decades while premiums increase 150% every decade. Plan administrators complain about the annual maximum benefit and deliberately withhold huge cash reserves to cover a potential 100% payout, but again rarely payout 5%. Plans can earn more interest on huge cash reserves than they pay. Further, dentists create treatment plans according to oral health needs, while third parties treatment plan according to profits. Third parties even blame dentists when treatment plans are rejected and patients are lead to believe it is the dentists' greedy fault. Even when dentist call the third parties for approval, so they can collect the appropriate patient co-payment, third parties begin and end the call with "this does not guarantee any reimbursement." Finally, the average $600/year premium only pays $30/year benefits which results in $570/year profit for the third party. Cumulatively, employer premium payers pay $12,000/20 year life of employee for an average of $600/life of services.

Many practicing dentists with 2000 patients receiving a $50/month direct prepayment/patient ($1.2 million/year) would be focused and more than happy to keep 2000 patients healthy. Which oral health system do we want?

Oral health care can become universal by redirection of current premiums directly to dentists. A fair market value "UCR" fee could even be established and updated once the McCarran-Ferguson Act is amended to include dentists. After emergency care, standardized diagnostic procedures establish the intermediate foundations necessary for final, long lasting, outcomes and maintenance with an emphasis on prevention and education before, during, and after treatment. Treatment outside of the knowledge and skill of general dentists are easily defined and referred to specialists.

Finances are easily controlled by issuing debit cards with an annual maximum determined by the employers paying the premium ($600/year/employee). Without third party interference, patients and doctors can easily work within this budget to provide more care than offered in the current typical paradigm. Even with dental insurance, all premium paying patients pay their uncovered balances out of pocket which automatically influences oral health care decisions to proven treatments. More expensive "elective" services are already out of pocket, but can be affordable with the suggested payment model, and even spread over time since premiums would not disappear at the end of every year, but would accumulate during employment and beyond. Since only 50% of premium payers see a dentist, the initial expense might be $1000/year for the first three to five years to establish a good foundation for natural preventive maintenance. Patients could be rewarded with the $1000 annual maximum for regular 6-month periodic exam, prophylaxis, and necessary radiographs.

Prevention and maintenance of a healthy mouth is less expensive and more predictable with patient cooperation and well-established, objective monitoring. Poor oral hygiene, damaging diets, habits, deferred 6-month exams, cleanings, radiographs, and treatment of incipient conditions leads to the high cost of oral health care. Patients who live this lifestyle should be responsible for the increased costs.

This model helps present patients with multiple restorations and missing teeth have a workable plan compared to planning that is depriving them of care now. Furthermore, no dentist is bonused for engaging in more aggressive risk selection; or more stringent system approval, cost containment, and denial or rationing of care.

Provider dentists would agree to provide services according to this new paradigm which will not cost more than the current premiums paid by employers. Specialists can work within this system. That's more than enough work and profit for any practicing dentist in a competitive, fee-for-service, free enterprise America. It may even open the door to mentoring young professional associates, and alphabet mini-dents like Community Dental Health Coordinator (CDHC), Expanded Function Dental Auxiliary (EFDA), Advanced Dental Hygiene Practitioner (ADHP), and Dental Health Aide Therapist (DHAT). Dentists focused on oral health over financial concerns will enjoy an immediate increase in patient satisfaction. It can become a non-government supported, affordable national wide program re-establishing the patient-doctor relationship based on the Hippocratic Oath, selflessness, excellence, and trust that we all want. ◆

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Laser Safety in Dentistry

By William P. Leavitt, DDS, MPA

Laser radiation safety may soon be knocking at every dental office door in Nevada. After several impromptu office visits, it is obvious some seasoned laser users, without even a single laser related complication, may benefit from a review of laser safety training. Just as when pioneers in ultra-violet radiation (x-rays, gamma rays) later discovered needful safety measures, today we know laser damage can go undiagnosed for years. A lack of contemporary application of laser safety can pose a rather dangerous situation for dentists, patients, and auxiliaries. This article will identify areas with which every laser-using dentist must be proactive. Rather than go through a plethora of legal issues, this article will highlight three fundamental laser safety topics. All three can easily be resolved with simple, consistent controls and protective measures.

In 1996 the American National Standards Institute (ANSI) identified safety measures and controls needed in every health care facility using a laser system. Yes, this means ANSI identified standards for every dental office in the US. Oh boy, another referee[1] added to the dental milieu. Unless one has parted with the necessary 'C'+'D'-Treasury Notes to purchase ANSI's booklet, one may not know about all the itemized laser regulations for dental offices.

Dr. Leavitt is the Laser Safety Officer, Laser Certification Course Director, and Laser Safety Trainer at the UNLV SDM.

Dentists who have used lasers for a number of years well understand the devices they use. However, unless their continuing education is updated in laser safety protocols, they risk leaving a high risk issue unaddressed.

Recently, I was made aware of this possibility in a most emphatic way. Essentially, a long-time laser using dentist wrote an email stating the diode laser he had been using didn't cause any eye damage, and therefore didn't require eye protection. He failed

to mention whether or not he had delineated a nominal hazard zone (NHZ) in his office. Although the laser device he was using had a nominal ocular hazard distance (NOHD) of only 2.96 feet, it could affect eyes within that distance, including those of observers, operators, patients and auxiliaries. Perhaps he mistakenly thought diode lasers are less powerful and therefore don't have as much potential for eye damage. Diode lasers are actually the most harmful to the eye of all dental lasers, not because of wattage, but because of wavelength.[2]

If one has been using a laser (e.g., eZlase, iLase, NV, Micro980, Navigator, Odyssey, etc.) and has not consistently required eye protection for auxiliaries, an auxiliary could sue for ocular damage diagnosed years later. Diode lasers primarily affect the retina and conjunctiva. Erbium-doped (e.g., Waterlase, VersaWave) and CO_2 laser beams don't penetrate past the aqueous portions of the eye, primarily affecting the eye's watery parts. Each laser device requires eye protection for its wavelength. An Optical Density (OD) rating also is given for that wavelength. The OD should be at least '4+' but most prefer at least a '5'.

