Fall 2017
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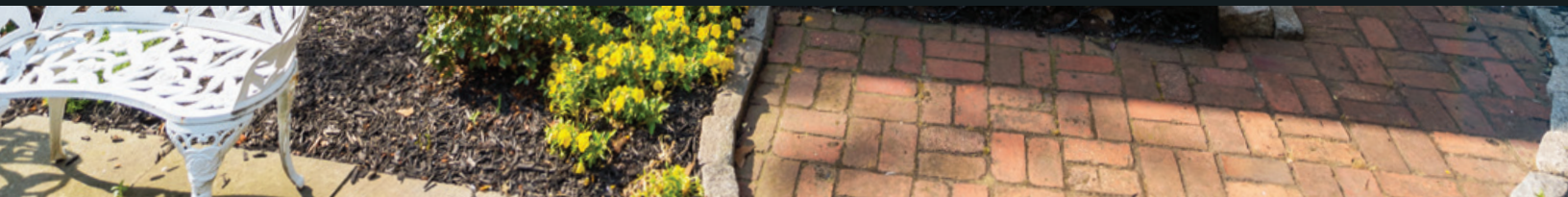
NDA JOURNAL

Official Magazine of the Nevada Dental Association and Component Societies
A Peer Reviewed Journal

Membership Issue



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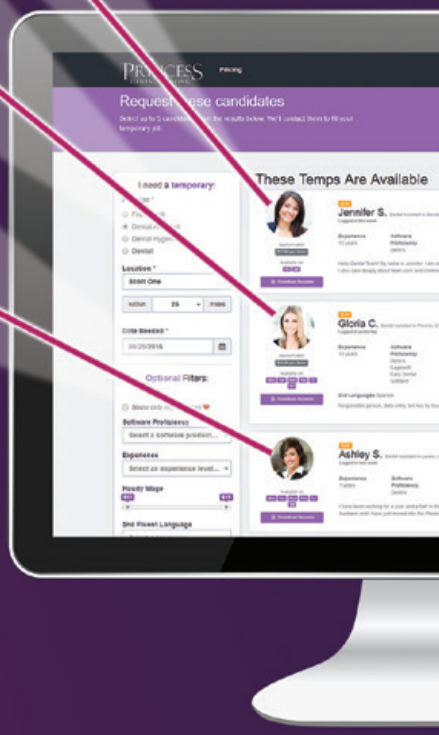

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NDA JOURNAL

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NDA JOURNAL

FALL 2017

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Why Boards, Part II

Our readership may not be surprised that the *NDAJ* has received quite a bit of 1st and 2nd hand commentary after the Spring 2017 editorial, which was particularly focused on the potential for Boards, and regulators in general, to act in unconstitutional fashion. What might be unexpected is that there have been grumbles to the NDAJ from proponents of both "sides" of the issue relative to our own NV SBDE, the generally pro-board faction and the board naysayers. Perhaps the ubiquitous objections from both camps indicate the editorial was fairly even handed.

In the editorial NV SBDE is never mentioned, although other state dental boards are, along with data regarding the generally ineffective board defenses to lawsuits within state, federal circuit, and even U.S. Supreme Court appeals. Since the publication of the Spring 2017 NDAJ, the Fifth Circuit has affirmed the Texas SBDE loss over regulatory overreach into constitutionally protected rights. Originally confined to Texas, because the Texas Board appealed to the Fifth Circuit, the holding now also directly affects Louisiana and Mississippi. The TX SBDE is now finished appealing and the plaintiffs in the case will be awarded legal fees ultimately paid for by the dentists of Texas.

It appears that the topic of regulation is of great interest to many Nevada dentists. Our peer reviewers thought the editorial was timely.

Salient points in the editorial included that poor Board conduct occurs in part because the safeguards the Constitution guarantees are not present in administrative venues. Essentially, the regulation maker, the regulation administrator, the regulation prosecutor, and the regulation adjudicator are all combined into one entity... any real checks and balances are illusory.

Constitutional purists will also opine that regulatory "law" is in and of itself unlawful because it is not developed as our Constitution directs. Regulatory enthusiasts argue that as long as the Congress, the Constitutional source of law, authorizes the development of regulations via third parties, it is lawful. However, the Constitution grants Congress alone the power to create law. It does not grant Congress the power to delegate law creation. Think of a parent loaning the family car to a child. That loan does not transfer ultimate parental dominion or control nor grant the child the authority to loan the car.

A singular reason our Constitution exists is because the British were creating prerogative "law" for American colonists without the colonists' input. When our nation was founded, licensing did not exist for citizens, only foreigners doing business in the United States. In 1950, 5% of jobs required government permission, today the number is greater than 20%.

In 2015 the North Carolina SBDE lost at the level of the United States Supreme Court because there was no balance of legislative, executive, and judicial powers (and no one regulating the overzealous regulators) as the NC SBDE attempted to control others, including non-dentists. The issue addressed evolved from tooth-whitening to conclusions about board members' potential loss of legal immunity when acting unconstitutionally. Individual board members and others can avoid personal liability when constitutional conduct, what the original editorial pleads for, is shown to exist.

At press time, Senator Michael Lee (R-Utah) introduced the Restore Board Immunity Act that would give states two options to potentially regain immunity. Both involve bringing the regulators towards a more, but not pure, Constitutional footing (which

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again to purists makes the reform unconstitutional in and of itself). To qualify, boards would be able to either show their own supervision by the state legislative and executive branches and/or report why their licensing requirements are necessary to protect public health and safety.

Emphasizing the apparent sensitivity of these issues, none of the 1st or 2nd hand NDAJ contacts preferred to formalize thoughts in writing for the NDAJ. Those that are not generally supportive of the Board did not want to expose themselves to possible retribution. Members advocating for the NSBDE cited the conflicting positions as both individuals and government representatives.

Those critical of boards didn't think the Editorial was detailed enough, for instance by not publishing public domain documents critical of the NV SBDE obtained from licensees, other regulators, or constitutional courts of law. Some board supporters seemed to take the Editorial personally, and reflexively called for the Editor, that would be me, to be "fired."

Another reportedly stated "he," that would be me again, "does not represent me." That is an accurate statement in that the NDAJ doesn't represent individual dentists, although the NDAJ may bring certain singular dentists to light for conduct "above and beyond" that is beneficial to what and whom the NDAJ does seek to represent, our profession, and thus ultimately the patients we serve.

Editorial autonomy is certainly not limitless and there are times when Editors are not doing a satisfactory job for the organization they represent. It is my view that editorials should include questioning topics that may be uncomfortable for us as dentists, as a review of the last ten years of NDAJ offerings will confirm.

Because of the volume of response from Nevada Dentists overall, the NDAJ has solicited more information about our own Board to report. Since the last issue, the NDAJ has been unofficially advised of instances of circumspect NV SBDE behavior towards licensees by members of the NV SBDE.

The NV SBDE for several years has been issuing, when deemed appropriate, "rehabilitative letters" rather than disciplinary stipulations. When such letters are issued, no report is filed with the National Practitioner Data Bank. On at least one occasion, the NV SBDE ruled to temporally decrease a stipulated 4-year probation.

Further, a NV SBDE member opined that the majority of the 16 areas the Board was criticized by the State of Nevada investigation have been addressed.

The NDAJ has also received an official report of overall NV SBDE activity for the 2016–2017 licensing year. Please see below.

No matter which side of the controversy the NDAJ readership gravitates towards, the plea is still the same: to treat each other and, thus, our patients, ethically.

As always, the NDAJ welcomes formal, informal, or confidential comments from readers. The NDAJ does not consider anonymous submissions.

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Investigations and Board Action Report-Period 07/01/2016-06/30/2017

Total number of complaints received: 247

Total number of investigations conducted: 119

Total number of cases pending: 49

Total cases remanded – no board action- 48

(On average 64.8% of cases are remanded –no action per Legislative Audit)

Total number of Actions taken by the Board: 14

10 Corrective Action Plans-Non Disciplinary Stipulations

4 Disciplinary Stipulations

Corrective Action Plan Non Disciplinary Stipulation Agreements are remedial and are not considered to be discipline by the Board.

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Executive Director's Fall Message

I would like to thank those of you who have renewed your membership religiously throughout the years; you are helping to protect not only yourself, but your colleagues, your patients and the dental profession.

This is the inaugural Membership Issue and it goes out to not only members but to all practicing dentists in the state. Our communication about member value and what is going on at the State Association has been lacking and I promise it will get better. It will be better both in content and how it is delivered. In this issue you will find listed the many benefits and offers available to members. As your Executive Director and a retired dentist, I hope you trust me when I say that so much of the benefits of being a member comes from the efforts of the many volunteers and staff behind the scenes at all levels of the tripartite. I along with the NDA contract lobbyist and the whole NDA legislative committee are very active educating legislators about issues important to our profession. It comes down to money provided by the dues to support advocacy efforts at the national and state levels. Any dentist who uses the excuse" I get that whether I am a member or not" should be ashamed. The alternative is that without a strong membership position your tripartite association will not be able to sustain its strong advocacy position and that will affect everyone—members and non-members.

To those who have not joined—it is time. No more excuses.

You need to become part of organized dentistry because with high membership numbers—we are strong. It makes no difference what kind of practice you have or how you chose to practice, a strong profession benefits us all. There is no more important time to join organized dentistry. We have been lucky the last few sessions with the mid-level provider issue and I believe it is coming our way this next session as strong advocates in the state legislature who favor this healthcare provider are close to term limiting out. Issues like the use of mid-level providers, in lieu of dentists, threaten the very foundation upon which your profession is built.

To those who have not renewed—please come back.

We have instituted many different payment plans to help with cash flow. We are looking at automatic renewal with 12 monthly payments and hope to have that ready for the 2018 dues cycle.

To those that renew every year—again thank you.

You have helped make this profession great!

Strength comes with numbers and a strong profession benefits everyone in it.

In this new time of heightened competition, I hope you will consider the NDA's new dental supply buying service—NDA Supplies. With average savings approaching 30%, you can pay your membership dues with the savings. You can do comparison shopping through their website at ndasupplies.com to see how much you will save.

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George Mcalpine, DDS

President's Fall Message

I'd like to thank David White for his passionate service to the Nevada Dental Association as President last year. David's summer meeting in Whistler, British Columbia was filled with lively discussion and critical assessment of our strengths and weaknesses. I am very happy to have David for one more year on the executive committee. I'll admit that I am not ready to lose his quick wit and ability to articulate complex issues.

Although the legislature is not in session this year, we must continue to maintain our relationships with current legislators and prepare to build new ones as members change. We will continue to fight for dentistry and dentists in Nevada and oppose things that could hurt our profession and our patients. The recurrent push for midlevel providers is one thing that comes to mind.

As I reflect back on my last 43+ years in the dental profession, I confess I kind of miss the former simplicity of dentistry. Our choices were simple—amalgam or gold for posterior teeth and composite (Adaptic or Concise) for the anterior teeth, although some of us still did a gold foil here and there. Alginate, rubber base or compound for impressions. Lab options for crown materials were limited. Corporate dentistry was pretty much unheard of. Student debt was not the crushing burden it is today. Dental insurance reimbursement was actually pretty good. Sadly, the days of the solo practitioner seem to be fading fast. Where will our profession be in 20 or 30 years? We can look at our physician colleagues to get a sense for where we may be in 15 or 20 years from now. It is illuminating to point out that less than 15% of physicians belong to the AMA.

In August, Rick Dragon and I attended the Western States Presidents Conference in McCall, Idaho. This annual event includes some of the brightest minds in dentistry. This venue provides a great opportunity to discuss challenges and successes experienced in other members of the 14th District plus California. With 6 dental schools and over 11,000 dentists, California is in the forefront of many of the issues we face in here in Nevada. Membership continues to be, justifiably, one of the hot topics. The Nevada Dental Association, as in many other states, has experienced a slow decline in membership. If we can't reverse this trend, at some point, organized dentistry in Nevada may cease to exist. It is essential that those of us belonging to the NDA try to bring our nonmember friends and peers onboard otherwise we will slowly wither away.

In closing, one of my favorite quotes from Benjamin Franklin—"We must all hang together, or assuredly we shall all hang separately."

Sadly, the days of the solo practitioner seem to be fading fast.

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Andrew Ingel, DMD, FAGD & Michael Scherer, DMD, MS

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Dental Director/ & Dental Consultant Positions Available in Nevada

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The Nevada Dental Association works diligently to represent you and the dental profession in the state of Nevada. The NDA had another very successful legislative year in 2015 by building legislator relationships, its stellar lobbyist team, and its influence on oral health policy at the national and state level working to enhance and protect the profession for our members and patients. We plan on another successful session in 2017 with the help of you as a member and your membership dues.

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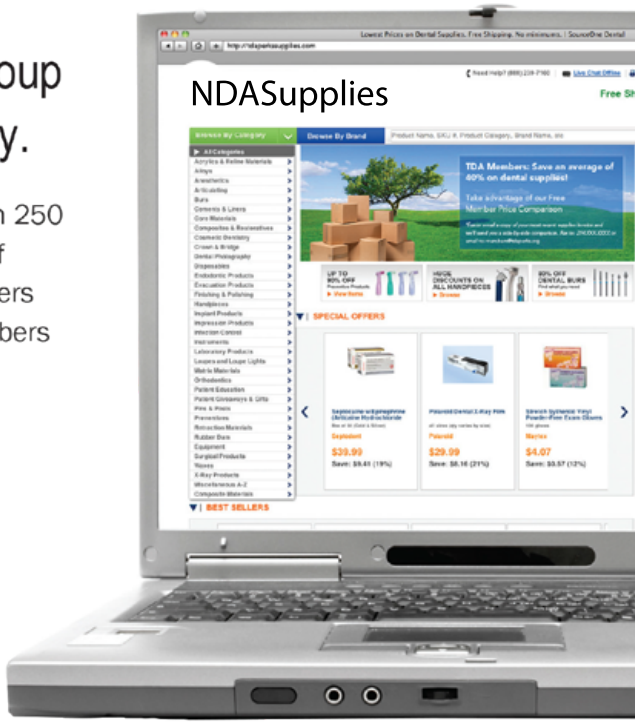

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Advocacy After the Legislative Session

By The FPA Team

With another legislative session behind us and the recently passed legislation still fresh with that new bill smell, we wanted to make sure your minds don't drift too far away from politics and government. Believe it or not, now is when a lot of the important work gets done. We're deploying new modern communication tools to make sure all of you are in the loop as we dredge through the quagmire that is the regulatory process. But first, we want to give you a glimpse into our off-season schedule and let you know that we *need* you along the way.

