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NDA JOURNAL

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NDA JOURNAL

SPRING 2016

ON THE COVER

Cover photo submitted by Sam Thomas, DDS, PhD

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Evaluating the Evaluators

of Evidence Based Recommendations

Some of us get nervous when new standards are foisted on private practice dentists, upon whose shoulders all the academics, administrators, regulators, association and society members, and others stand. Evidence based treatment is a fairly well-accepted paradigm today. After all, who can argue that treatment should be based on evidence of benefit to patients? However, one concern might be who evaluates the evidence best? Many groups have a stake in the query: patients, private practice providers, academics, regulators, third party payers, plaintiff and defense attorneys, and in the case of controversy, ultimately juries who are the final say in establishing an acceptable treatment within the standard of care. It would seem logical that the different parties would opine differently on what is reasonable evidence. For instance, consider the following:

Many health professionals noticed the recent US Preventive Services Task Force (USPSTF) recommendation to not screen, via mammography, for breast cancer until age 50. This new recommendation was "evidence" based and was a significant change from the long-standing recommendation to begin screenings at age 40, which the American Cancer Society (ACS) still advises.

What may be of more specific interest to dentists is that the USPSTF has also evaluated other evidence and opined about oral cancer screenings.[1]

1. **Does screening for oral cancer lead to decreased morbidity and mortality from oral cancer?**
   Although the studies used to evaluate this question are nearly ten years old, the USPSTF found that "oral cancer mortality rates were similar in the screened and unscreened study groups."

2. **Are there effective treatments for mitigating the morbidity/mortality of oral cancer if the lesions are identified earlier rather than later?**
   "No controlled studies examining treatment efficacy of early detection of oral cancer lesions were identified. Treatment of oral leukoplakia, a form of premalignancy, has been studied with several modalities, demonstrating success at promoting remission; but the numbers of trial patients are small (10 to 59, about 50 for most) and there have been no long-term (>2 years) follow-up studies to assess the effects on cancer incidence or mortality."

Thus the USPSTF, and the National Cancer Institute (NCI)[2] , both do not necessarily recommend routine screening for oral cancer because of a lack of evidence for potential benefit. On the other hand, the ACS still recommends regular checkups during routine dental visits.[3]

Closer to home, an American Dental Association (ADA) panel stated in May 2010 that: "We still don't understand the answers to a lot of fundamental questions like the progression of the disease and whether intervention helps. It's plausible that early diagnosis helps, but we don't even know that."[4]

A comprehensive review article in the May 2010 *JADA* concluded that screening by means of visual and tactile examination to detect potentially malignant lesions may result in detection of oral cancers at early stages of development, but that there is

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insufficient evidence to determine if screening alters disease-specific mortality in asymptomatic people seeking dental care. The panel suggested that clinicians remain alert for signs of potentially malignant lesions or early-stage cancers while performing routine visual and tactile examinations in all patients, but particularly in those who use tobacco or who consume alcohol heavily. Finally, *JADA* acknowledged that additional research regarding oral cancer screening and the use of adjuncts is needed.[5]

The ADA statement can be contrasted with tear-out ads in sports magazines offering free topical tobacco products. It is ironic that a sports publication, reporting on humans that make their livings from being arguably the most physically impressive members of society, advertises tobacco products. Not surprisingly, tobacco marketers have historically attempted to affiliate with respected groups, such as doctors, to promote their product.[6]

Tobacco use in now accompanied by varied cautions from: "Warning: This Product Can Cause Gum Disease and Tooth Loss" to the Surgeon General's: "Smoking Causes Lung Cancer, Heart Disease, Emphysema, and May Complicate Pregnancy." Tobacco companies would not so burden their products without evidence that it was true (perhaps combined with legislative and tort based promptings). Baby bottle syndrome and restoration displacing caramel candies can also lead to tooth loss, but, milk and caramel have not been linked to oral cancer, thus radically altering the relative risk-benefit analyses.

It is admirable that the ADA recognizes the importance of cancer screening, particularly in tobacco and alcohol users, even if evidence-based studies have not scientifically demonstrated the benefit of oral cancer screenings. Of course, the institutional review board (IRB) approval processes for human studies in this area would be interesting. How could such a study be perfected ethically and morally?

It is obvious that there are significant differences of opinion on what treatment is best. How does one evaluate the objectivity of those who offer opinions? Aside from patients, whose lives are the predominant issue in question regarding treatment, all other stakeholders can probably be evaluated on the basis of economics to a degree.