The second fundamental is one not so well known. It centers on the 'Laser Plume'.[3] Plume is what ANSI calls the 'laser generated airborne contaminants' portion of laser operation. When a laser is used, contaminants are generated as a colorless airborne cloud of gases, vapors, and aerosols containing viable bacteria, viruses, cellular debris, and/or noxious fumes called a "plume." These contaminants require filtering with a .1 micron airway mask. Generic face masks do not adequately filter such contaminants. Anyone breathing such aerosol contaminants can infest their bronchial mucosal tissues, making it possible for them to become blood-borne.[4,5] Individuals may develop shortness of breath, asthma, infection, an uncontrollable cough, etc. and may become another potential litigant.

Included in this second area, is consideration for "splash back" or blood spatter from laser devices. In a study done by the Univ. of California, San Francisco[6] it was discovered that laser devices used in the oral cavity will spatter liquids up to 10 centimeters from their tip. This is usually diminished

through high speed evacuation (HVE). Proper disposable shielding of laser handpieces should always be utilized and considered part of biologic waste.

The third fundamental area is the Laser Safety Officer. ANSI standards make it mandatory for every facility using a Class 4 dental laser to have a LSO. There must be an accompanying manual of controls and safety measures. These can be taken from ANSI's booklet and applied to situations but must include emergency procedures, standard operating procedures, maintenance, etc.

Although the non-ADA affiliated Academy of Laser Dentistry (ALD) identifies safety fundamentals in its Curriculum Guidelines and Standards for Dental Laser Education, most educators tend to superficially handle them during their brief seminars. Realistically, in allowing adequate time for the required discussions and understanding of physics, history, and principles before issuing a certificate of laser training, some instructors tend to minimize safety training. To be fair, most include discussions on wearing protective eyewear and displaying the required signage. A few discuss the need for a .1 micron airway mask. But, how many former students recall the presentation including required marking of the NOHD, assigning a LSO, or an office manual containing Laser Safety Control Measures? It may be that there is not enough consistency in approved laser certification courses to provide dentists a clear understanding of all required facility laser safety protocols.

The Nevada State Board of Dental Examiners is currently reviewing several laser incidents. The Board may soon see a need to require dental auxiliary laser safety training certification as well. Similar to x-ray devices, laser devices emit damaging radiation. Similar to dental handpieces, laser devices emit colorless contaminated aerosols. Perhaps Nevada dentists can expect to document fulfillment of such training via another check box on renewal applications. ◆

Thanks to NDA employee and graphic artist Anthony Ferreri for this cartoon submission.

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Reflections on Light

By Robert E. Horseman, DDS

I'm getting along in years now and with more time on my hands, I'm starting to think more about The End than The Beginning. When I used to go to Sunday School with a dime tied in the corner of my handkerchief for the offering, I recall being told that, assuming we got there, Heaven would be a place where all our questions would be answered, where perfect understanding would at last be ours and presumably there would be no pop quizzes to spoil the lessons. That pleases me to no end, because I have some questions that need answering.

People who regularly report to the *National Enquirer* about their out-of-body experiences all seem to agree on one point—they are all drawn, as if by a celestial magnet, toward a beautiful white light. So one of the first things I will do when I get there is ask some questions about light and its properties. This has been bothering me for a long time, ever since the fifth grade when I first learned that light travels at a speed of 186,282 miles a second.

The concept of light traveling is unclear to me. I think light just is. Or it isn't. That's what switches are for. Click! Light on. Click! Light off. I remember myself clearly at ten years of age as a sort of prepubescent detective Columbo bracing my teacher: "Ma'am, could I ask you just one question here? I'm a little confused, I won't take a minute of your time, I know you're busy. I apologize for bothering you, but maybe you could just help me out here. Just for a minute, I won't keep you."

Then I would try to find out how we know that it takes light 32 light years to travel from a certain star to the Earth. Who threw that switch? Is this written down someplace? What makes light go? Why doesn't it just stay where it is? Does it go in a straight line just to our planet like a flashlight beam, or does it go to all the other planets as well and at the same time? My teacher aged visibly during the fifth grade, developed a tic and seemed genuinely relieved when we got off astronomy and into the American Revolution.

But now, some eighty years later, I still wonder about the mysteries of light. The smallest unit of light is called a 'photon.' I thought that was a Japanese bed. Did you know that? I

Robert E. Horseman, DDS, graduated from USC SD in 1943, was a USN Marine Pilot in WWII. He has practiced dentistry from California to Australia and back and is a long-time Contributing Editor for the Journal of the California Dental Association. *He is now retired and enjoys making it through each day.*

don't mean to bother you, but there's just one more thing. Like, if I point a flashlight with a couple of C cells into the dark, the beam will penetrate, say, a hundred feet or so and then what? Does the light say, "Well, that's it! I'm pooped, I can't go any farther, I'm not gonna make it!" and just stops in midair or describes a gentle trajectory towards the ground? At 186,282 miles a second, it doesn't have much time to decide on a course of action.