First, the Nevada State Board of Dental Examiners (NSBDE) has a number of regulations to sift through. When new laws are passed regulatory bodies like the NSBDE are tasked with their implementation. Think of the new laws as two dots on a map whose routes to one another need to be filled in. That's where the regulators come in. As you know, you work in one of the most regulated industries in the state.

However, it's not just the NSBDE we need to worry about. You, as a licensed dentist, are regulated as a provider of health care, as a prescriber, as an employer and as a businessperson. NDA Executive Director, Dr. Bob Talley, does a great job as an advocate and as the voice of dentistry in Nevada—legislators seek his counsel and regulators request his advice on dental matters—but he can only be so many places at one time. That's why we have a team looking out for you and making sure you have a place at the table on every issue.

Here are some of the regulatory bodies and committees the NDA government relations team keeps a close eye on:

The Nevada Board of Pharmacy meets every other month and, during this interim, is tasked with implementing weighty legislation from the Governor's office aimed at preventing opioid abuse and other pharmacy matters—including aligning Nevada with federal regulations coming down the line.

The **NSBDE** meets every other month and will tackle everything from the Governor's requirement that Board's create a path to licensure by endorsement for out-of-state providers to continuing education for prescribing opiates, as well as other regulatory matters on conscious sedation and Botox.

The state **Medicaid** division is constantly updating its manual and working to conform to federal changes. Ask anyone—nobody knows this Magna Carta-sized document better than Joanna Jacob of FPA.

The **Legislative Commission** is the body of legislators that works when the Legislature is not in session. It meets six times per year to make big decisions on everything from agency audits to approving or disapproving regulations.

The **Legislative Interim Health Committee** keeps a close eye on all things health care. Dr. Talley has spent considerable time with this committee and has been summoned before the body as a respected voice of Nevada Dentistry.

The **Legislative Interim Finance Committee** decides how the state spends its money during the interim. The state spends hundreds of millions of dollars each biennium on health care. We keep a sharp eye on this committee as agencies scramble for extra dollars.

The Department of Health and Human Services serves as an umbrella agency for several state health care functions, including the Cancer Registry, which is currently working to update the way providers are required to report findings of cancer.

The **Governor's Office of Workforce Innovation (OWINN)** is a brand new Executive Department office consisting of several industry councils, including health care, which are working to ensure Nevada has a strong surplus of skilled professionals in all industries.

Other bodies we monitor include, the Nevada Tax Commission, the Department of Insurance, the Local Health Districts, the Department of Business and Industry, Network Adequacy Council, OSHA, and the list goes on.

Of course, we don't expect you to monitor these groups and understand all of the ins and outs—you have teeth to care for! That's what NDA is here for. All we need is an open line of communication so that we can call on you as the expert when needed. During the remainder of 2017 and into 2018, NDA will be deploying a host of communication tools to make sure you have the best capabilities possible to lend your voice when it matters most.

It is an honor to serve the Nevada Dental Association.

Information Security in the Age of the Data Breach

PCI Non-Compliance Can Be Costly

Every few months it seems like there are more revelations of large scale data breaches that expose the personal or financial information of millions of Americans. In 2017 there have been breaches of Arby's, Verifone, Dun & Bradstreet, Saks Fifth Avenue, Intercontinental Hotels Group, Chipotle, Kmart and Verizon that have resulted in credit card numbers or personal information being obtained by malicious characters.

The following graphs, compiled by the Identity Theft Resource Center (a non-profit advocacy group), states that the healthcare industry is one of the largest targets for data breaches. By far the largest threats to data security are hacking, skimming and phishing.

Hacking normally involves obtaining credentials to install malware that can monitor and extract sensitive information. Skimming is the process of attaching a physical device in the card processing environment to duplicate and steal the data. Phishing is the practice of sending fraudulent emails or phone calls purportedly from a reputable company to get individuals to reveal information such as passwords, personal information or credit card numbers.

To address these issues, the credit card industry has responded with a set of guidelines called Payment Card Industry (PCI) Compliance to ensure that any business that accepts credit cards has implemented secure procedures to protect transmission of card information. PCI Compliance is a requirement for any business that accepts credit cards, but the actual requirements that your business must meet is determined by the equipment and the method of communication used in processing.

As part of PCI Compliance, every business must complete an annual Self-Assessment Questionnaire (SAQ) unique to the processing environment. For example, a stand-alone credit card terminal that attaches over an analog phone line has a very simple SAQ that focuses on in-office procedures to protect credit card data. This is because the terminal encrypts all information at the point of entry and then sends the information over an analog phone line which are much more difficult than IP connections for hackers to actively monitor. If your office uses a credit card processing terminal that connects over the internet or through your computers, not only will you have a more demanding SAQ that will ask about your network security, you will also be required to perform quarterly external PCI network scans to ensure that your network is secure from tampering.

PCI Compliance will usually be handled by your credit card processor even if they use an industry-approved PCI subcontractor. However, it is the merchant's responsibility to make sure that their business has completed all the required steps to achieve compliance. While some credit card processors are very proactive in helping dental offices attain compliance, many don't view it as their

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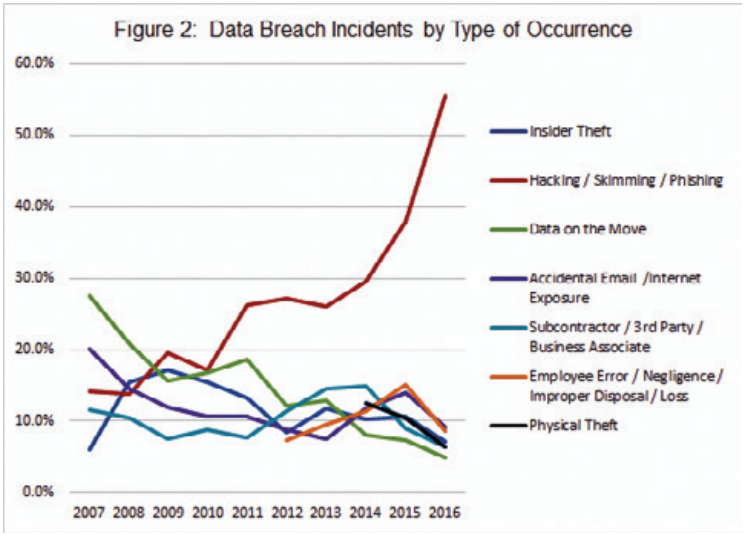

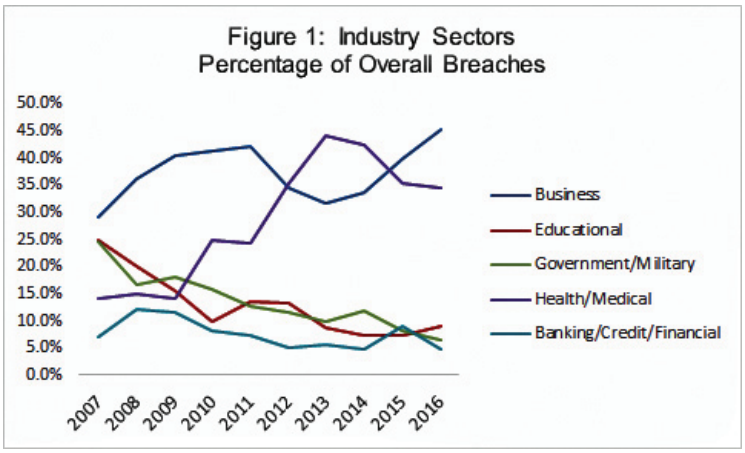

responsibility. When Best Card reviews statements from dental offices to prepare cost comparisons, approximately 60% of dental offices are being charged monthly or quarterly PCI Non-Compliance fees. Best Card averages 90% PCI compliance for our dental offices and charges approximately 25% of the annual cost other processors do for PCI compliance.

Having worked with thousands of dental offices for their PCI compliance, below are some helpful tips for any dental office to avoid PCI issues, maintain security, and identify calls from scammers trying to get information.

- If your office stores physical credit card numbers, be sure to keep all card information locked up when not in use and to shred any card numbers once no longer required for business or legal reasons.
- If you have your office phones connect over IP (instead of analog phone lines), your router must separate phone activity from the rest of your office internet activity. While this should be common practice, many internet service providers such as Comcast, AT&T, etc. have not updated the firmware on the routers that they offer to businesses to be compliant with this practice. Currently you can receive a waiver for this vulnerability to achieve PCI compliance, but beginning January 1, 2018 these routers will no longer be compliant without an update.
- Change passwords to systems if you have an employee leave. Former employees might login remotely and run fraudulent refunds to their own credit cards.
- Never store card numbers on a computer unless they are being stored in an encrypted format (where you cannot see full credit card number) by a PCI approved software/gateway/processor.
- Be very careful when giving access to your passwords or allowing others to remotely login to your office computers. We have had offices that have called us after "Microsoft" called and said that they immediately needed to login to their computers. This is a common scam used to compromise your network and install malicious programs.
- We have had offices call us because "PCI" called and demanded to see a copy of their PCI Scan report. Any PCI compliance steps would be handled in conjunction with your processor, there are no "PCI police" that would call you by phone. Giving away this information would essentially give a roadmap to hack your office network.
- There are many unscrupulous credit card processing companies that will call and say that your equipment or your network is not PCI compliant. They may even say that they need to do an "update" to your terminal and give you something to sign. Unless this call is coming from your credit card processor and they can provide your merchant number, this is an underhanded solicitation. The caller will have no information on the integrity of your systems unless you give it to them. These companies will try to scare you into signing a new agreement that usually has expensive costs and punitive contract terms.
- MasterCard has begun issuing credit cards that begin with a 2 (previously all MC began with a 5) and some terminals need an update to accept these new cards. At Best Card, most of our terminals/online software systems auto-updated but we did have to re-download our VX520 terminals. MasterCard wanted updates completed by 6/30/17 and can assess non-compliance fees of $2,500 per occurrence in the first 30 days, escalating to $10,000 in the next 60 days and up to $20,000 per occurrence for subsequent violations, but Mastercard will send a warning before assessing fines. If you get sales calls saying you are non-compliant and may get fined, there might be some truth to this and you should check with your present processor.

Data security and PCI compliance are an ever-changing part of the business environment, but with reasonable preparations and updates it should be very manageable!

If you have any questions about PCI compliance or the credit card processing industry in general, feel free to reach out to Best Card at (877) 739-3952. They save the average dental office $1,860 (27% average savings) per year on their processing costs and offer excellent customer service. If you have a recent statement from your credit card processor and would like a detailed, no-obligation cost comparison, you can send the statement via email to CompareRates@BestCardTeam.com or fax to 866-717-7247. Best Card is the endorsed credit card processor of the Nevada Dental Association as well as 25+ dental associations nationwide.

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Bisphenol A in Everyday Life and in Dentistry

By Joseph G. Mirci DDS, MAGD; Michael J. Rethman; Andrew M. Bateman

Everyday Life

Bisphenol A, also known as BPA, has been the subject of much conversation over the last few years. BPA was discovered in 1891, but didn't become popular until the 1950's, when it was discovered that it could be used as a starting material to make polycarbonate plastics and epoxy resins.[1] In the late 90's, its usage began to be questioned after scientists proposed that it might be harmful to humans. Since, increasing evidence has accumulated that links BPA to various health problems, especially in children. As a result, its usage in many products has been curtailed.

Polycarbonate plastics are easy to work with and mold, and are relatively cheap. Additionally, polycarbonate is fairly temperature resistant, impact and shatter resistant, and it is see-through.[2] As a result, polycarbonate can be found in almost anything within an arm's reach. BPA-containing polycarbonate is mainly found in plastic food storage containers, plastic water bottles (including some baby bottles), optical wear (polycarbonate lenses), CDs and DVDs, and sports equipment (helmets, shoulder pads, etc.).[3]

Epoxy resins are monomers that can be linked together by a chemical reaction with themselves or with other co-reactants to form a cross-linked polymer. These polymers are often very hard and have high mechanical resistance.[4] Epoxy resins are most commonly found as a liner in metal food and beverage cans, and are also used as a liner in some water pipes.[5] Free, or unpolymerized BPA is also in thermal paper, which is most commonly encountered in the form of sales receipts.[6]

It is highly unlikely that the reader will make it through a single day without encountering one of these products containing BPA. They will likely come into direct contact with it multiple times and in a variety of ways. Indeed, the ways in which humans are exposed to BPA are vast.

The primary way in which humans are exposed to BPA is through the diet.[7] As mentioned above, BPA can be found in many products that come into direct contact with food and beverages, such as storage containers, bottles and cups, and metal food and beverage cans.[5] It is possible for BPA to leach into food and water from these sources.[7] The rate at which BPA leaches out is highly variable and not completely known, but increasing temperature and age of the container are likely to increase the leaching of BPA into the food or water. The BPA is then ingested with the food or liquid.