Consider the following anonymously authored table:

Group	Priority	Group Analysis of Evidence
Patients	Life	Treatment that will avoid death
Private Doctors	Patients/ $$	Ideally place patient concerns above all else. Practically, evidence demands that overhead be covered. (Financially successful doctors may be more likely to be patient centered than doctors with too many car payments.)
Academics	$$	Academics are paid by third parties, not patients. When the sources of funding are identified, the conflict analysis is straightforward.
Regulators	$$	The more vacuous regulations, the better to justify regulatory sinecures. A lack of logic, misinterpretation of the law, and creating standards on the fly are effective for this group.
Third Party Payers	$$	Anything to deny payment (i.e. from stale dating to aggressive end of life planning) is evidence of optimal payor function, per the Home Office.
Attorneys	$$	See Regulators supra. Confusion and controversy are evidence of ultimate attorney benefit above all other players.

How does one decide which group to defer to?

Historically, patients have been recognized to have ultimate authority, including legal and moral authority, to choose being responsible for their own treatment decisions. That some would now diminish this recognized patient right is unquestionable.

A few today gravitate towards giving more authority to third party payers, which now nearly equates to the federal government, the largest third party payer of all. However, many patients are simply not comfortable trusting government to optimally allocate care on an individual basis.

Continues on page 6 ➲

➲ *Continued from page 5*

Known sources with proven historical veracity might be deferred to. Where does dentistry as a profession stand? The *Washington State Dental Association News* opined that: "The ADA promotes community water fluoridation based upon numerous high-level scientific studies that demonstrate fluoride to be safe and effective.[7] At the same time, the anti-fluoride group fervently denounces fluoridation by citing numerous low-level evidence studies linking fluoridation with everything from canker sores to cancer. The ADA rebuts the antis claiming they are using 'junk science' and insisting that high-level science is necessary for a meaningful debate. Yet, at the same time, low-level evidence is the most prevalent form of evidence used in the clinical practice of dentistry."[8]

Dentists at this time, particularly relative to physicians, still have the freedom and opportunity to primarily choose treatment planning paths, after the informed consent process. This agency needs to be used wisely and guarded against non-clinical interlopers. ▪

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Plans are under way for our Annual Summer Meeting to be held at the Meritage Resort in Napa Valley, California June 16–18, 2016. You will find registration material in this issue of the *Journal*. I hope you will consider attending our meeting and bringing your family. Dr. Wilbur has planned many nice events including a free Welcome reception, free breakfasts both days and a free CE class given on Saturday by our own Dr. David Chenin on "High Tech Orthodontics." Remember there is a lot more to do in Napa than just wine. We are hoping to get as many of the NDA past presidents as possible to attend this meeting.

These are the legislative activities we are participating in:

- Interviews of candidates for State Assembly and Senate to educate them on our issues
- Participation in selected Assembly and Senate caucus functions to get to know new candidates and make some decisions on who we need to interview
- Interim Legislative Healthcare and coalition meetings
- Several Nevada State Board of Examiner meetings and workshops
- Medicaid town hall meetings
- NDA Legislative Committee meetings to determine our legislative agenda for 2017

Please "Save the Date" for our Advanced Laser Dentistry course on Saturday September 24, 2016 at the UNLV School of Dental Medicine. This is an advanced course only for laser users. Participants must own a laser and have the safety certificate to take this course. Dr. Robert Convissar, Director, Laser Dentistry, New York Medical Hospital of Queens, is the instructor. More details and signup sheet to follow.

Finally, I am pleased to announce that our Editor Dan Orr was inducted as President of the American College of Legal Medicine (ACLM) at its annual meeting in Austin, Texas in February. He is the second dentist president of the ACLM since its establishment in 1955. The ACLM is comprised of dually qualified health professional attorneys and singly qualified attorneys or health professional members. The ACLM represents the specialty of legal medicine in the American Medical Association.

The ACLM is the most prominent professional society in the United States concerned with addressing issues that arise at the interface of law and the health professions. Works contained in the ACLM's *Journal of Legal Medicine, Legal Medicine Perspectives*, and other publications have been cited by state and federal courts including the United States Supreme Court.