It must be the same with these distant stars. Suppose some folks on Alpha Centauri want to dazzle us with a little light show, some colored strobes and dancing fountains; anybody in charge there would veto this idea as impractical because it would take 157 gazillion years for the display to reach us and by that time most of us would have tired of waiting and gone home. "These Earthling have no patience," the Alpha Centaurians would complain. "They won't even wait for Christmas, start decorating in October, for crying out loud!"

And since the Earth turns on its axis (another leap of faith), suppose the light did finally reach us and we were on the opposite side? By the time we found a parking space and located a good viewing angle—WHOOM!—at 11,176,920 miles an hour, the show would be over and we would have missed the whole thing. Then would the light have just gone on forever? My flashlight won't; even with fresh alkaline cells.

From a practical viewpoint, our light would take as long to get to them as theirs to us, so what they are looking at even as we speak is probably primordial ooze and not even worth sending down a saucer to check out.

With dentistry edging into lasers at slightly less than the speed of light, could I bother to ask one little question here? There's something I don't understand. I'm sorry, it's not your fault, it's mine. I know you told me all this before, but could we just go over it once more? Just take a minute. I remember the acronym stands for "light amplification by stimulated emission of radiation," or LABSEOR, which was shortened to LASER because 'by' and 'of' are prepositions and thus forbidden to appear in the middle of acronyms by the Joint Emergency Reserve Kibitzer Service (J.E.R.K.S.).

Laser's big feature is that it's coherent light. What might render you incoherent is the price. What do I get for my $40,000 laser besides some fancy light that can cut, coagulate and vaporize? Could I achieve the same degree of one-upsmanship on the cutting edge of my ever-shortening life with a $40,000 BMW? I know it will only go about 120 mph, but at least it's the kind of traveling I understand. ◆

Health Savings Accounts

By Rock Rocheleau

One of the biggest health insurance trends is the use of Health Savings Account (HSA) eligible health plans. According to consulting firm Celent the number of HSA accounts has increased by 73% from 2006 to 2008. HSA accounts were authorized in 2003 by President George W. Bush with the intention of providing an alternative way for consumers to pay for medical expenses.

HSA eligible health plans are High Deductible Health Plans (HDHP) that provide coverage with a higher than normal yearly deductible; $1,500 or $2,500 compared to $500. There is a little confusion between HSAs and HDHPs because an HSA is often incorrectly referred to as the health plan. The health plan is actually the HDHP and the HSA is a tax free investment account that you are allowed to deposit money into to pay for qualified medical expenses. You cannot open an HSA unless you have a qualified HDHP so most consumers and agents, like me, simply call qualified HDHPs HSAs.

Aside from the confusion HSAs are an excellent option. Here is how it would work. Let's say you have a health plan with $500 yearly deductible that costs $300 a month. You are switching to a HDHP with a $1,500 yearly deductible that only costs $200 a month. The HDHP saves you a $100 a month or $1,200 a year in premium. Your premium savings of $1,200 a year would cover the potential cost of the higher deductible. Deposit the $1,200 tax free, into an HSA bank account and the money can be used for "qualified" medical expenses. Additionally, if the money is not used it accumulates for future medical expenses or it may accumulate with interest and be a source of income after retirement.

The advantage of an HSA comes down to basic arithmetic. As a consumer you are willing to take on a small risk and pay more of the medical expenses if a major illness or accidents occurs in exchange for a lower premium. The lower premium provides you the savings that can applied towards the potential medical expense. I say potential because HSA's typically do not make sense if you have medical conditions that are known to exceed your yearly deductible.

Answers to common HSA questions:

How much can I contribute to my HSA each year?

The yearly amount of deposits into your HSA cannot exceed $3,000 for individual and $5,950 for family. If you are over 55 you can contribute and extra $1,000 a year into your HSA.

Do my HSA contributions have to be made in equal amounts each month?

No, you can contribute in a lump sum or in any amounts or frequency you wish. However, your account trustee (bank, credit union, insurer, etc.) can impose minimum deposit and balance requirements.

Can my employer contribute to my HSA?

Contributions to HSAs can be made by you, your employer, or both. Contributions to HSAs can be made by you, your employer, or both. All contributions are added to determine whether you have contributed the maximum allowed. If your employer contributes some of the money, you can make up the difference.

What are "qualified medical expenses"?

Qualified medical expenses are any expense that would be covered by your health plan and a corresponds to a list of items updated annually by the IRS. This list currently includes costs like dental exams, vision exams, lasik eye surgery, durable medical equipment, and over the counter prescriptions.

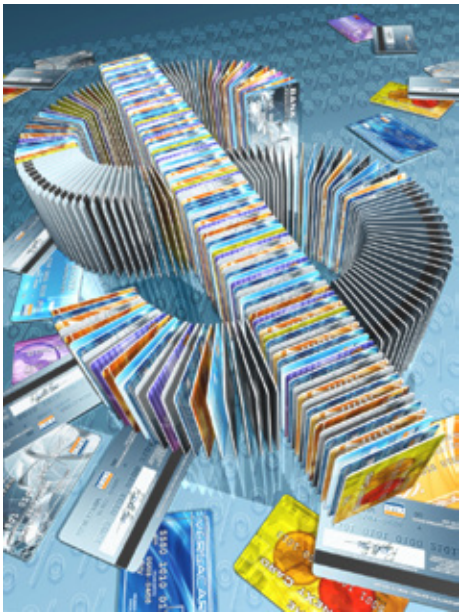
When would you recommend an HSA?

HDHP health plans are best when the yearly premiums savings of the HDHP compensates for the higher deducible or when a consumer is willing to accept a higher deductible on the hopes that they will not have a lot of medical expenses this year. ◆

Rock Rocheleau is President of Brock-Rock Insurance Group and has been providing health insurance in Nevada for over 10 years.