According to the FDA, the average dietary BPA exposure is 0.2-0.4 micrograms/kg-bw/day for infants and 0.1-0.2 micrograms/kg-bw/day for children and adults.[8] The FDA also found that orally ingested BPA is rapidly metabolized to its inactive form, and results in much lower internal exposure to active BPA than what occurs from other routes of exposure such as injection.[8]

It is theorized that most dermal absorption occurs through the handling of thermal paper, most commonly encountered in the form of sales receipts.[6] Unlike epoxies and polycarbonates, in which the BPA is "locked up" in polymers, thermal paper contains "free" BPA monomers. This active BPA can be transferred to the skin where it can be absorbed or accidently ingested through hand to mouth contact. In a recent study, BPA was found in 94% of thermal receipts at concentrations ranging from below the level of quantitation (1 ng/g-receipt) to 13.9 mg/g-receipt, with a mean of 0.211 mg/g-receipt.9 The study estimated the daily intake of BPA through dermal absorption to be 17.5 ng/g-receipt for the general population and 1300 ng/g-receipt for occupationally exposed individuals, both of which are minor when compared to exposure through diet.[9]

As we have seen, there are many ways for humans to be exposed to BPA, but what are the consequences of this?

There are many adverse effects that BPA has been suggested to cause, but the most common is its role as an endocrine-disrupter.[10] Estrogen is present in males and especially in females, and has very important roles in both sexes. Estrogen is important in females for initiating puberty and for developing and maintaining secondary sexual characteristics, such as breasts, and it also plays an important role in the menstrual cycle.[11] In males, estrogen helps regulate the reproductive system and the maturation of sperm.[11] Estrogen crosses the cell membrane and binds to an estrogen receptor (ER) on the nuclear membrane. The activated ER translocates into the nucleus and acts as a transcription factor by binding to specific sequences of DNA. In other words, estrogen controls the expressions of certain genes, many of which control the functions mentioned above.

Xenoestrogens are unintended products derived from manufactured sources and are found in plastics, resins, and methacrylate-based dental materials, including some dental composite resins, and dental resin sealants, and bonding agents.[12] Like estrogen, xenoestrogens such as BPA can

bind to the ER and activate it to become a transcription factor.[12] Estrogen receptors are found throughout the body, but are most concentrated in the reproductive organs, brain, and gastrointestinal tract.[12] The balance of hormones is complex and small changes in hormones can signal large systemic changes. Thus the binding of xenoestrogens can have many adverse effects, especially in young children, who are still developing. The altered transcription rate can cause early female puberty, reduced sperm count in males, and altered reproductive structure functions in both sexes. The increased activity of the reproductive structures has also been suggested to cause breast, ovarian, testicular, and prostate cancer.[10] Some studies have also linked exposure to BPA to gestational diabetes, type II diabetes development, asthma, obesity, altered permeability and inflammatory responses in the intestines, and certain neurological issues.[12] Studies of pediatric exposure to BPA have linked it to altered metabolism and childhood growth, and neurodevelopment in addition to the effects listed above.[12] Although the half-life of BPA is reported to be less than six hours, recent data demonstrates that it may persist and be stored in adipose tissue, which suggests that it may have longer-lasting effects than originally thought.

The general consensus about BPA is mixed; some agencies say BPA poses no health risks at the current levels and others say it does, especially to children.[13] An increasing amount of research is being devoted to studying the effects of BPA and its derivatives on humans, with the federal government spending $30 million to support research.[12] In July 2012, the FDA banned the use of BPA in infant bottles and children's drinking cups. The FDA is also supporting the industry's shift to replace BPA in food storage materials, although it insists that BPA doesn't pose health risks at current levels.[8] Many manufacturers are already making plastics that don't contain BPA and labeling them as such. There are no requirements to mark that a plastic contains BPA, making it difficult for consumers to identify plastics that contain BPA. However, plastics marked with the Resin Identification Codes 1,2,3,4,5, and 6 are unlikely to contain BPA.[14] Plastics marked with a [7] may or may not contain BPA. More recently, if a plastic product doesn't contain BPA, it is clearly marked.

Dentistry

During World War II, a group of German researchers discovered a new process that could polymerize dental methacrylates at room temperature. Although they initially found success, the clinical results reported during the mid-1950s showed that chemically cured methacrylate restorations were associated with many problems; some of them included an increase in discoloration, recurrent tooth decay, and pulp reactions. These side effects were thought to be attributed to polymerization shrinkage and monomer leakage.[15]

To reduce the shrinkage from polymerization, they added inert filler particles to the self-curing methacrylate resin. Seeking to improve the overall strength and adhesiveness of the restorations, in 1956, Bowen, one of the key researchers, explored the possibility of using epoxy resins (diglycidyl ether of bisphenol A) mixed with silica particles. The in vitro results were promising, but the presence of moisture created a problem that inhibited the polymerization process of the epoxy resin. To overcome this problem, Bowen attached methyl methacrylate groups to the end groups of the epoxy resin, which converted the epoxy resin to a dimethacrylate. The outcome was successful and resulted in a new resin called bisphenol A glycidyl methacrylate, or bis-GMA, or otherwise known as Bowen's resin.[15]

Bowen's resin presented some important advantages, including reduced shrinkage during polymerization and the ability to form cross-links (which are stronger than linear polymers) during polymerization. However, due to the higher viscosity of bis-GMA, it became more difficult to add filler to the monomer and to mix the chemically cured composite. To solve this problem, different monomers with lower viscosities (for example, triethyleneglycol dimethacrylate, or TEGDMA) were mixed in to dilute the highly viscous bis-GMA monomer and make it possible to incorporate more filler.[15]

Bowen' s composite material and resin have become more significant to the dental field than most any other dental innovation. The combination of these materials with the acid-etching technique made new treatment options possible. Carious lesions could be prevented by the use of sealants, Class IV restorations and composite veneers could be placed successfully, orthodontic brackets could be bonded, and metallic and ceramic constructions could be bonded by using the acid-etching technique with resin. By using composites rather than silicate cements, dentists could increase the longevity of Class I, II, III and IV restorations. During the last few years, more clinicians have found that posterior composites, when placed properly, can result in acceptable clinical restorations. This is a huge advancement in the studies of composite restorations.[15]

Considering the enormous success the dental profession has experienced with bis- GMA–based materials, clinicians found it somewhat alarming that some of these materials, such as sealants, were implicated as being estrogenic. One study has shown that contaminants from a bis-GMA– based sealant altered the proliferative nature of cultured human breast cancer cells.[16] Researchers suggested that the changes in cellular behavior were due to the estrogenicity of bisphenol A and bisphenol A dimethacrylate, or bis-DMA, components found in some dental sealants; these components were identified by mass spectrometry.[15]

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Because of the possibility that some components of modern dental resins are estrogenic, and the increasing use of resin-based materials in dental practice, the need exists to review and discuss existing facts regarding these resins and their safety. To the right is a small, yet current list of some of the dental products that are currently used in many practices that contain Bisphenol A, or some form of it.

There are many other products that contain Bisphenol A, or one of its more prevalent forms, and one can find out which products those are by looking at the product's MSDS sheet.

There is growing concern over dental-related exposure to BPA that is derived from bis-GMA and other related compounds. Many studies have been devoted to further understand BPA exposure from sealants and composite dental restorations. Research conducted by Abby Fleisch, a pediatric endocrinologist, and her colleagues, concluded that BPA does indeed form in the mouth after composite fillings and selants.[17] They didn't determine whether this posed a health risk, but they found that rinsing the completed dental work vastly decreased whatever risk there might be. They concluded that the benefits of sealants far outweigh the risk.[17]

Similarly, a 2008 report by the National Toxicology Program (NTP) states that, "Dental sealant exposure to bisphenol A occurs primarily with use of dental sealants [containing] bisphenol A dimethacrylate. This exposure is considered an acute and infrequent event with little relevance to estimating general population exposures."[18] The NTP reported that bisphenol A in food and beverages accounts for the majority of daily human exposure.[18]

Conclusion

BPA is a common industrial chemical that has been associated with a variety of biological disorders. Studies suggest that BPA can mimic the effect of the female hormone estrogen, thereby raising concerns about its safety. BPA is found in almost every demographic of the population. While BPA itself is most commonly found in plastics, BPA-based resins are used in the manufacture of dental composites and dental sealants. The long-term effects of BPA and its estrogenic derivatives in humans are unknown, and further investigation is needed. This is of special interest to dental professionals, as these materials are routinely used in the practice of dentistry.

In view of the documented exposure during dental treatments for adults and children to bis-GMA- based dental composites and sealants, the routine use of these materials, especially in children, should be considered. It is difficult to say that such a minimal amount of bis-GMA in dental products could be the direct cause for health concerns that are linked to this product.

In 2012, the FDA stated "recent studies provide reason for some concern about the potential effects of BPA on the brain, behavior, and prostate gland of fetuses, infants and children." However, the FDA "recognizes substantial uncertainties with respect to the overall interpretation of these studies and their potential implications for human health effects of BPA exposure. These uncertainties relate to issues such as the routes of exposure employed, the lack of consistency among some of the measured endpoints or results between studies, the relevance of some animal models to human health, differences in the metabolism (and detoxification) of and responses to BPA both at different ages and in different species, and limited or absent dose response information for some studies."[19] Based on this conclusion, the FDA continues to provide for the use of BPA in dental materials, medical devices and food packaging.[20]

As more research is conducted, if BPA is found to be harmful to humans,

dentistry will likely come under fire for the use of BPA derivatives in various restorative materials. Whether the backlash will be similar to one for amalgam is unknown, and will likely depend on a number of factors. However, this raises an important question: Can dental researchers find a material that is safer and more durable than amalgam and composite, or is gold still one of the best restorative materials?

Product	Type	Contains	%
Charisma	Resin	Methyl acralates, bis-DMA	Not listed
Clearfill bond & primer	Bonding agent	BPA	Not listed
Dyract	Resin	Bis-DMA	< 35
Encore	Build up material	Bis-DMA, TEGDMA	Not listed
Estethic X	Resin	Bis-GMA, bis-DMA, TEGDMA	< 15, <15, <10
Filteck	Resin	Bis-GMA, TEGDMA	Not listed
Flow it	Resin	Bis-GMA, bis-DMA, TEGDMA	Not listed
Fasttray liquid	Mold	Methyl Methacrylate	96
Gluma	Microprime	2-Hydroxyethyl Methacrylate	20-50
Ionoseal	G.I.	Bis-GMA, u-DMA	Not listed
Luxaflo	Resin	DMA derivatives, u-DMA	Not listed
Luxatemp	Temp. crown material	u-DMA	Not listed
Orthoresin	Denture acrylic	Methyl methacrylate	100 ppm
OpalDam	Gingival Barrier	DUDMA	80
Panavia	Bonding Agent, resin	GMA, DMA derivatives, BPA	Not listed
Rely X	Cement	DMA derivatives	25-35
Supreme Plus Flowable	Resin	Bis-GMA, TEGDMA, DMA	15, 15, 5
Smart Temp	Temp crown material	DMA/GMA derivatives	Not listed
Structur 2 SC	Temp crown material	Bis-GMA, U-DMA	35-40, 15-20
Teets	Denture acrylic	Methyl Methacrylate	> 98
Tempspan	Temp crown material	EBPA, DMA, U-DMA, bis-GMA, HDDMA	Not listed
Tetric Flowable	Resin	Bis-GMA, U-DMA, TEGDMA	10-30, 7-13, 3-7
Unicem	Cement	TEGDMA, DMA derivatives	25-35, 22-34
Ultra-blend	Liner	U-DMA	58
Ultradent LC block-out resin	Resin	TEGDMA	16
Microprime	Microprime	Hydroxy ethyl Methacrylate	25-45

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The Domino Effect of Board Complaints

By John A. Hunt, Esq., Raleigh & Hunt, P.C.
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For a licensed health care professional, receiving a complaint from their licensing board ("Board") can truly be an unnerving event which can set into motion any number of other events, i.e., the domino effect. The goal of this article is provide licensees with a general outline of the various factors to consider when deciding how to respond to a Board complaint.

In Nevada, each of the health care professional Boards have their own statutes and regulations which, in varying degrees specificity the standards and procedures governing the complaint and its process. Obtaining and reviewing the relevant statutes and regulations should be the starting point when beginning to address how to respond to a Board complaint.

The first question usually asked by a licensee is whether they need an attorney to respond to the complaint. Hiring an attorney can be a very expensive proposition. Sometimes, however, a licensee's malpractice insurance will cover, to one extent or another, representation and defense of a Board complaint. A licensee should carefully review their insurance policy and/or speak with his or her agent about such coverage. If coverage is available, it usually will not cover reimbursement to a complainant or reimbursement of the Board's attorney's fees/costs incurred by the Board during the course of the investigation.

If coverage is available, the licensee should consider requesting the insurer to assign one attorney to address the Board's complaint and another to address any related civil malpractice case, if any. This consideration is suggested because both types of matters have their own goals, claims, standards, procedure, and the like. Sometimes, these goals might be seen as coming in conflict with one another. For example, in a civil malpractice context, the attorney may be very leery of the licensee making any admission but, in the administrative context before a Board, an admission may be required to resolve a pending investigation. The effects of any such admission in one arena need to be carefully considered in another arena.