Affiliate news from Best Card

Changes in the credit card processing industry that affect your practice



Debit card processing costs are decreasing due to the Durbin Amendment of the Dodd Frank Act. Effective October 1, 2011, **banks with greater than $10 billion in assets that issue debit cards will have their earned fees capped at 21 cents per transaction and .05%.** There are additional fees paid to Visa/MasterCard/Discover and to your credit card processing company to process these transactions. Banks with less than $10 billion in assets have no regulatory rate caps. How much can a dental office expect to save? Best Card, the NDA's endorsed credit card processing company, estimates that their dental practices will save between $40–100 per month (approximately 40% debit card savings).

NOTE: it is *not mandatory* that your credit card processor pass the lower debit fees on to your dental practice in the form of lower rates. If you do not see a notice regarding debit rates being lowered on your recent credit card processing statement, chances are your processor is not passing their savings on to you.

A New Mandatory IRS law is effective January 2012. The Federal Housing Assistance Tax Act of 2008 includes the enactment of Section 6050W of the Internal Revenue Code. **All credit card processors must annually report credit card payment card activity to the IRS for all merchants.** Processors will be required to file an annual information return with the IRS and provide each merchant with a corresponding Form 1099-K, reporting monthly and annual gross sales effective January, 2012 for 2011 calendar year transaction activity. Section 6050W also requires reporting entities to perform backup withholding from merchant funding by deducting and withholding Federal income tax, (Federal withholding is currently 28%) from the gross sales amount of reportable transactions if (a) the merchant fails to provide the merchant's TIN to the reporting entity (withholding begins January 1, 2012), or (b) the IRS notifies the reporting entity that the TIN (when matched with the name) is incorrect (withholding begins after notification from the IRS). *To avoid backup withholding, it is critical that merchants provide the same name and TIN* (also known as EIN-Employer Identification Number) *to their processor that they use when filing their tax return.* Many credit card processors are reporting as high as a 50% mismatch rate (our endorsed credit card processor, Best Card, had a mismatch rate of less than 6% and is contacting those dentists to correct the TIN information). *If your credit card processor has not specifically told you that your information matches, contact your credit card processor to verify that you are not a mismatch or your dental practice could have 28% of your credit card deposit volume withheld beginning January 2012.*

Implementation is costly and nearly all processors have begun charging a monthly regulatory bundle fee (Best Card has a $3.95 fee while many processors are charging up to $9.95.) If you have a mismatch, you will also be charged a monthly IRS noncompliance fee (Best Card charges $8.95 while many other processors are charging up to $19.95).

Read that contract! Before you sign a contract for credit card processing, know all terms. Carefully *check lease costs and all fees*, including termination and PCI compliance fees. Many processors charge $30–150/month for 48-month leases; Best Card sells PCI compliant equipment as low as one payment of $100 and you own it outright. Most processors have 3-year contracts with $500–1,500 early termination fees; Best Card has a low $25 close fee. Most processors charge an annual PCI (payment card industry) compliance fee of $79–129; Best Card charges $30. ◆

If you have additional questions on the above regulatory requirements, call your present processor or call Best Card at 877-739-3952. The fees you are paying to accept credit cards may be too high. Fax a credit card processing statement to 866-717-7247 and Best Card will prepare a detailed, confidential and complimentary cost comparison. Dental practices that have switched to Best Card have saved an average 23% annually in credit card processing fees!

SNDS Executive Director's Message

Robert Anderson

I hope everyone had a wonderful summer and had a chance to get away, spend time with family and friends, and enjoy our clear skies here in southern Nevada. Though we have no membership meetings during the summer, it's a busy time for the SNDS behind the scenes, putting together the details of our program year.

We kicked off our program season with our annual Community Night event. Just over 40 exhibitors joined almost 130 dentists in what is always our largest, best attended meeting of the year. In addition to the great door prizes donated by our corporate partners, and the Gold Coast's great prime rib dinner, the highlight of the evening was the presentation of the Fae Ahlstrom Heritage Award.

This award honors those who played a significant role in their community and in organized dentistry in southern Nevada. This year, our recipient **Dr. Robert Morrison**, certainly filled the bill. Dr. Morrison graduated from dental school in 1951 and has been licensed in Nevada since 1952. During that time he served as President of the then Clark County Dental Society and later the Nevada Dental Association. He went on to serve as our ADA District Trustee and then as a candidate for President of the American Dental Association. In his spare time, Dr. Morrison also hiked the length of Great Britain over two summers, and published a book about his exploits. Now retired and living in Kentucky, Dr. Morrison was not able to attend Community Night because he was on a cruise in Alaska! His son, Dr. Dougal Morrison, a longtime Las Vegas optometrist, was on hand to receive the award for his father.

Also in attendance was a longtime friend of Dr. Morrison, and namesake of our award, **Dr. Fae Ahlstrom**. She and her family were a delight, as always. We enjoyed hosting Dr. Robert Ahlstrom, who practices in Reno, but made the trip to Las Vegas for the Community Night presentation of the Fae Ahlstrom Heritage Award.

We also announced our 2011–2012 Continuing Education Series, and posted it on our website. With the ADA Annual Meeting in Las Vegas this October, we are not kicking off our CE series until November 18, when we host Dr. Paul Homoly. Our series then continues with Dr. Baldwin Marchack joining us on March 23, 2012, Dr. James Jacobs on April 20, and Amy Parrish and Carrie Webber rounding out our series on May 4. There is no fee increase this year for SNDS members, and all four seminars (24 CEUs) are available at a $750 subscription rate for the series. Naturally, seminars are available on an individual basis, and all are at a discounted rate for SNDS members.

In other CE news, the SNDS will be expanding our popular CE Café series to six seminars this year. Each seminar will be held after work, with a light dinner at 6:00 pm and a two-hour seminar from 6:30–8:30 pm. The seminars will be held at Nevada State Bank locations around the valley, and Burkhart Dental will be helping with food and speaker arrangements. Because of these great sponsors, there is no cost for this series to the Society, so all six seminars are free to SNDS members! We do ask that you RSVP to the SNDS office prior to the seminar so that we have a head count. Look for a complete schedule in the CE section of our website, or call the SNDS office. We are very happy that we are not only able to continue to offer the CE Café series free to members, but can expand the series as well! SNDS members can acquire a combined total of 12 free CEUs by attending all six seminars.

We also hope to see everyone at our November member dinner meeting on November 8 at the Gold Coast Hotel. Watch for the Prezfax for details about our program for the evening!

With so much going on, this is an excellent time for members to invite non-member colleagues to join the ADA/NDA/SNDS. If you'd like to invite a colleague to the November dinner meeting as a guest, contact the SNDS office so we can make sure your guest is welcomed. I'm happy to report that our membership numbers are growing this year, mostly thanks to personal contacts from members.

I hope that as the seasons change and we enjoy more moderate temperatures in Las Vegas, that you get out and enjoy what our area has to offer, and continue to work together to put a smile on southern Nevada! ◆

One of my goals for this year is to make the Southern Nevada Dental Society a "home" for dental continuing education. We in Las Vegas are blessed with great weather, numerous outdoor activities, wonderful shows and superb dining. If we can successfully tie these to a series of first-class dental CE, we can become a mecca for dentists worldwide. Ask any dentist in the northeastern U.S. if they would rather attend a CE course in Las Vegas during December or stay home in the cold and snow!

Our present CE program is strong enough that we're able to produce non-dues revenue, which means, that we don't have to raise dues to provide benefits to our membership. I would like these revenues to increase and thus do even more for members!

Here's an explanation:
Non-dues income
= more member benefits
= more members

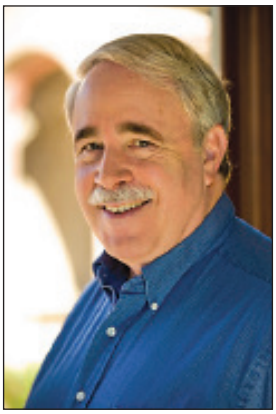
Our business partners (aka corporate sponsors) help us provide meals at no cost to members at our regular meetings at the Gold Coast Hotel. Income from our highly successful Infection Control courses and from Community Night also help balance our budget successfully.

One of the first steps for our CE program was to increase the number of CE Café meetings from four to six. If you haven't been paying attention, members can now receive 12 hours of CE for *free*! The programs are held after work and highly socialized—people like to actually talk to each other. What a concept! Upcoming courses include: "Turning Patients Into Raving Fans," "Last Minute Tax Strategies," "Caries Detection," "Economic Trends And Social Media," "Using 3D Radiology in Diagnosis," and "Bone Grafting and Implants."

Our all-day Friday courses features:

- Dr. Paul Homoly—*Case Acceptance: A Non-Sales Approach*
- Dr. Baldwin Marchack—*Solutions for Patients with Compromised Dentition*
- Dr. James Jacob—*Esthetic Periodontics: Setting the Foundation for a Beautiful Smile*
- Amy Parrish and Carrie Webber—*I Don't Know a Good Dentist*

The price for the entire package this year remains the same. This cost averages out to be about $28 per hour of CE and includes a continental breakfast and lunch. And you don't have to travel very far to accumulate all the hours that you will need for your State dental license!



Joel Casar, DMD

Our other positive news is that after two years of attrition, our membership numbers are actually up 6%. That's not a huge amount but after two years of losses, we're back on the right track. We recently held a retreat with a cross-section of our delegates and officers to plan for the Society's future. Increasing our membership numbers was one of the many topics. In the next few months, you'll see some changes designed to help us towards this goal.

We are also planning to improve the flow of information between the Society and our members. I appointed Dr. Lydia Wyatt as Chief Delegate, tasking her to keep all delegates informed. The delegates are charged with informing the membership of important information and returning members' thoughts and concerns back to our Society.

All-in-all, members need to know what's happening to their profession. Whether it be questions about mid-level providers coming into our state, trends in patient care or simply how we might be effected by changes in insurance companies "policies."

A final word…keep informed and active or be ready to accept what we are forced into. ◆

Dr. Dougal Morrison accepts the the 2011 Fae Ahlstrom Heritage Award award for his father, as presenter Dr. James Jones, looks on.

SNDS Dentist Health and Wellness Committee

By Richard Walker, DDS, MEd, Chair

The SNDS Dentist Health and Wellness Committee (DHAWC) continues to provide assistance to the dentists of Southern Nevada that suffer from the disease of addiction. The committee could not operate without the valued efforts of our committee members: Michael Duboff, Peter Mansky, Franson Tom, Richard Walker and Bob Anderson. The DHAWC provides a life-saving service for the members of the SNDS.

The rewards are great for the members of the committee in seeing recovering dentists return to happy and productive lives. However, this pales to the joy that recovering dentists have in getting a new lease on life. If you are interested in helping your colleagues, please join our committee. Contact me at 702-774-2684 for more information.

In August, I attended the biannual ADA Dentist Health and Wellness Conference in Chicago. The keynote speaker was Gil Kerlikowske, Director or the Office of National Drug Control Policy (ONDCP). A component of the Executive Office of the President, ONDCP is responsible for setting and monitoring federal government policies regarding efforts to reduce the demand for illegal drugs, prevent the initiation of substance abuse by young people, combat drug production and trafficking, and reduce drug related crime, violence and disease.