If insurance coverage is not available, various factors come into play when deciding whether to hire a private attorney to assist in responding to a Board complaint. Such factors include the licensee's past history with the Board, whether the licensee has had prior complaint with the Board, whether the Board has taken prior action against the licensee, the relative seriousness of the complaint, the relative complexity of the complaint. If the Board's complaint appears to only address a relatively simple matter and the licensee has no history with the Board, a licensee may decide hiring a private attorney may be unnecessary. It is suggested, however, when in doubt, do not be penny wise and pound foolish. At a minimum, a licensee may want to consult an experience administrative law attorney to have the attorney review the complaint and answer prepared by the licensee. In the end, it probably is always in the licensee's best interest to have experienced legal counsel in dealing with Board matters.

In crafting a response to a Board complaint, whether with or without an attorney, it is critical to understand that trained investigators and Board members—most of whom are also trained licensees in the applicable field—will be the ones reviewing the matter. Overstating a position or responding as if the targeted reader were a lay person simply will not be effective. The Board personnel reading the response are general experts in the licensee's field. If a licensee thinks they will be able to fool the Board or dazzle them with their credentials or jargon common to the field, they should be disabused of that position sooner rather than later. The Board is generally comprised of the licensee's peers who will know whether a response is truly warranted and/or cannot be justified.

Before addressing the allegations in a Board's complaint, a licensee is probably best served by telling the Board about his/her background, education, awards, community service, experience, years in practice, other licenses, etc. If the licensee has had no prior Board actions, he/she may want to consider addressing the years of exemplary service provided to the community. A copy of the licensee's curriculum vitae should be attached to any answer submitted to the Board.

If it is reasonable to assume the result of the investigation could result in either revocation, suspension, probation, restriction of practice, or a fine then the licensee should seriously consider engaging an expert sooner rather than later to assist in preparing the response to the Board. It is generally more advantageous to provide the Board with an expert's opinion at the earlier stages of the process, as opposed to waiting until the latter, i.e., a formal board hearing. Like in a civil matter, the expert should be provided all available material to review. If possible, a licensee may want to retain an expert who is also licensed

in Nevada and who is readily familiar with the applicable standards of care.

What can the licensee expect after submitting the written response to the Board's complaint? Initially, shortly after submitting the written response, the licensee or attorney should consider contacting the Board to make inquiry if any addition information or documents are needed. Such an innocuous inquiry may garner tremendous benefits in that it may open channels of communication which might be helpful in satisfactorily resolving the matter. If there is a reply to the licensee's response, most Boards will provide the license with a copy. Sometimes, the licensee may be able to provide a supplemental response. After the complaint, response and any supplemental responses are evaluated by the Board, a number of options are available to the Board, including dismissing the matter, entering into a stipulated agreement, or proceeding to a formal hearing.

Licensees obviously seek to have the complaint dismissed. In determining whether to dismiss the complaint, Boards take various matters into consideration, including the licensee's prior history with the Board, the severity of the complaint, standard of care, documentary evidence, whether the licensee acknowledged any wrong doing which may be of import to allay any concerns raised in the complaint. Instead of dismissal, some Boards may remand the matter with or without concern to the licensee's file and in doing so; the Board may also indicate what matters, if any, raised in the complaint that may be revisited in the event the licensee should receive future complaints.

If the complaint is not dismissed, the licensee should seriously consider or reevaluate hiring experienced administrative counsel, if not done already. If the complaint is not dismissed or remanded to the licensee's file, then the complaint will continue to be processed by the Board and further action will be forthcoming. Boards, however, are generally amenable to entering into stipulated agreements, sometimes referred to as consent orders, to resolve complaints.

If at all possible, the licensee should attempt to resolve the complaint at this stage (i.e., shortly after it is learned the complaint is not being dismissed or remanded to the licensee's file) pursuant to a stipulated agreement. It is probably safe to say that should the licensee proceed to a full Board hearing and the Board finds violations, the severity of the final Board action will exceed that of the terms and conditions earlier offered in a stipulated agreement. Further, a stipulated agreement will generally allow the licensee to avoid a public hearing and avoid having to provide testimony under oath which may be used in a judicial setting.

Generally, there are two types of stipulated agreements which may be offered to resolve a complaint. One requires the Board to report the action taken to the National Practitioners Data Bank (NPDB). This type of stipulated agreement is sometimes referred to as a disciplinary stipulation. The other type of stipulated agreement is purely remedial and generally does not require the Board to submit an adverse action report to the NPDB. This type of stipulated agreement is sometimes referred to as a remedial or corrective action stipulation. It is important to note both types of stipulations will be deemed to be a public record.

A remedial or corrective action stipulation will contain no provisions for revocation, suspension, probation, reprimand, fine, or restriction of practice. If any one of these provisions is contained in a stipulated agreement, it must be reported to the NPDB (i.e., a disciplinary stipulation). A remedial or corrective action stipulated agreement usually will require the licensee to obtain supplemental education, reimburse the complainant, and/or reimburse the Board's attorneys fees, costs, and/or investigative expenses. Lastly instead of probation, a licensee may consent to his practice being voluntarily monitored for a given period of time.

Short of dismissal or remand to the licensee's file, a corrective action stipulation should be pursued as it generally does not require an adverse action report to the NPDB, which could start other proverbial dominos to fall, as addressed below. It becomes critical in drafting a response and negotiating with the Board to not only address the Complaint, but also recognize and try and plan for the consequences of any resolution with the Board.

Board action, whether order or stipulation, could impact other areas of the licensee's professional life:

- If the Board's action involves either revocation, suspension, fined or restriction upon practice, there must be an adverse action report reported to the NPDB. A Report to the NPDB can trigger a number of adverse effects. For instance, an adverse action report the NPDB can impact provider contracts with insurance companies. It is not uncommon for provider contracts to contain language allowing the insurance company to terminate the provider contract based upon an adverse action report.
- In addition, an adverse action reported to the NPDB may also affect hospital privileges.
- An adverse action report also may impact your membership in professional associations. For instance, certifying boards, national memberships, and local memberships, different professional associations.

- Further, if an adverse action report involves the reporting of a felony conviction or plea, the Office of the Inspector General ("OIG") may choose to issue an order restricting the physician's ability, for a period of five (5) years, to render care to Medicaid and Medicare patients.

Clearly, it's not just the action of the Board that a licensee must consider when deciding to proceed to a full board hearing or enter into a stipulation with the Board. Depending on the action taken by the Board, it can create a domino effect which must be addressed by licensee. As one might expect, each of the above referenced entities have their own reporting requirements, procedures, timelines, regulations, terms and condition which must be reviewed, analyzed, and considered.

If the likely result is an adverse action, then the licensee, prior to the Board adopting any actions must be aware that most provider contracts, hospital privileges, and professional associations, as well as the OIG, require such action be reported to them within a given time-frame. It is critical for the provider to know the reporting requirements of the respective entities so as not to run afoul of them, which in some cases, may result in automatic termination of the provider contract, hospital privileges, professional association membership, or the ability to provide Medicare and Medicaid services.

Depending on the severity, if it is contemplated that eventually the Board is going to file an adverse action and it involves either a revocation, suspension, probation, restriction of practice or a fine, the licensee must consider taking a pro-active approach and place insurers, hospitals, professional associations and possibly the OIG on notice about the anticipated Board action before it is finalized. The licensee may also want to consider withdrawing from these entities prior to Board action if the contemplated action could result in the termination of the relationship between the licensee and the entity. Withdrawal prior to a final action by the Board usually will negate the necessity of the entity filing an adverse action report to the NPDB.

In closing it is hoped this article given some insight to the administrative complaint process. However the best advice of all to avoid a complaint in the first place is to always communicate positively with your patients. Bad bedside manners and failure to communicate is usually the countless basis for the initiation of complaints to the Board which otherwise would never have been filed.

Event Calendars

Nevada Dental Association

October 2017			
10/19–23	ADA Annual (ADA Delegates, Alternates, ED)	Atlanta, GA	
November 2017			
11/21	NDA Executive Committee	Video Conference	6pm
11/30–12/2	ADA Lobbyist Conference	San Antonio, TX	
January 2018			
1/16	NDA Executive Committee	Video Conference	6pm
1/20	NDA Midwinter Meeting	Las Vegas	9:30am

Southern Nevada Dental Society

October 2017			
10/10	Executive Committee Meeting	SNDS Office	6pm
10/19	Dinner Meeting "Case Off, Can you Top This"	TBD	TBD
10/26	SNDS Board Meeting	SNDS Office	6pm
November 2017			
11/1	Mentorship Financial Panel Discussion	UNLV (dinner provided)	6pm
11/4	CE Premier Next Level Endo, Sponsored by Brassler	TBD	9am-4pm
11/7	SNDS Committee Meeting	SNDS Office	6pm
11/28	SNDS Board Meeting	SNDS Office	6pm
August 2017			
8/23	Dr. Ed DeAndrade "Soft tissue Grafting"	Implant Direct	6pm

Northern Nevada Dental Society

October 2017			
10/10	NNDS Executive Committee Meeting	5605 Riggins Court, #101A, Reno	5:30pm
10/12	NNDS General Membership Dinner Meeting with Dr. Aaron Heide	Atlantis Casino Resort Spa, Reno	6pm
10/17	NNDHP Advisory Board Meeting	5605 Riggins Court, #101A, Reno	5:30pm
10/19	AGD Gen'l Membership Dinner	TBD	6pm
November 2017			
11/7	AGD Dinner Meeting	TBD	6pm
11/14	NNDS Executive Committee Meeting	5605 Riggins Court, #101A, Reno	5:30pm
11/16	NNDS General Membership Dinner Meeting presented by Stanley Malamed, DDS	Atlantis Casino Resort Spa, Reno	6pm
11/17	All Day Continuing Education Course with Dr. Stanley Malamed	Atlantis Casino Resort Spa, Reno	8am
11/21	NDA Executive Committee Meeting	NNDS & NDA offices	6pm

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SNDS Executive Director's Message

With the recent events and devastation of hurricane Harvey the power of community and volunteerism is humbling. It is in the crisis that communities come together and have the ability to show strength and compassion for one another. It easy to get caught up in our own lives and even have thoughts of what have you done for me lately. But when we take the focus off ourselves and turn our energies toward building others through education, mentorship, volunteerism we make our community stronger. Have you invested in your community lately? If not, maybe now's the time.

I want to take a moment to thank those who take the time to build community through volunteerism. Our community is stronger through those who give their time and energy to others. There are many ways to give back to your community. This will be our 16th year offering Give Kids a Smile providing dental treatment to those children that are underserved in our community. Our next Give Kids a Smile event is at UNLV SDM on Feb. 3, 2018, sign up online at sndsonline.org. The SNDS Angel program was established this year with Dentists volunteering their time to help other Dentists that are temporarily unable to practice due to injury or illness. If you are interested in joining the Angel program, sign up at sndsonline.org. What about Mentorship, have you ever considered taking the time to help develop and educate a future or new dentist, sign up at sndsonline.org. SNDS and UNLV School of Dental Medicine are hosting the first Benefit for Smiles Gala on December 1. The goal of the Gala is to raise funds to support the Saturday clinics at UNLV SDM providing care for Veterans, battered women, and children. To support this event and cause find the link on our website at sndsonline.org. I also want to recognize the students from UNLV SDM who traveled to Bolivia providing dental treatment, amazing work was done there and lives were changed. Thank you to all that engage in these efforts to build our community.

I can't talk about volunteerism without thanking those that are involved daily in the efforts to support organized dentistry

I can't talk about volunteerism without thanking those that are involved daily in the efforts to support organized dentistry. Have you ever considered being involved? What about advocacy, there are many in our dental community that volunteer their time to advocate for dentistry and for you, have you considered engaging in supporting their efforts. Peer review is a committee of volunteers supporting our local doctors by offering mediation services. Maybe you are gifted in leadership, we need you to support our local committees. There are so many ways we can give and build our community, there is strength in numbers.

Don't be the one sitting on the sidelines criticizing that efforts are not good enough, I encourage you to put your skin in the game. What are your strengths and how can you support your community?

"It behooves everyman to remember the work of the critic is of altogether secondary importance, and that, in the end progress is accomplished by the man who does things"

-Theodore Roosevelt

Joseph Wineman, DMD

2017 Legislative Session

and its impact on Businesses to include Dental Practices

While the NDA and its lobbyists did not achieve a "win" during this legislative session (The non-covered services bill was shot down, the fluoridation of Washoe County was defeated), it did advocate for our profession in other ways particularly with respect to proposed bills from either the Senate or the Assembly that if passed could have affected businesses, to include dental practices, across the state. What follows is an explanation and/or outcome of the top bills affecting our work places.

1. Paid Sick Leave: Would have required employers with 50 or more employees to provide full time employees with sick leave at a rate of 1 hour for every 40 hours worked. Further, it would have required employers to allow accrued sick leave to be rolled over each year until it reached maximum of 80 hours.
» Vetoed

2. Paid Maternity Leave: Paid maternity leave was discussed at length this session, in particular, during hearings and meetings on a bill that passed titled the Nevada Pregnant Workers' Fairness Act, which will require businesses with 15 employees to make "accommodations" for pregnant employees. Employers will be required to do the following:

- Post a required notice in the workplace in a conspicuous place at their business locations, in an area that is accessible to employees;
- Provide all new employees with a notice at the beginning of employment; and
- Provide a notice to any employee, within 10 days, who informs her immediate supervisor that she is pregnant.

The notice must contain the following:

- Employees have the right to be free from discriminatory or unlawful employment practices (based on pregnancy, childbirth, or related medical conditions) pursuant to *NRS 613.335* and sections 2 to 8, inclusive, of the Act.
- Female employees have the right to reasonable accommodation for a condition relating to pregnancy, childbirth, or a related medical condition.