Kerlikowske's presentation, "Prescription Drug Abuse: National Perspective and the Role of the Dental Profession," provided statistics on prescription opioid drug abuse problem as the fastest growing drug problem in the US and indicated that dentists prescribed 7.7% of immediate-release opioids in 2009.

Do you know any dentists that may have an addiction problem. We can help!

SNDS members can contact Richard Walker, DDS or Bob Anderson 702-733-8700.

NNDS members can contact Michael M. Day, DSS, chair of the Northern Nevada Dental Society Dentist Health and Wellness Committee at 775-287-2931.

The ONDCP's Prescription Drug Abuse Prevention Plan has four components:

1. Education
2. Prescription Drug Monitoring Programs
3. Proper Medication Disposal
4. Enforcement

Kerlikowske advised that dentists can help educate patients on risks of opioids and other controlled substances and how to use, store and dispose of them properly.

As of May 2011, Nevada is one of 35 states with an operational Prescription Drug Monitoring Program. You can access the Nevada Prescription Drug Monitoring Program database to determine if a patient is receiving controlled substances from other healthcare providers. You may request an account for the Nevada Prescription Drug Monitoring Program directly at *https://rpt.pmp.relayhealth.com/nv* or through the Nevada Pharmacy Board website, click on Controlled Substance Abuse Prevention Task Force.

Regarding medication disposal, the Drug Enforcement Administration (DEA) is drafting a final rule on controlled substance medication disposal. Once the rule is issued, dentists can work with patients to ensure that medications are disposed of properly. The enforcement goals of the ONDCP are to assist states and localities in addressing "pill mills" and "doctor shopping." There is no single solution. We all have a role to play and success will come from coordination and collaboration at all levels of government and cooperation of healthcare providers. ◆

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

NNDS Executive Director's Message

Lori Benvin

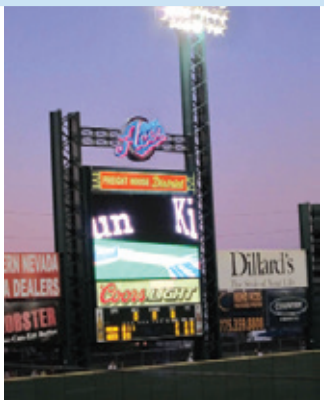
What is a New Dentist in northern Nevada? Is it someone who just graduated from dental school? Someone who just opened their own dental practice? Someone who recently joined in partnership with a practicing colleague or purchased an existing practice? Someone who has just joined the Northern Nevada Dental Society? We are grateful if we can answer "yes" to all of those questions and we welcome you and congratulate you on your accomplishments into this great profession.

Technology certainly has more than arrived for our new generation of young adults. With iPods, iPads, smart phones, iPhones, Facebook, emails, Skype, and so on, it is difficult to know what portal to reach out to contact new dentists and our newest members—it's exhausting! As a newly-joined Facebook user, I was a little slow in caving to the peer pressure to join. I hope the membership, and new members, will "like" the NNDS Facebook page and "friend request" me. I am learning and navigating my way through FB and I am trying to post all of the NNDS events in addition to the mass emails I send out. Please look me up: *Northern Nevada Dental Society* or *Lori, NNDS*.

I invite all of you to join us at one or more of our upcoming events. Face-to-face time with your colleagues is the only valuable way for you to share ideas and get assistance from older dentists who are more than willing to mentor/assist you. We have a special camaraderie included with opportunities here in the north that you should find very inviting and warm. Check us out on Facebook, on our new website at www.nndental.org, email me at nnds@nndental.org, or just call me. I am happy to send you any information I can to encourage you to join us and meet your esteemed colleagues and make new friends.

We have exciting continuing education opportunities for you; watch for the flyers and RSVP today. ◆

NNDS Annual Spouses/Guest Night at Reno Aces Baseball Club



As we enter the fall season and memories of vacation fade, the excitement of an outstanding series of dinners with the NNDS begins to build. A new school year has started, the leaves are changing, and if you listen to the radio or turn on the television, you know that football is once again dominating Sundays. There must be something in our American psyche that draws us to competition. Whether it is the weekend warriors trying to ride up the trail before their friends or those who are more weekend than warrior and are looking at fantasy teams, there seems to be something about besting those around us. This attitude serves us well in the city leagues, on the playgrounds, or playing cards, but when it comes to our profession, it comes with caution.

Competition can drive us to learn more, improve our facilities and improve our dental teams—thus providing a higher quality of dentistry to our patients. Competition has another side too. It can lead us to speak poorly of another's treatment without knowing the circumstances to garner a patient's trust; can propel us to provide treatment that is out of our range of competency, and worse yet, treatment that is not required. Talking with colleagues, both local and out-of-state, they often talk of their "competition" and how they try to get a leg up on them. In reality our competition is not each other, but the other things in life that we compete for—the trip or vacation, a car, college tuition, or even making rent or paying bills. These tough economic times are hard on our patients and on us as well. Competition brings with it a fire that can move us forward or burn us down. Now more than ever, we as a profession should be using a different "C" word.

That "C" word is **camaraderie**. I think that camaraderie is the better half of competition. It allows us to work hard and be positively motivated by those around us to become better in our profession. At the same time it gives us the tools to speak with our colleagues in a courteous, professional matter about mutual patients or treatment outcomes we think could be improved.