» Passed

3. Private nursing space: Mandatory for business with more than 50 employees-employer must provide the employee time as well as a clean and secure location (not a bathroom) for the female employee to nurse her child or pump breast milk. Businesses with less than 50 employees are exempt if it would place an undue hardship on the business.
» Passed

4. Baby changing stations are now mandatory in both men's and women's bathrooms in new construction of public buildings.
» Passed

5. Wage discrimination: If an employee felt that they had been slighted on wages because of discrimination based on race or sex, they could have been allowed back pay for a period beginning two years before the date of filing an unlawful employment practice complaint and ending on the date the Nevada Equal Rights Commission (NERC) issues an order regarding the complaint. Bill would have created a tiered system of civil penalties for pay discrimination rather than a flat civil penalty. Specifically, the employer would have been required

»

to pay $10,000 for a first offense, $15,000 for a second offense, and $25,000 for a third offense.
» Vetoed

Another wage discrimination bill stated that if an employee complained to the Nevada Equal Rights Commission regarding unpaid wages, and the employer was found to have been guilty of failing to pay the wages, a court would have been allowed to award treble (triple) damages to the employee.
» Did not pass

Another measure took a different angle and tackling wage discrimination. If a Nevada company wanted to bid on a government contract for the state, they would have to certify that they have pay equity across the organization and be able to prove it. This would have been very challenging for many businesses who provide goods and services to the State. The business community worked with the bill sponsor to amend the bill so that it creates a voluntary pay equity certification program. Businesses could then use that fact that they are certified in marketing materials. Also, if only out-of-state companies are bidding on a contract, the company with certified pay equity may take advantage of a 5 percent bidder preference.
» Passed

6. Non-Compete clause: Several bills were introduced with the intent of restricting non-compete clauses. Dental connection—what happens if an associate wants to leave and start their own practice? The non-compete bill that ended up passing states that a covenant for non-compete is void and unenforceable unless the non-compete covenant:

- Is supported by valuable consideration;
- Does not impose any greater restraint than is required to protect the employer;
- Does not impose any undue hardship on the employee; and
- Imposes restrictions that are appropriate in relation to the valuable consideration.

The bill will also allow a former employee to work for a former customer or client so long as the employee did not solicit the client or customer; the client or customer voluntarily left and sought the services of the former employee; and so long as the employee is otherwise complying with the other provisions of the non-compete contract as to time, geographical area, and scope of restrained activity. Any non-compete provision not in compliance is rendered void and unenforceable.
» Passed

7. Higher Taxes on New Homes: A bill was introduced that would have required $1500 residential construction tax to go to school construction. In Clark and Washoe County, the plan was to have the developer pay this tax for new construction (of course the tax is passed on to the home buyer).
» Passed the Assembly but never made it out of committee

8. Minimum wage increase: Three separate proposals would increase minimum wage. One would have required an increase of 75 cents per hour each year for 5 years until it reached $12 per hour or $11 per hour if the employer offered health insurance. Another would be have required an increase each year until it reached $15 per hour.
» Vetoed

A separate measure: Senate Joint Resolution 6, seeks to amend the Nevada Constitution to increase the minimum wage to $9 per hour. Beginning on January 1, 2022, the minimum wage must be increased by 75 cents each year until it reaches $12 per hour. As a joint resolution, this measure must pass again in 2019 and receive approval by a vote of the people.

9. Sick Leave Usage: Would have required employers to allow employees to use sick time to care for a family member, limited to 6 months' worth of sick time. Noncompliance would have resulted in $5K fine.
» Did not pass

10. Mandatory Leave for Employees who are (or whose family or household members who are) victims of domestic violence, sexual assault, or stalking starting January 1, 2018. The new law covers all Nevada private employers.

Under the new law, an employee is eligible for this leave if the following criteria are met:

- The employee has been employed by the employer for at least 90 days; and
- The employee or the employee's family or household member is a victim of domestic violence, sexual assault, or stalking.

For purposes of this law, the term "family member" means the employee's spouse, domestic partner; minor child; or parent or other adult person who is related within the first degree of consanguinity or affinity to the employee, or other adult person who

is or was actually residing with the employee at the time of the act which constitutes domestic violence.

An employee is not eligible for this leave where a family member is the victim and the employee is the alleged perpetrator.

Eligible employees can take up to 160 hours of leave within 12 months immediately following the date on which domestic violence occurred. Time off can be taken for the following purposes:

- for the diagnosis, care or treatment of a health condition;
- to obtain counseling or assistance;
- to participate in a court proceedings; or
- to establish a safety plan, including any action to increase the safety of the employee or the employee's family or household member.

Employers can require that employees provide documentation (e.g. police reports, copies of applications for protection orders, affidavits from victims' organizations, or documentation from a physician) to support the employee's use of leave. This documentation must be kept confidential by the employer.

In addition to leave rights, the new law also requires that employers provide reasonable accommodation for employees who are (or whose family or a household member are) victims of domestic violence. Possible reasonable accommodations include, but are not limited to:

- transfers or reassignments;
- modified schedules;
- new work telephone numbers; or
- other reasonable accommodations that do not create undue hardships and that are necessary to ensure the safety of the employee and the workplace.

» Passed

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News from the Northern Nevada Dental Society

With autumn approaching we look forward to welcoming many new dentists and their families to northern Nevada. We were able to meet and greet many of you at the NNDS New Dentist function at Beer NV and most recently at the NNDS Open House picnic at Bartley Ranch. Thank you all that attended, we hope that you had the opportunity to meet many of your fellow colleagues as well as our leadership dentists. The NNDS has another opportunity for you to come and bring a guest, spouse, family or friends on Sept. 20 for a professional soccer game. See our website and check your email for more details and sign up!

The Northern Nevada Dental Society has a great line-up of continuing education opportunities for our 2017/18 year. October 12, we host Aaron Heide, M.D. to talk about "Dentists preventing Strokes." In November we are extremely fortunate to welcome Dr. Stanley Malamed for a general membership dinner meeting on 11/16/17 "What's new in Local Anesthesia" and on 11/17/17 "10 Minutes to Save a Life: Emergency Medicine in Dentistry." Sign up on-line, download a copy of the flyers or call the NNDS office today. Check out our website or this journal for our event calendar in 2018 including Dr. John DiMuro, NV Chief Medical Officer and Larry Pinson from the NV State Board of Pharmacy, a Vendor Night in February and other quality continuing education planned for 2018.

I'd like to thank our members and new members who will be renewing their tripartite membership this fall. Dues statements will be mailed out in November. We value you and we want you to appreciate the value for belonging. If you have any comments or feedback on how the NNDS the NDA or the ADA can help you and your practice, we want to hear from you. We now have made membership value our top priority and have formed a committee to discuss your issues, your wants from your membership, and your needs to belong. Please give us your thoughts and views.

Please continue to watch for our upcoming events and continuing education opportunity flyers and notifications in your mailbox, email and on the NNDS Facebook page. We have some excellent education coming up. If you are not receiving them please contact the NNDS directly or email me at nnds@nndental.org.

Welcome Newest NNDS Members

Nathan Antione, DMD – General

Jake Banks, DDS – General

John Eric Cercek, DMD – Endodontics (welcome back)

Clayton Fisher, DDS – Oral Pathologist

Stephen Frugoli, DMD – General

Natalia Montoya, DMD – General

John Silvaroli, DMD – General

Spencer Fullmer
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NNDS President's Summer Message

The changing of seasons is fun and exciting. Fall, for me, means crisp morning air, perfect mountain biking conditions, and of course football! These things make me happy, and give me a feeling of comfort. As I look ahead to the fall activities and opportunities that we have planned for our members of the NNDS, I get that same feeling of happiness and comfort.

The level of camaraderie was palpable with an all-time high attendance at our annual barbecue, and we will soon be having a spouses/family night at our local professional soccer venue. Essential and applicable CE courses will be offer, and the opportunity to serve those in need will be met with our annual J. F. Glover charity golf tournament, and a Remote Area Medical (RAM) event. For these reasons, to name a few, membership in the NNDS actually does bring happiness and comfort.

We should strive for comfort, but we all have heard about the dangers of getting too comfortable. We are not progressing, or growing if we are too comfortable. In this vein, I would like to share a "practice pearl" that was shared with me while in my endodontic reside. This initially made me uncomfortable, but has since proven to be invaluable.

I've been asked, "as an endodontist, what is your favorite piece of equipment". My microscope is number one, and a very close second is my intra-osseous (IO) injection kit. One of our goals as dental professionals is to provide painless treatment. We've all experienced trouble with anesthesia, specifically with mandibular, posterior teeth. This no longer need be the case because of IO injections.

This short journal article is not the platform to present the needed detail for implementation of the 10 injection, but suffice to say that without the 10 injection, 1 would only offer to treat maxillary teeth. Now, when working on the mandible I have complete piece-of-mind that patients will sit up at the end of treatment and report a completely pain-free experience. Yes, I was initially uncomfortable with even the idea of the IO injection, now...I couldn't imagine practicing without it. Learn about it, or give me a call. I would be more than happy to talk about it with any of you.

We should strive for comfort, but we all have heard about the dangers of getting too comfortable. We are not progressing, or growing if we are too comfortable.

An appropriate challenge to all of us would be to enjoy life's comforts this fall, but to try something new too! May we all enjoy prosperity this fall season. Warmest regards.

News Briefs

A Student's Take on the New Dentist Committee

By Taylor Cohen (This article was originally published on ASDA's blog Mouthing Off on August 27, 2017, and is reprinted with permission from the American Student Dental Association.)

I am at the start of my third year, wondering how I am going to survive through all the clinical requirements, when I am asked to be a student representative for the New Dentist Committee of the Southern Nevada Dental Society. I hesitated at first, having so much on my plate already. In the end I decided it would be a very good opportunity to get involved in a different aspect of dentistry. A year later, I can officially say I am glad to be a part of this group. The New Dentist Committee is comprised of local dentists who have been out of school for 10 years or fewer. I joined two others as the dental student members of the committee. The committee's main objective is to build strong leaders within organized dentistry by advocating for member benefits, resources and services. They also strive to bridge the gap between dentists and dental students.

Over the past year, I have been able to help plan successful events both in social and academic settings. The social events allowed dental students to mingle with local dentists and gain different perspectives on life after dental school. Preparing for that transition can be tough, and it helps to talk to others who have gone through it recently. Several of the new dentists graduated from our school, so they had advice for how to stay on track during the last two years and graduate on time. On the academic side, we hosted a variety of panels at the school where professionals came in to speak about topics from financial planning to legal pitfalls, including how to avoid getting sued. Students found these panels extremely valuable, since we don't necessarily learn that information in the classroom. In fact, these panels were such a success that several more are planned for the upcoming year. New topics will include CV and resume writing and contract negotiation.

The dentists on the New Dentist Committee of the Southern Nevada Dental Society have truly been amazing to work with. They are always open to student ideas and constantly reach out to see if there is anything we may need. Thanks to this organization, students are starting to feel less panicked about what comes after graduation. I look forward to working with them and the new student representatives. Together we're building a strong base of support and information for students and professionals.

The ADA's New Dentist Committee also exists at the national level, representing each of the ADA's regional districts. Find out more at http://www.ada.org/en/member-center/leadership-governance/councils-commissions-and-committees/current-councils-and-commissions/new-dentist-committee.

Student and professional members of the SNDS's New Dentist Committee

Opioid Manufacturers Sued

Oklahoma is the fourth state to sue opioid manufacturers over their marketing practices, claiming that they fueled the state's epidemic of opioid addiction. Drug overdose deaths increased eightfold from 1999 to 2012, surpassing car crash deaths in 2009. Teva Pharmaceuticals recently agreed to pay $1.6 million for substance abuse treatment to settle a lawsuit brought by two California counties (http://tinyurl.com/yaj3gd3v). A retired Border Patrol agent noted that the broad governmental solutions to the opioid epidemic are focused on the pharmaceutical companies, pharmacists, and doctors, and never even mention the transnational criminal element bringing killer heroin and fentanyl to the illegal market in the U.S. through sanctuary cities and cartel hub cities. "Could it be that the trial lawyers association figured out they can't litigate the transnational criminals?" Mexican poppy fields cover an area larger than the District of Columbia (http://tinyurl.com/yckqgnyt).

ADMISSIONS AND STUDENT AFFAIRS

The Office of Admissions and Student Affairs is nearing the end of the selection process for the incoming Class of 2021. There were 1,951 applicants for the 2016-17 application cycle. We are gearing-up to welcome approximately 82 new students to the UNLV School of Dental Medicine family. The 2017-18 application cycle for the recruitment of the Class of 2022 began on June 1. As of August 4, 1,128 applications have been received.

The Class of 2020 White Coat Ceremony will take place at 3 p.m. on Friday, September 22 at the Artemus W. Ham Concert Hall on the UNLV main campus. This ceremony marks our second year student's transition from preclinical to clinical instruction. Participants will affirm their commitment to uphold the ethics, integrity, and professionalism expected of health providers as well as sign the UNLV SDM Honor Code agreement. We are privileged to have Dr. Gillian Galbraith, former SDM Biomedical Sciences Chair as our keynote speaker.

ADVANCED EDUCATION IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS RESIDENCY PROGRAM

In July, we welcomed six new residents into the Advanced Education Program in Orthodontics and Dentofacial Orthopedics and Master in Oral Biology program. Class members include the following:

Graydon Carr, DDS
University of the Pacific Arthur A. Dugoni School of Dentistry

Alexander Dao, DMD
Temple University

Daniel Jarrett, DMD
Midwestern University – Illinois

Andrew C. Lee, DDS
University of California, San Francisco

Sogol Shantiyai, DMD
Midwestern University – Arizona

Melissa Ven Dange, DMD
Western University of Health Sciences

ADVANCED EDUCATION PROGRAM IN PEDIATRIC DENTISTRY

The six members of the Class of 2017 completed their program in June. We wish Dr. Quynh Bui,

Dr. Li Feng Cao, Dr. Chandler Hyer, Dr. Samuel Oh, Dr. Laurita Siu, and Dr. Nasim Zarkesh all the best.

OFFICE OF RESEARCH

Dr. Elena Farfel is developing and implementing a research project with the Periogen Company. Approximately 12 dental students were engaged in summer research projects. The School of Dental Medicine is engaging in collaborations with other schools at UNLV including engineering, medicine, and nursing.

Faculty Publications

JL. Ebersole, D. Dawson III, P. Emecen-Huja, R. Nagarajan, **K. Howard**, ME Grady, K. Thompson, R. Peyyala, A. Al-Attar, K. Lethbridge, S. Kirakodu, OA. Gonzalez. The Periodontal War: Microbes and Immunity. *PubMed*. July, 2017.

Q. Bui, C. Nguyen, J. McDaniel, S. McDaniel, K. Kingsley, K. Howard. "Selenomonas noxia Screening among Pediatric Patient Samples: A Pilot Study." *Journal of Oral Health and Dental Care*. 2017. Available from http://www.scientificoajournals.org/pdf/johd.1009.pdf.

C. Demopoulos, M. Ditmyer. "Bridging the HPV Knowledge Gap." *Dimensions of Dental Hygiene*.June, 2017.

D. Orr. "Dental operator-anesthetists." *Journal of the American Dental Association*. July, 2017.

FACULTY NEWS

We are pleased to welcome Dr. Jeffrey Ebersole and Dr. Linh Nguyen. Dr. Ebersole is the Associate Dean of Research and a Professor of Biomedical Sciences. Dr. Nguyen is a Visiting Assistant Professor of Biomedical Sciences. We also welcome back Visiting Assistant Professor of Clinical Sciences Dr. Amy Tongsiri who completed her DMD degree at SDM in 2008.

- From July 10–14, Dr. Benjamin Barborka and Dr. Brian Chrzan attended the ADEA Emerging Leaders Meeting in Freeport, Maine.
- Dr. Woo presented "Multifocal localized juvenile spongiotic gingival hyperplasia treated with combined laser and topical corticosteroid therapy" at the American Association of Oral and Maxillofacial Pathology conference.
- Dr. Gayla Raz is now a Diplomate of the American Board of Periodontology.
- Dr. Edward Herschaft, Dr. Stan Nelson, and Dr. Eve Chung traveled to Tianjin, China June 17-July 3 to conduct elective courses to dental students as part of an ongoing exchange program with the Department of Stomatology, Medical School of Nankai University.

COMMUNITY SERVICE REPORT

Faculty, students, and staff continue to provide preventive services in community-based, underserved settings in Clark County. Services are offered at health fairs, career fairs, and the school-based sealant program (Seal Nevada South). From May 12, 2017 to June 30, 2017 a total of $8,917

in donated services was offered to children, adults, and seniors at 21 separate events. During these events 180 screenings (81 children, 59 adults, and 40 seniors) were completed and fluoride varnish was provided to 127 individuals (75 children, 32 adults, and 20 seniors). Informational events targeting children had 732 attendees and events targeting families had 645 attendees.

DEVELOPMENT NEWS

In partnership with Henry Schein, the School of Dental Medicine hosted a Digital Dentistry Demonstration on Saturday, June 17. Thanks to E4D Technologies and their loan of CAD/CAM equipment, we were able to provide several same day crowns for patients during the school's Saturday Community Clinics, which provide low-cost and no-cost dental care to children, women, homeless persons, and veterans. Thanks to a $10,000 lead gift from Henry Schein, the School kicked off a Digital Dentistry fundraising campaign to secure cutting-edge technology featuring Planmeca's same-day dentistry product line.

Recent donations to the School of Dental Medicine include over $130,000 of in-kind support from Ormco to support our Orthodontic Clinic, $10,000 from Delta Dental to support our Saturday Community Clinics, and $10,000 from Absolute Dental to support our Hispanic Student Dental Association's mission trip to Bolivia. We thank all of our donors for their support and generosity. To learn more about supporting the UNLV School of Dental Medicine, please contact Nikki Khurana-Baugh at 702-774-2362 or via email at nikki.khurana-baugh@unlv.edu.

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Similarities Between Bill Cosby and Dr. Greg Minton, DDS, MD

*By Oscar Goodman, J.D.**

I've found the Bill Cosby prosecution strangely similar to one in which I successfully defended a criminally accused Nevada dentist years ago. Earlier this year I saw Dr. Dan Orr at the annual meeting of the American College of Legal Medicine, which ACLM President Orr had asked me to speak out. I reminded Dr. Orr about our previous case and he said it might be valuable for today's dental association members to hear, so I agreed to write an article for the dental association journal.

In 1993, I was flying back to Las Vegas from Los Angeles and by happenstance my seat mate was the colorful journalist Ed Becker. I had known Ed from being around courthouses where I was trying cases and respected him as an investigator, author, and a nationally recognized expert on organized crime, alleged members of which formed basically my clientele.

Ed told me that as an active member of Accuracy in Media, a watchdog group designed to monitor press coverage of trials, he was concerned that an oral and maxillofacial surgeon in Carson City was being treated in a heavily lopsided manner by the local press which was covering the doctor's legal proceedings where he was going to be tried for multiple acts of sexual molestation of patients while they were under the influence of an anesthetic cocktail.

After the plane trip, I received a phone call from Dr. Gregory Minton, the accused physician. He told me that Becker convinced him to fire his attorney and hire me.

Dr. Minton agreed to a very handsome fee and we met in my Las Vegas law office. The facts were atrocious. Seven of his patients accused him of various acts of oral sex, and each was circumstantially corroborated by the doctor's employees who gave statements reflecting that the doctor, at their 5 o'clock losing time, told them to "go home, lock the office door, close the drapes, and turn up the music" while the patient was in the dental chair and their "ride" sat in the waiting room. The patients all testified, then the people waiting for them testified, as to what the patient told them the doctor had done.

My practice never brought me into the arena of the effects of anesthesia on patients and although I was pretty good at cross-examination of informants and FBI agents, I never had ventured into a case where multiple plaintiffs brought forth accusations which were eerily similar to each others.

In addition to the fact pattern, the Reno and Carson City newspapers and television channels were blasting away daily, calling for a "lynching" of my client.

I got lucky. After fruitlessly looking for a defense expert, I was referred to Dr. Dan Orr of Las Vegas. Dr. Orr told me that anesthetized patients often hallucinate, and at times about having sex with the doctor, after receiving anesthesia. Dr. Orr was a law student at this time and even advised me of several cases from the mid-1800's where the phenomenon was first recognized. Dr. Orr then arranged to film a typical surgical procedure involving conscious sedation for third molar removal which demonstrated the profound effects of anesthesia nicely during an immediate post-operative interview with the female patient.

A USC anesthesia professor, who was referred by Dr. Orr and who was considered an expert on the effects of certain anesthetics on patients also participated.

This was all new to me and to the jurors during the trial. The prosecutor scoffed at the very suggestion as being preposterous. The judge belittled such theories as being ludicrous.

I tried the case doing what I do best, showing prior inconsistent statements of my client's accusers (including documented admiration for Dr. Minton and gratitude for treatment received), weaving a thread through the alleged victims who testified they had not spoken with each other, yet they all shared a common investigator, some the same employer (the police station), were prepared for trial by the same prosecutor, and knew socially the employees of my client, an obvious potential source of bias on the part of my client's employees which very well may have shaped opinions against Dr. Minton.

As I was gaining headway, sensing that some of the jurors appeared to objectively consider our side of the story, the prosecutor pulled his ace in the hole. He called a tall, handsome witness, another OMS from Las Vegas to the stand. He happened to be a Past President of the state dental association and had impeccable credentials overall. The jury perked up and listened attentively to the prosecution's expert testimony. He too ridiculed the theory advanced by Dr. Orr as being "hogwash" and "wishful thinking." I flew back to Las Vegas feeling the testimony had been devastating to my client.

Once again, I called on Dr. Orr. When I explained the situation, he told me that he had a patient who could be

helpful regarding not only his own testimony but also in rebutting the prosecutor's expert's testimony, if she would agree to testify. As Dr. Orr shared with me, essentially, the patient had come to Dr. Orr for treatment after being treated by the prosecution's expert. Dr. Orr asked her why she chose not to return to the expert for treatment and the patient told Dr. Orr that after receiving anesthesia from the expert, that he had taken her into the desert and had sexual intercourse with her. Dr. Orr, with his experience as an anesthesiologist and surgeon, and based on other factors, didn't believe the story, but understood she felt her statement was true.

At my request Dr. Orr contacted his patient and she subsequently agreed to speak with me. I met with her and she confirmed her recollection of the incident as related by Dr. Orr.

That Monday the trial recommenced. The district attorney repeated his argument about the absurdity of the hallucination theory and the prosecution witness continued to belittle our position.

My turn to cross-examine came. I first asked the expert: "Have you ever had a patient hallucinate?" Answer: "No." "Did you ever have a patient (and I described the woman I had interviewed just the day before)." Answer: "Yes." "Did she receive anesthesia as part of the procedure?" Answer: "Yes." "Did she complain of any impropriety on your part?" Answer: "No." Did you take her into the desert and have sexual intercourse with her?" Answer with a highly offended tone and a sneer on his lips: "Absolutely not."

I turned to the judge, who was visibly showing his contempt for me in the jury's presence, and said I had no further questions, but that I was not excusing the expert now and reserved the right to call him back during my defense. Reluctantly and in an apologetic manner, the judge told the witness to be available until my defense was concluded. The OMS stated he was very busy and needed to get back to his practice. The judge said: "Mr. Goodman apparently doesn't care." The jury felt the tension and knew the judge was thinking this was one of Goodman's games ant that I was just wasting everybody's time.

With that mood in the courtroom, the prosecutor rose and with false humility and the overconfident conceit of one who thinks his position is unassailable said: "The State rests."

The judge ordered me to proceed, forthwith. I had called Dr. Orr previously and he had provided the court with his opinion, bolstered by ancient anesthesia legal cases, such as one from the 1850's wherein a doctor was accused of rape but that multiple witnesses, including the patient's fiancé, stated the crime never happened. Dr. Orr also had provided the video he made that clearly demonstrated that, in his words, the testimony of anesthetized patients is "reliably unreliable."

I then called our own surprise witness, and respectfully showed her to the witness chair. I could sense the judge's nascent apprehension and by the jury's body movement to the front of their seats I knew I had the courtroom's attention despite the apparently insurmountable case against us.

After some preliminary questions, I brought the witness to the point where she was in the prosecution expert's chair and he had given her a shot of anesthesia, after which: "… he took me to the desert and brutally raped me." The jurors were aghast; and the judge believed I was suborning perjury.

I turned to the bailiff and said: "Please have the plaintiff expert come back to the courtroom." The tall handsome dentist came in. He and the woman in the witness chair exchanged looks of recognition. Our witness pointed to the expert and shrieked: "That's him. That's the man who raped me." She sobbed and shook uncontrollably. The jury could not look at the expert.

Does this all sound somewhat familiar with regard to a recent case in which alleged drugged victims testified against someone, with the additional circumstance of many, many years passing? I speak of the Bill Cosby case. What I learned so clearly those days in Carson City was that anesthetized patients are indeed "reliably unreliable" witnesses. The legal principle established in early anesthesia cases and documented modernly by Dr. Orr that the testimony of anesthetized patients is not reliable, was clearly demonstrated. The prosecution proved nothing near the criminally required "beyond a reasonable doubt."

Dr. Minton was found not guilty by a jury of his peers.

**After a successful criminal defense legal career, Oscar Goodman was elected Mayor of Las Vegas from 1999-2011. He is married to current Las Vegas Mayor Carolyn Goodman. He is a member of the Screen Actors Guild and appeared in Casino and Red Herring. He is a Founder of the Meadows School and currently resides in Las Vegas.*

Editor's note: Such accusations are mitigated by never being alone with a patient. Patient's memories are often confused in dental fora, more so when controlled substances are involved. At times, patients are legally predatory.

With regard to Dr. Minton, we may never really know whether the accusations were true. However, it is clear that the Carson City district attorney was unprepared and never proved the case beyond a reasonable doubt. In addition, such proof would have been relatively straightforward to obtain considering the disloyalty of Dr. Minton's office staff. With regard to the prosecution's expert OMS witness, I had the opportunity to help successfully defend him when he was accused by regulators of exceeding the scope of dental practice for doing pre-admission physical examinations (as required by hospitals) for patients being admitted for hospital based procedures.

Treasures of Pioneer History

Well Known Dentist Called to Spirit World

There are many people throughout Utah who will regret to learn of the death of Dr. William H. Groves, which event occurred at 7 o'clock last evening at the St. Mark's hospital. Dr. Groves was 61 years of age and for more than half that time had been a resident of Salt Lake City. For many years he was recognized as being the head of his profession—that of dentist—here. Some years ago he retired from business, and since then he has devoted much of his time to books. He was a man of excellent attainments, and possessed many warm friendships. An ardent worker in any cause which he espoused, he was regarded by many as somewhat eccentric in many ways, but withal was honest, sincere and generous. He had the courage to stand up for what he believed was right, though he might thereby give offense to friends whose views differed from his. The practice of his profession brought him considerable means, in the handling of which he sought to be careful and judicious. In this matter he was known for many acts of charity and generosity, in helping those whom he found in need and in devoting his money to a good purpose. These noble traits of his character endeared him to a large number of acquaintances.