Camaraderie is part of the backbone that makes dentistry a successful and honored profession. Despite different practice philosophies and abilities, we congregate and discuss our profession for the mutual benefit of all those involved. Each month we practice our camaraderie at NNDS dinners. We get to know each other, build relationships —both personal and professional— accumulate top-notch knowledge to help our patients and improve our foundation of our humanistic approach to dental care. A great example of this was our annual Spouses' Night. It was held at the Ace's Ballpark and we invited to bring our family. What a great showing and a great way to show our loved ones our camaraderie! I thank all of our attendees for taking time out of your busy lives and supporting each other.

Quincy L. Gibbs, DDS

With the economy in a downturn it is important to remember that our profession is built on personal relationships and communication—in and out of the office. It is this camaraderie that makes our profession strong and will help it stay strong as we enter difficult times. I invite you to your NNDS meetings and to not discount the power of a handshake and conversation with a colleague. You may be surprised by the success it brings you. ◆

Welcome New NNDS MEMBERS

Michael S. Gilman, DDS – General
Anthony V. Guillen, DMD – General
Derek L. Johnson, DMD – General
Jarom N. Luu, DDS – Oral Surgery
John W. Mahon, DDS – General
Kevin Olson, DMD – Pediatric
Patrick Silvaroli, DMD – General
Shane Sykes, DMD – General
Joshua D. Woolley, DMD – General

NNDS Save the Date

All of our events are updated on our website at www.nndental.org.

Nov. 10	Membership dinner meeting. 6:00 pm, The Grove Event Center. Reno Police Department, "Drug Abuse and the Dental Patient"
Dec. 9	Annual Christmas Party. 6:30 pm, Harrah's Automobile Museum
Jan. 12	Membership dinner meeting. 6:00 pm, The Grove Event Center. Oral Surgery Symposium
Feb. 23	Dinner meeting. 6:00 pm, Atlantis Hotel Casino Spa, Reno. Dr. Stanley Malamed
Feb. 23–24	All day CE course. 8:00 am, Atlantis Hotel Casino Spa, Reno. Dr. Stanley Malamed

By Karen P. West, DMD; UNLV SDM Dean

Greetings from the SDM!

Overview of the Class of 2015

This academic year, we welcomed our 10th class since the SDM inaugural class began in 2002! From a pool of 2,288 applications, 82 outstanding students comprise the Class of 2015. There are 32 female and 50 male students. Fifty-one students are Nevada residents while 31 hail from Arizona, California, Colorado, Florida, Hawaii, Montana, Oklahoma, Utah, and Washington State. We also accepted 26 UNLV graduates—our largest number to date—and 11 graduates of UNR. The average age of the group is 25.8 with a range of 20–35 years old. *(You can view more stats about the Class of 2015 in the table to the right.)*

Orientation festivities included a luncheon provided by ASDA, an introduction to SDM faculty and first year advisors, presentations about community service activities, and an introduction to the SDM Honor Code and expectations regarding ethics and professionalism.

The week culminated with a hike and barbecue at the Mt. Charleston Lodge. Over half of the class participated in the hike to Cathedral Rock led by faculty members **Drs. Ron Lemon, Rick Walker, Stan Hillyard** and **Teena Ancajas**. Everyone enjoyed the food, camaraderie and cooler weather!

Community service

Our students have been extremely busy with community service events in Clark County, Mesquite and Pahrump over the past few months. Services include dental screenings, fluoride varnish treatments, oral hygiene instructions and oral cancer screenings to children of all ages as well as adults. Faculty, SDM students and staff along with UNLV predental and CSN dental hygiene students all participate in these worthwhile events for the community of Southern Nevada.

New faculty spotlight

The newest addition to the full-time faculty at the UNLV School of Dental Medicine is **Dr. Valerie Thompson**. Originally from Twin Falls, Idaho, Dr. Thompson opted for the sand, surf and sun of California and obtained her undergraduate biology degree from California Lutheran University in Thousand Oaks. Knowing she had a passion for dentistry she added to her educational breadth by a minor in art—including sculpture, photography, painting and drawing. When she applied to dental school, she was thrilled that there was a school in Las Vegas, since she had relatives in the area. She completed four years of study at the SDM and graduated in May 2009. After a year of practice, she joined the part-time dental school faculty in the summer of 2010. A year later, in May 2011, she became a full-time member of the faculty. It is clear that she loves teaching and appreciates "the other side" of dental education. We welcome Dr. Thompson to the faculty and look forward to her continued involvement.

Awards

Dr. Ronald R. Lemon was selected as the winner of the Case Presentation Contest held during the Endodontic Opinion Leaders Conference meeting at Half Moon Bay, Calif. in July. The meeting is sponsored by Dentsply Tulsa Dental, Tulsa, Oklahoma. Endodontic educators from many dental schools in the United States are invited to present clinical cases for judging. The winner is selected by audience participation and a panel of professional judges. Dr. Lemon presented a case entitled, "Internal —Vital Bleaching, a New Treatment for Tetracycline-Stained Teeth." The $5,000 prize is donated to a dental school chosen by the winner. ◆

Class facts

Degrees	
4-year degree only	77
2- year with 4-year degree	8
Master's degree	2
2-year degree only	0
Foreign dental	0
No degree	3
(UNLV fast-track—1; degree in Dec—1)	
4-year degree or higher	96%
Majors	
Science	73 (89%)
Biology	56
Biochemistry	3
Microbiology	2
Exer Science	2
Chemistry	2
Physiology	1
Dental Hygiene	1
Food Science, Health Ecology, Kinesiology, Neurobiology, Zoology	1 each
Others: Business (2), Engineering (2) Accounting, Communications, Management, Marketing, Mathematics (1)	
Double Majors: 2 (Automotive Tech., Business)	
Minors: Chemistry (14), Business (2), Biology, Neuroscience, Management, Math, Psychology (1)	
Languages spoken	
Arabic, Armenian, Cantonese, Gujarati, Hindi, Hmong, Ilocano, Italian, Japanese, Khmer, Korean, Laos, Latvian, Mandarin, Persian, Portuguese, Russian, Spanish, Tagalog, Telugu, Thai, Vietnamese	
Miscellaneous	
Married students	30 (37%)
Engaged	1
Number of children	23
Dental legacy students	11
Medical legacy students	7
Dental hygienists	1
Military scholarships Army (4), Navy (1), NHSC (1), IHS (1)	7