For several months the deceased had been in failing health, but his spirit struggled against the body's frailties and upon every occasion when he could leave the sick room and be out among friends he would do so. His last appearance on the street was two weeks ago today, though for a week previous he had been receiving attention at the hospital. On the occasion named he came downtown and transacted some business, then returned to the hospital. He leaves an estate of considerable value. He has no immediate relatives in Utah, but has a sister in Illinois and a brother and sister in New York. The funeral services will be held Sunday morning, commencing at 11 o'clock, in the Fourteenth Ward assembly rooms. An invitation is extended to friends to be present.—Desert News, April 27, 1895.

Dr. Grove's Funeral—The funeral services over the remains of the late Dr. Wm. H. Groves was held in the Fourteenth Ward assembly rooms on Sunday at 11 a.m. The speakers were Elders Franklin D. Richards, Moses Thatcher, John Henry Smith, Angus M. Cannon and George H. Taylor. They referred to Brother Grove's industry, thrift and moral uprightness, of his professional attainments, and of his studious character. References were briefly made to the provisions in his will by which a bequeath was made to St. Mark's hospital and also for the founding of a hospital for the benefit of the Latter-day Saints. His remains were placed in the burial ground of Elder F. D. Richards, in the City Cemetery. The bequests spoken of were $500 to the St. Mark's hospital where he died, all his real estate—valued at $75,000 or more—for the founding of the Dr. W. H. Groves Latter-day Saints hospital, and his personal property to his brother and two sisters. Desert News, April 29, 1895

Isaac Morton Behunin

Isaac Morton Behunin was born in Richland, Oswego County, New York, September 8, 1831. He was the son of Isaac and Meribah Morton Behunin. The family moved to Kirtland, Ohio in 1834; thence to Nauvoo, Illinois where Isaac Morton was baptized September 12, 1839 and confirmed a mem-ber of the Church of Jesus Christ of Latter-day Saints. They left Nauvoo at the time of the exodus in 1847 and arrived in Salt Lake City September 9, 1849 from Council Bluffs. He lived at various times in Ephraim, Sanpete County; Circleville, Piute County and Spring City, where he became a farmer and a blacksmith. He also served as the pioneer dentist of that community. Isaac Morton passed away January 15, 1910 at Spring City, Utah. A pair of forceps made by him was given to my father, Isaac William Behunin, who pulled many teeth for his children and the neighbors' children. When I was a little girl living in Ferron, Utah father took me to John L. Allred's home to have a tooth extracted. I was reluctant to have the tooth pulled unless he would put something on it to deaden the pain. "Sure I will," said Mr. Allred. I can imagine he gave father a wink. He went to the kitchen and returned with a bottle and rubbed some of its contents on my gums. I re-member telling father very disgustedly on the way home that he couldn't pull any more of my teeth because all he put on it was lemon extract.—Crystal B. Guymon

The Ethics of Using Secret Shoppers/Patients in Healthcare

Applying the Army-Baylor 7-Step Model for Organizational, Ethical Decision-Making

By CPT Peter Houhoulis, MS, USA; CPT Jill Rodgers, SP, USA; Dr. Karen Zucker
Army-Baylor Graduate Program in Health and Business Administration

1. Frame the Question

Is it ethical for healthcare organizations to use secret shoppers to assess the patient experience?

2. Set Out the Organizational Situation

Background

- Healthcare has become a competitive marketplace where organizations try to demonstrate their attentiveness to quality and the patient experience. In recent years, greater effort has been put toward understanding patient satisfaction and how it relates to revenue generation.
- The use of secret shoppers is a practice in which an organization hires an outside individual to pose as a normal customer to evaluate and report on the customer experience. Secret shoppers have been used successfully in retail markets and are now being used by some healthcare organizations.

Organizational issue

- While feedback received from secret shoppers has proven helpful in identifying process improvements that may benefit patients, some physicians feel that the practice is predicated on deception and can actually harm the physician—patient relationship.

3. Note the Contextual Factors

Stakeholders

Patients

- Possible negative impact on the care given to patients (e.g., exposure to unnecessary studies, tests, etc.)

Providers

- Possible effects of the secret shopping practice on the patient-physician relationship
- Failure to view the physician as a professional
- Potential consequences of using deceitful tactics in a field where honesty and trust are core values Healthcare

Organizations

- Identification of potential areas or services needing improvement
- fees charged by secret shopping companies are small In comparison to revenue lost due to patient dissatisfaction
- Overhead costs and wait times are increased by staff/employees who perform their jobs inefficiently
- Impact of reducing the practice of medicine to a business model

4. Revisit the Question

Is it ethical for healthcare organizations to use secret shoppers to assess the patient experience?

5. Ask and Answer Relevant Questions

1. How would the other side define it? Critics feel that secret shoppers take already limited time and resources away from real patients, and that the secret shopper method introduces deceit into the trusting patient-doctor relationship.

2. What Is your intention? The intention of using medical secret shoppers is to evaluate and ultimately improve the patient's experience.

3. Whom could your decision injure? This practice could potentially erode the trust between physicians and patients, as well as with management In addition, patients could be potentially harmed by the delay in care caused by sham patients.

4. Can you discuss the problem with the affected parties? Yes, discussion with employees, especially providers, can greatly improve the implementation of secret shoppers.

Adapted from L.L. Nose's 12 Questions for Orgies/Monet Decision Making." Miss without the Sermon. }larva:el Business Review 1982.

6. Identify and Weigh Alternatives

- Utilize other methods of customer feedback such as customer surveys
- Notify medical facilities and physicians in advance when a secret shopper will be visiting
- Limit secret shopping to telephonic and/or web-related interactions only
- Develop organizational policy for use of secret shoppers only when certain metrics fall below set standards
- Allow secret shopping with no restrictions

7. Decide

Yes, it is ethical to use secret shoppers in healthcare as long as parameters are in place that ensure secret shoppers do not disrupt the delivery of services and that valuable resources are not wasted.

White Paper on Repeal/Replacement of the Affordable Care Act

By Jane M. Orient, M.D., for the Association of American Physicians and Surgeons
Reprinted with the permission of the AAPS

Executive Summary

Repealing the Affordable Care Act (ACA), known as "ObamaCare," after it has been in effect for 7 years is rather like trying to uproot kudzu. It is deeply entwined in American medicine, and despite soaring premiums and deductibles combined with difficulties accessing actual medical care, many people are dependent on it. One needs to avoid collateral damage.

ACA is also integrated into the structure of the "health-care delivery system,"which is built on an unsound foundation: forcible redistribution of wealth and the concept of "comprehensive coverage" as the most favored way to pay for medical care. This structure will inevitably collapse. The first priority is to save the people who are trapped in it.

Medical institutions built on liberty and sound financing will arise if allowed to do so. They cannot be built by congressional or bureaucratic diktat. America must not waste this opportunity for genuine reform, and instead try to replace one tottering structure with another centrally planned disaster that resembles it.

The ACA structure must be allowed to wither and die as a result of administrative actions that deprive it of its nourishment: mandates and coercive redistribution. The same actions will relieve the chokehold that government has on innovation and financing mechanisms, and allow excellence to flourish.

Introduction

The problem with the ironically named Affordable Care Act (ACA or "ObamaCare")—is with the foundation. Like a building on an unsound foundation, it cannot be fixed by "tweaking" or patching up the cracks. ACA has so many complex, interdependent parts that attempts to alter parts of it will upset the balance with unpredictable, likely disastrous effects.

Worse, ACA is inextricably tied to the rest of the American "healthcare delivery system." Besides the radical changes in health insurance and medical institutions, ACA makes many changes in Medicare and Medicaid and heavily depends on them. About half of the "healthcare dollar" passes through these federal programs, and 90% passes through some third party. As with the Leaning Tower of Pisa, there is a legacy to be preserved: the legacy of Barack Obama, and also of Franklin Roosevelt, Lyndon Johnson, Richard Nixon—and Marx and Lenin.

However much expense and ingenuity is lavished on shoring up the edifice, gravity eventually wins. One can keep piling on lead counterweights, but the masonry will someday crumble because of the abnormal stresses. When it falls, building inhabitants and bystanders are in grave peril. The laws of economics are just as inexorable.

At the root of ACA is a requirement that people buy a product from a government-favored private company—health insurance—that they do not want, or at least do not want on the terms government forces on them. This in turn is based on the fallacy that the way to an equitable state of "universal healthcare" is through comprehensive third-party payment. When that fundamental economic fallacy is uprooted and people are allowed to spend money in more efficient ways, then the inherent waste in the current system would be avoided, to the benefit of the entire economy.

Political & Timing Considerations

ACA is now "status quo," and its supporters will do everything they can to perpetuate it. Outgoing President Obama himself has reportedly been meeting with leaders of the Democratic Party to develop strategies for preserving ACA. Congressional Republicans may also be unnecessarily reluctant to repeal the massive legislation, now that it has been in effect for many years with millions who believe they are dependent on it.

If the incoming President Donald Trump waits for Congress to act on ACA, then it appears likely that nothing—or nothing good—will be achieved in the foreseeable future. Worse, the Republican-controlled Congress could increasingly blame the Republican President Trump for inaction, and vice-versa. Democrats might then win big in the midterm elections, retaking control of the House or Senate, and ACA could subsequently be perpetuated by the incoming Democrats in Congress.

The better strategy, accordingly, is to adopt approaches that can be taken unilaterally by the Trump

Administration, without requiring congressional approval. If Congress wants to concur or expand on action taken by the Administration, then that would be welcome. But if Congress instead wants to delay until after the midterm elections, ACA could and should be deconstructed without waiting for congressional action that may never happen, or that might only perpetuate the worst flaws, with a Republican imprimatur.

ACA as constructed is inherently unstable and would have inflicted intolerable pain on many already, including the special interest groups that got it passed, had Obama not made dozens of unilateral changes. These included exemptions for some employers and the illegal spending of money that Congress did not appropriate to shore up insurers. Many provisions, including tax increases and a harsher individual mandate, are timed to go into effect after Obama leaves office. Their ill effects, and the effects of congressional alterations, can conveniently be blamed on Republicans.

ACA can only be enforced, if at all, by the incoming Trump Administration. Executive agencies controlled by the President have enormous discretionary authority. The linchpin of ACA is the individual mandate, which compels people to buy health insurance under threat of penalty by the IRS, which is part of the executive branch. The definition of acceptable coverage is determined by the Department of Health and Human Services (HHS), which did not, for example, have to mandate contraceptive coverage. Actions that could be taken by the Trump Administration include adopting a policy of non-enforcement of any penalties for not purchasing health insurance, refusing to bail out insurers, and abiding by the district court decision in U.S. House of Representatives v. Burwell, which declared the taxpayer subsidies on the health insurance exchanges to be illegal. Supporters of ACA attempted to intervene in the U.S. House of Representatives v. Burwell case, but the judiciary is no more than a co-equal branch of government. Incoming President Trump was elected to dismantle ACA, and he should make clear that the judiciary lacks "the power of the purse" and the enforcement authority that are properly conferred only on the other two branches of government. There is not as much time as may first appear to dismantle such complex and far-reaching legislation as ACA. Early voting for the midterm elections begins a mere 21 months after the November election, with campaigning beginning far earlier than that, and there are many issues that will compete for politicians' time between now and then. If the Trump Administration waits on a decision by the D.C. Circuit in U.S. House of Representatives v. Burwell, and then review by the U.S. Supreme Court after that, no time will be left for Congress to act before the midterm elections, and the opportunity for reform may then be lost forever. Accordingly, reform that can be implemented administratively has inherent advantages over legislative options. Fortunately, ACA can and should be repealed in practice through administrative actions, without awaiting approval by Congress or the judiciary. The same executive actions that allow ACA to self-destruct would at the same time make it possible for the free market to develop better, actually affordable options.

The Legacy and the Foundations

Prosperity depends on free enterprise, which absolutely requires protection of private property and freedom to spend one's resources as one chooses. Centralized government planning, which is what ACA essentially imposes, creates enormous inefficiencies and hinders prosperity under the guise of reducing inequalities. The seductive goal of egalitarianism is not new, but has been around for centuries. It is based on the fundamental axiom of socialism: from each according to his means, and to each according to his need.

The economic principles and the morality of socialism were decisively, irrefutably debunked in the early 19th century by Frédéric Bastiat in The Law[1] and Economic Sophisms. Attempts to implement them in practice, outside of monastic communities, have had a failure rate of 100 percent. Early American settlers at Jamestown and Plymouth were dying of starvation and disease until they privatized property. Every single utopian community in America failed.[2] Attempts to implement socialism worldwide, with or without retention of nominal "private" ownership of the means of production (national socialism or fascism vs. communism) have always resulted in misery and violence, and caused at least 100 million deaths.[3] The social welfare states in Western Europe or Canada are often touted as shining counterexamples, but it must be remembered that these are "mixed economies," whose prosperity comes from free enterprise. Moreover, the final outcome is not yet known. These nations, like the U.S., are consuming their capital from the past and mortgaging their future, accumulating huge, unpayable debts.

So proposals to "modernize" our system are really attempts to tweak a very old, consistently disastrous, idea. We must remember that whatever the government "gives," it first takes—from the "forgotten man."[4] The taking may be outright and visible through taxation, confiscation, and monetary penalties, or hidden through debasement of the currency ("inflation"), capital controls, suppressing market interest rates, or regulations preventing productive activity.

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Once a building is occupied—or once people have become dependent on a bankrupt system—one cannot simply demolish it without causing enormous immediate harm. So the first priority is to let the people out. Some suggest that a new "Pisa Tower" has to be complete before the doomed one is demolished, and they even propose the equivalent of piling up more lead bricks. But the evacuation needs to start immediately. As noted above, the Trump Administration can and should do that under its existing statutory and constitutional authority.

The rotting structure comprises Medicare and Medicaid as well as ACA. All are based on the concept of legal plunder, or forcible redistribution of wealth from those who own it to those to whom it does not belong. None of them are insurance products. Their acceptance depends on deceit. Social Security recipients (Medicare is Title 18 of Social Security) were told and believe that they funded their own retirement, including medical insurance. In fact, the Supreme Court held, in Helvering v. Davis, early in the New Deal, that Social Security is constitutional only as a tax, not a pension plan. The rationale reminds one of the Court's upholding ACA. Benefits are an entitlement—a privilege—dependent on Congress. There is NO contractual right to anything, no matter how much a "beneficiary" paid in.[5] Workers' "contributions" are immediately spent on benefits to persons already retired, and any surplus is spent on other things, thereby reducing the apparent size of the federal deficit. "We owe it to ourselves" means we promised it to our descendants, some yet unborn. The financing system was unsustainable from the start, being dependent on continuous population growth or unlimited economic growth. The U.S. population is not replacing itself, a substantial part of the working-age population is claiming disability or simply not working, people are living much longer, and economic growth is stagnant at best.

Most Ponzi schemes are stopped at the stage in which benefits are paid by new "investors," rather than by investment income, and the perpetrators imprisoned. Social Security and Medicare are past that stage, being dependent on deficit financing, as outgo has already exceeded revenue for several years.

Medicare, Medicaid, and ACA are all "pay as you go." They do not have insurance reserves. Increasingly, they are managed-care programs, not insurance at all. Premiums are not risk-based, and benefits are determined by the discretion of the managers, not an indemnity table agreed to by contract. The payment and delivery systems are co-mingled. The system benefits by restricting service. With the passage of MACRA (the Medicare Access and CHIP Reauthorization Act), our single payer system for seniors—Medicare—is being turned into the equivalent of a giant, capitation-based HMO. Physicians are gatekeepers who profit by rationing care and are punished for providing too much.

Medicare and Medicaid are supposed to be "safety net" programs. Of course, one can't go anywhere when enmeshed in a safety net, and the safety-net programs are serving as a poverty trap.

Letting People Out

People who want to be out of the supposedly voluntary Medicare program can simply be released immediately. Such action could be taken by the Trump Administration or Congress, or both. The Centers for Medicare and Medicaid Services (CMS), a division of the Department of Health & Human Services (HHS), should issue new regulations permitting patients and physicians alike to opt out of Medicare and Medicaid on a per-service basis, just as participants in other entitlement programs can. By analogy, in many states families are allowed to participate in public school activities and sports without enrolling as public school students, and that system works well without imposing a "take it or leave it" basis. Additionally, CMS could issue a new regulation directing carriers to reimburse Medicare beneficiaries (patients, not "providers") who receive services from a nonenrolled or disenrolled physician and submit their own claim with an itemized bill, without imposing any claims submission requirement on the physician.[6] This would inject a much-needed dose of free enterprise into the system, reduce costs by eliminating bureaucratic paperwork, and cause Medicare patients to become more cost-conscious since they would be paying directly for the costs of the services. Many patients would choose not to submit claims. The economic savings would be immense and grow over time. Yet patients who have become dependent on Medicare would not be deprived of benefits simply because they choose a physician not in the system. Congress, for its part, could easily:

- Repeal the rule that people can't leave Part A without losing their Social Security benefits.
- Repeal the requirement that enrolled "providers" file claims for all covered services rendered to Part B beneficiaries.
- Expand the current "opt out" provision to allow physicians to work outside the system on a patient-by-patient basis without an all-or-none opt-out.
- Institute a patient-value-based system by repealing the Byzantine Medicare price control system, the

Resource-Based Relative Value Scale, which is based on the Marxist Labor Theory of Value,[7] for nonparticipating physicians.

- Exempt nonparticipating physicians from MACRA. Medicare can determine reimbursement based on its concept of value to the system, and patients in cooperation with their physician determine the fee based on their values, without the costly, privacy-destroying MACRA reporting systems.

People who like their Medicare could keep their Medicare and stick with Medicare "participating" physicians (more than 90 percent of all physicians at this time). They would be better off if the system is unburdened by people leaving it. But people are going to like their Medicare less and less, thanks to Obama's cuts, the increase in Part B premiums, and MACRA, which turns doctors into rationing and government surveillance agents. States set Medicaid requirements. The ACA Medicaid expansion increased enrollment much more than anticipated, but 60 percent of the new enrollees were previously eligible—the "woodwork" effect, attributable at least in part to the individual mandate. Medicaid is estimated to deliver 20-40 cents worth of medical value per dollar spent. Many do not consider it worth the bother of signing up, or the loss of access to physicians who are unwilling to participate. Those who don't like their Medicaid would not have to keep it, and each state could decide whether to continue to accept all who do like it. Block grants to the states would make it possible for states to allocate funds more efficiently, without counterproductive federal requirements.

Those who like their ACA plan could keep it, if still available, but the government could no longer require young, healthy persons to pay premiums many-fold higher than actuarially fair, nor could it illegally take money from current and future taxpayers to subsidize unaffordable plans. Because of high premiums and narrow networks, more people would choose to leave ACA if they were not financially punished for doing so.

People leaving their current unsatisfactory arrangements are potential customers for new products—if the government doesn't block them—including affordable policies for catastrophic, unpredictable contingencies, which is true insurance.

The Replacement

Many assume that we need one big, centrally planned federal replacement plan for everyone, which will allow all to "keep" their ACA benefits. The "winners" might choose to do so. The "losers" (far larger in number) likely would not. Remember that many "Exchange" enrollees have lost plans repeatedly already.

In a free market, many different structures are built, without governments, think tanks, or advocacy groups dictating the plans. Innovation of course cannot be predicted or forced to happen. The government's job is to make and enforce fair, reasonable, predictable rules that foster innovation and competition.

"There is no return to the status quo ante," say opponents of immediate ACA repeal. But maybe that situation was not so great either.

It is true that many insurance plans that people liked were wiped out by ACA requirements. It's déjà vu for Lyndon Johnson's cancelling seniors' private insurance plans, to assure that "his" Medicare program would succeed. The market for insurance for persons age 65 and older (and needed actuarial information) has been gone for 50 years—but reviving a market for younger people should be much less difficult.

A vibrant competitive market could develop rapidly if permitted. Some of the needed conditions are listed below. Some would require federal or state legislation, but many could be achieved or facilitated through executive action at the regulatory level:

- Honest pricing. All facilities should be encouraged to post their prices—it should be clear that there are NO antitrust constraints for doing this. Facilities and managed-care plans that want to keep their pricing and reimbursements secret would face a massive exodus of patients who prefer to know their costs.
- Honesty in reimbursement. Patients should demand access to information about what insurers reimburse for specific procedures before buying the policy and before undergoing elective procedures. Government agencies should not contract with insurers who refuse to provide this information accurately.
- Tax fairness. Individually owned policies should receive the same tax treatment as employer-owned policies—including exclusion from payroll tax, the biggest or only tax low-income workers pay. Out-of-pocket payments should receive the same treatment as insurance premiums (a greatly expanded Health Savings Account concept). This is especially important for low-income workers, from whom the payroll tax takes 15 percent off the top of their earnings, and who benefit little if at all from an income-tax deduction.

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- Removal of barriers to competition. This includes certificate-of-need laws, attempts to regulate direct primary care practices or health sharing organizations as if they were insurance companies, or regulations and payment policies that only large or already existing entities can meet (a form of "economic credentialing"). ACA restrictions on physician-owned hospitals should be eliminated to spur competition and competitive pricing.
- Group plans available through associations, not just employers.
- Repeal of insurance mandates that require all to pay for costly coverage they do not need or want.
- Repeal of antitrust exemptions for the "business of insurance" (McCarran-Ferguson).
- Enforcement of antitrust law against hospital systems that are driving out competitors.
- Repeal of all laws and regulations such as the HMO Act that protect or favor managed-care over casualty insurance, including laws that require or enable the "enrollee hold harmless clause" in provider agreements. This clause protects fiscally unsound plans against bankruptcy, and enables them to ration care through "providers" they control in order to protect plans against accusations that the plan practices medicine.[8]
- Fair trade and nondiscrimination. Insurance collusion with physicians/hospitals for a patient population is a restriction of trade and prevents any price negotiations. Reimbursement policy should not discriminate against independent facilities in favor of those owned or controlled by hospitals, insurers, or other favored customers.
- Streamlining regulatory procedures that unreasonably delay licensing of insurance plans or medical facilities.
- Streamlining licensure of physicians through reciprocity, and reject requirements such as costly, proprietary Maintenance of Certification that reduce physician supply.
- Removal of barriers to self-funded plans. Their access to re-insurance needs to be protected.

The Pre-Existing Conditions Problem

Guaranteed renewable insurance should be purchased when a person is young and healthy, and maintained continuously. Many responsible people have been unable to do this because of government policy, especially that which ties insurance to employment. Laws can be changed to prevent this problem in the future, but at the moment many people are stranded through no fault of their own. But regardless of fault, they are uninsurable.[9]

As demonstrated by the current escalation in prices, requiring coverage leads to a "death spiral" in voluntary insurance when low-risk people refuse to be overcharged to cover those at high risk. If people are exempted from the consequences of not buying insurance when healthy, moral hazard will ultimately destroy the concept of health insurance.

There is now a large pool of people with pre-existing conditions, and a free market is likely to develop appropriate products. Most could be covered at a higher price. Previously existing state high-risk pools could be re-established, as Alaska recently did. As market reforms—and restoring insurance to its role of reimbursing people for catastrophic losses—result in drastic reductions in price, the burden will be much less. For people who need care but can't afford it, charity is the moral answer. If taxpayers wish to fund a safety net, it is far more equitable to spread the costs over all taxpayers than to impose it on the sick or those who care for them, and far cheaper to pay for the care directly rather than to funnel the money through a middleman.

What to Do If You Are Uninsured

There are many possibilities:

- Join a health-sharing ministry.
- Join a direct primary care or membership-model practice.
- Join a "Wedge of Health Freedom" practice (jointhewedge.com) or other independent practice that receives direct pay from patients and is free to negotiate terms without third-party interference.
- Increase medical coverage on your auto insurance.
- Check into critical illness coverage.
- Deposit the premiums you would have paid into a dedicated savings instrument.
- Look into medical tourism for elective procedures, many of them within the U.S. (one idea is Medi-Bid.com). Research prices. The website www.surgerycenterok.com is a model; there may soon be many imitators. SmartChoice MRI, for example, advertises "no MRI for more than $600."
- Ask for a cash price quote ahead of time—even if you have insurance, as you may be better off not using

your insurance plan (and your pharmacist may be forbidden to tell you that).

- Look for a self-funded plan (or start one for your business).

Many who are uninsured choose to live that way, using emergency rooms as their point of access when they have a real medical crisis. Requiring people to purchase health insurance, as ACA does, is an economically inefficient way to address the problem of uncompensated care. (Many uninsured patients do pay for care, and insurers sometimes don't.) The use of savings and credit to pay unanticipated bills is rational, prudent, and responsible. Medical bills can be reasonable, as many facilities are demonstrating. Outrageously high "chargemaster" rates may result from hospital/insurer collusion that makes insurance look more necessary and valuable than it is, and allows some brokers to profit from "re-pricing" or arbitrage schemes.

Expand Opportunities for Charity Care

Medical care is traditionally an act of charity, and there was no "health care crisis" when a greater percentage of hospitals were true charities staffed with many volunteers, instead of the highly profitable but tax-exempt businesses that many are today. While no one is going to turn the clock back 100 years, and perhaps no one would want to, a partial restoration of the essential role played by charity in medical care would be immensely helpful.

Under legislation submitted in New Jersey and other states, physicians could qualify for protection from vast malpractice liability if they provide a certain amount of charity care in qualified clinics. One charity clinic in New Jersey has been so successful that some patients are even referred to it by the Medicaid program. Charity care is far more efficient than care covered by health insurance, because there is less paperwork and no issues as to what will or will not be covered for reimbursement. Participating physicians, benefiting from some limited protection against malpractice claims, are freed from having to practice defensive medicine and can provide timely, sensible care that they might otherwise avoid doing due to fear of an overzealous lawsuit.

HHS could adopt a pilot program to provide greater protection from malpractice for physicians who generously donate significant amounts of their time to charity care in federally qualified charity clinics. This would alleviate the growing financial crisis in the Medicaid program while extending greater access to care for needy patients, and this innovation could help the Medicare program also.

Both the federal government and states might explore the tax credit model used by Arizona for supporting charities and tuition for students attending private (including parochial) schools: a dollar-for-dollar state income tax reduction up to a certain limit. Georgia has enacted a similar program[10] for donations to rural hospitals.

Key False Assumptions

The language of egalitarianism and "fairness" frequently cloaks socialist concepts. False crises are created to promote big- government schemes. These are some of the false premises that reform advocates tend to accept without question:

- We need "universal coverage." No, we need optimal availability of actual medical care. We need a free market, not mandatory third-party payment.
- We need to "contain costs." No, costs are far too high, mostly because of comprehensive third-party payment. They can and should be greatly reduced.
- "We" are all responsible for everybody else's health care. No, we are responsible for caring for our own health and for paying for the necessities of life, including medical care when appropriate. Comprehensive third-party payment is the most expensive and least efficient way of doing that.
- Charity is demeaning; people have a right to help. No, charity is a blessing both to those who give and those who receive. Being dependent on government-forced redistribution is both demeaning and debilitating.
- The federal government can "assure" health care for all. No, the government can only take. Each lead brick piled on to stabilize a tottering structure is taken from another, better use, and can at most only delay the day of reckoning.

The legacy we want to preserve is the one of freedom, which brought us prosperity and wonderful advances in medicine. Piling on more lead blocks to try to salvage the icon of socialism is suppressing a return to greatness in America.

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