Calendar of Events

OCTOBER 2011–JANUARY 2012

October 2011

Wed. 19	SNDS Peer Review Committee meeting	*Contact SNDS office at 702-733-8700 for time & location*	
Thu. 20	AGD General Membership Dinner meeting	6:00 PM	*Location: To be determined*
Tue. 25	SNDS Executive Committee meeting	6:00 PM	*SNDS office*

November 2011

Tues. 8	SNDS Member Dinner meeting	5:30 PM	Gold Coast Hotel, Las Vegas
Tue. 8	NNDS Executive Committee meeting	5:30 PM	161 Country Estates Cir, #1B, Reno
Wed. 9	SNDS Health and Wellness Committee meeting	*Contact SNDS office at 702-733-8700 for time & location*	
Thu. 10	NNDS General Membership Dinner meeting	6:00 PM	The Grove Event Center at South Creek, Reno
Wed. 16	SNDS Peer Review Committee meeting	*Contact SNDS office at 702-733-8700 for time & location*	
Thu. 17	AGD General Membership Dinner meeting	6:00 PM	*Location: To be determined*
Fri. 18	SNDS presents: CE Seminar—Dr. Paul Homoly	9:00 AM	Gold Coast Hotel, Las Vegas

December 2011

Tue. 6	NNDS Executive Committee meeting	5:30 PM	161 Country Estates Cir, #1B, Reno
Wed. 7	SNDS CE Café, "Last Minute Tax Strategies"	6:00 PM	*Please RSVP at 702-733-8700*
Fri. 9	NNDS Annual Christmas Dinner & Dance	6:30 PM	Harrah's Automobile Museum
Fri. 9	SNDS Holiday Event	*Contact SNDS office at 702-733-8700 for time & location*	
Wed. 14	SNDS Dentist Health and Wellbeing Committee meeting	*Contact SNDS office at 702-733-8700 for time & location*	
Thu. 16	AGD Holiday Party	6:00 PM	Drs. Jason & Cariann Champagne's home
Wed. 21	SNDS Peer Review Committee meeting	*Contact SNDS office at 702-733-8700 for time & location*	

January 2012

Tue. 10	NNDS Executive Committee meeting	5:30 PM	161 Country Estates Cir, #1B, Reno
Thu. 12	NNDS General Membership Dinner meeting	6:00 PM	The Grove at SouthCreek, Reno
Thu. 19	AGD General Membership Dinner meeting	6:00 PM	*Location: To be determined*
Fri. 27	NDA MidWinter House of Delegates	9:00 AM	UNLV School of Dental Medicine

Classified Ads

Dental Opportunities

Seeking ambitious, enthusiastic business partner for well established fee-for-service group practice in Albuquerque metro area. State of the art facility. Well trained staff. Very high compensation for less than 30 hours work (average) per week. Please e-mail northcoorsdental@gmail.com or call Liz @ 505-836-1280. Albuquerque is an outstanding area for outdoor activities with excellent fishing, hunting, cycling and skiing nearby.

Practices for Sale

DENTISTS SERVING DENTISTS—Western Practice Sales invites you to visit our website, **westernpracticesales.com** to view all of our practices for sale and to see why we are the broker of choice for Sellers throughout Nevada, California & Arizona. Because we are owned by dentists, we know the profession well and understand your unique needs. **800-641-4179**.

Online CDE

Free! ADA-approved Dental Continuing Education

There are several good sources for ADA-approved Dental CE, including:

ADA Dental CE www.adaceonline.org

Proctor and Gamble Dental Care www.dentalcare.com

Kerr Learning Source www.kerrlearningsource.com

Affiliated Products

The following companies are NDA affiliated products. These products have been evaluated and are recommended for use in running your practice. Please let us know if you have any feedback or would like to recommend a product or service for affiliation.

For a direct link to the company weblinks, go to www.nvda.org/affiliatedproducts.shtml

Banc of America Practice Solutions	*Professional Practice Finance*	**800-497-6076 code 1D7F3 www.bankofamerica.com**
Best Card LLC	*Credit Card Processing*	**877-739-3952 www.BestCardTeam.com**
CareCredit	*Patient Financing*	**800-300-3046 x4519 www.carecredit.com**
citibank	*Student Loans*	**866-863-6758**
citifinancial auto	*Auto Financing*	**888-248-4325 www.citifinancialauto.com**
citimortgage	*Real Estate Assistance*	**888-466-3232 www.citimortgagecom/ada**
Collegiate Funding Services	*Student Financing*	**866-312-7227 www.cfsloans.com/ada**
CoreVault	*Offsite Data Backup*	**405-391-8123 www.corevault.com/nda**
EBSCO	*Subscription Service*	**800-527-5901 x1652 www.ebsco.com/errss**
FedEx	*Shipping Services*	**800-636-2377 www.1800members.com/nda**
Hertz	*Car Rental*	**800-654-8216**
IC System	*Collection Service*	**800-279-3511 www.icsystem/nda.htm**
TDIC	*Professional Liability*	**800-733-0633 www.tdicsolutions.com**
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