Dr. Orr is a Dentist Anesthesiologist and Oral and Maxillofacial Surgeon who practices in Las Vegas, Nevada. He is Professor and Director of OMS and Anesthesia at the University of Nevada Las Vegas School of Dental Medicine. He is a Diplomate of the American Board of Oral and Maxillofacial Surgery, the American Dental Board of Anesthesiology, the National Dental Board of Anesthesiology, the American Board of Legal Medicine, and is certified by the U.S. Ninth Circuit Court of Appeals. Dr. Orr is also a Life Member of the American Dental Association and a Life Fellow of American Association of OMS. ▪

For those that are interested, the ACLM Annual Meeting will be in Las Vegas next February. For more information please see: www.aclm.org.

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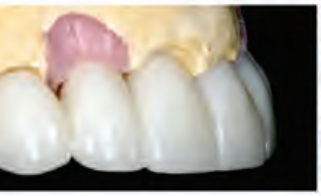

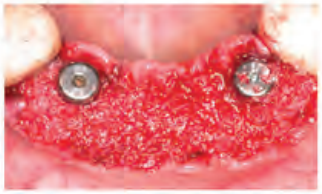

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Brad Wilbur, DDS

Spring is here, and with that comes elation about our increased membership! Maybe I did not get the other memos about what happens in spring, but the fact that Nevada leads the nation in increase in membership percentage is a superb accomplishment!

For years, Nevada has been suffering from steep declines in membership, so it's nice to be a sterling example for other states. Anthony Ferreri, assistant to Bob Talley at NDA and interim executive director at SNDS, has even been asked to present at the ADA Recruitment and Retention meeting about how it was done! Kudos go to Anthony, Emily Ishkanian, the new Chairperson of the Southern Nevada Young Dentists Committee, and also to Barry Lasko, head of Southern Nevada Peer Review. Barry has helped turn Southern Nevada Peer Review into a positive experience that has led to several new dentists joining the association. Emily has been a tireless worker turning events into gatherings that people want to attend. She also recently received acceptance from the national office for two grant proposals for future events, so the future is even brighter. Finally, leadership at the Southern Nevada Executive Committee has tried to be innovative, changing meeting times and dates, and making meetings more enjoyable to attend. I would liken all this to "A Perfect Storm," except in a good way. The manner in which we are relating to other dentists in such a positive manner has fostered incredibly impressive results.

Meanwhile, both the North East and Northern Nevada contingents have been able to maintain their strong percentages of membership. Lori Benvin has been a very strong leader at NNDS, and her work has been incredibly capable for many years. The Northeast section has done a terrific job of membership retention; I feel incredibly fortunate to be president when we have all of our sections doing well.

How do you celebrate an outstanding year? The Nevada Dental Association summer meeting in Napa will be a fantastic venue. The Meritage Resort, located in the southern Napa Valley, has all the amenities that go into providing a great setting for our association. On Thursday, June 16, there will be a free Welcome Reception at the Trinitas Wine Cave (located on site) from 6 to 8 pm. Friday morning is the executive meeting for NDA, and Friday evening is the Presidents Dinner, located at Artesa Winery. The winery is situated at the top of a hillside, with a view that can extend all the way to San Francisco! Transportation to and from the winery is included. On Saturday, June 18, Dr. David Chenin will be presenting CE about modern, innovative orthodontic techniques. Go online at the Nevada Dental Association website to sign up. ▪

NDA Summer Meeting

SAVE THE DATE!

NEVADA DENTAL ASSOCIATION

98TH ANNUAL SUMMER MEETING

JUNE 16–18, 2016

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Reservations: 855-890-3705
Rooms starting at $269 ($20 resort fee not included)

Group Name: Nevada Dental Association
Cutoff Date: May 22, 2016

For more information and reservations link, please visit:

http://nvda.org/summer-meeting/

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Registration Form

NDA 98th Annual Summer Meeting

June 16-18, 2016 • The Meritage Resort • Napa, CA

Registrations accepted until June 3, 2016

Event	Time	Attendees		Fee/person	Total
Registration—NDA Member/Spouse/Child		_____		$ 0	
Registration—Non-NDA Member (required)		_____	x	$ 300	$ _____
Registration—Non-ADA Member (required)		_____	x	$ 500	$ _____
Thursday, June 16					
Executive Committee Meeting	3–5 PM	_____		Included in conference cost	
Welcome Reception	6–8 PM	_____		Included in conference cost	
Friday, June 17					
Joel F. Glover Breakfast	7 AM	_____		$0	
House of Delegates	8 AM–12 noon	_____		Included in conference cost	
Lunch on Your Own					
President's Dinner Adult (Artesa Winery)	6–10 PM	_____	x	$ 150	$ _____
President's Dinner, Young Adult (Age 13–20)		_____	x	$ 85	$ _____
Entree Selection (Pick one per attendee, and fill in total next to corresponding choice)	(_____) Beef Short Ribs (_____)Vegetarian (_____) Grilled Wild Salmon				
President's Dinner Child (Age 5–12) (Childs menu is set: Spaghetti & Meatballs)		_____	x	$ 50	$ _____
Saturday, June 18					
Pliney Phillips Breakfast: Pierre Fauchard Academy Induction	7 AM	_____		Included in conference cost	
Continuing Education: "High Tech Orthodontics" *Dr. David Chenin*	8 AM–12 NOON	_____		Included in conference cost	
Special Option: Artesa Winery Dinner (Friday) Round Pond Winery "Summer Solstice" (Sat. Afternoon) *Both of these events are adults only and must be purchased together*	1 PM	_____	x	$ 230	$ _____
				Grand Total	$ _____

No refunds given past June 10, 2016. Hotel reservations and pricing are only guaranteed through May 23, 2016!

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Christmas in the Sub-Sahara Desert

By Sam Thomas, DDS, PhD

It is 4:30 am in the cold Sub-Sahara Desert. An Imam's call to prayer from the distant Mosque pierces the chill of dark. The screech of the Pharaoh Eagle-Owl shatters the early morning stillness. I unzip my faithful sleeping bag and crawl out of my tent and peer out through the glassless windows just in time to see a large group of local Arabs that have gathered, hoping to see the dentist. My fingers are aching from yesterday's work, but the day beckons. The time for sleep is over as day three begins. I have already completed 600 extractions. We have four days left to do all we can do.

The day buzzes along without a break. By 11:30 am we have been operating steadily for five hours. A tsunami of broken teeth, abscess, and decay confronts us in a seemingly endless deluge. People squat everywhere in make shift shelters hoping to be seen. How can we help them all I wonder?

I am a humanitarian dental missionary from Reno, Nevada who has come to TChad, Africa, to treat the less fortunate, for Christmas. This is my only vacation for the year. I am doing what matters most to me and to my wife, helping the impoverished. TChad fits the bill as the poorest country on the planet. Libya lies to the north, Sudan to the east, the Congo to the south, and Nigeria to the west. TChad's southeastern border is filled with refugees from Darfur. The average life expectancy in TChad is 49 years of age. The infant mortality rate is 60%. A deadly form of malaria, induced by the protozoan parasite, Plasmodium Falciparum, is as common place as the winter flu in the United States. The deadly threat of Boko Haram attack is palpable wherever I go. Water and food are precious and scarce. Medical care is rare. Dental services do not exist for the poor and 80% of the people of TChad are impoverished.

This is not our first excursion into Africa. In 2007, my wife, who is a nurse, and I built a TB/HIV clinic in a remote village in TChad and provided free dental care. In 2010, we worked at the Jerusalem Clinic in Zambia, a medical/dental clinic for lepers. We had come armed with 20 duffle bags full of dental supplies provided generously by Western Dental Services, Henry Schein and some local caring dentists. From gloves to gauze, from lidocaine to needles, from sutures to composites, from toys to toothbrushes, from Clindamycin to Amoxicillin to Ibuprofen, all were carefully packaged, repackaged and weighed. We were a mobile dental office. We also carried a portable dental unit with us that ran on a diesel generator.

We reached Ndjamena, the capital of Tchad, late at night after a grueling 20 hour flight from San Francisco. There was a khamsin (sandstorm) when we arrived. Using headlamps, we set up our tents on the rocky dirt floor which would be our clinic and home for the next seven days. Our host, an American medical doctor, had procured two ancient but precious dental chairs from a local hospital storage room. Patient flow was organized by numbers, but soon that system broke down as 5–6 patients started using the same numbers. When plombes (restorations) were requested by the more discerning, we would fire up the old generator and accommodate our patients if possible. Most people required extractions, because the teeth were non-restorable.

The news of our dental clinic spread quickly through the rural Sub-Sahara. Soon the mayor of the town, the governor, their respective entourages, the local press and Al-Jazeera TChad Television heard about us. They came to interview us, but then remained to receive their care as dental services are a novelty in TChad. Only the very wealthy can travel to Khartoum or Paris to obtain it since local dentists are non-existent. The poor and the poorer, the young and the old all came. People trekked through the Sub-Sahara for miles and waited all day to be seen by the dentist. Armed guards were sent to protect the clinic and to maintain order. Local officials called to check on our safety. On the last day of our visit, the First Lady of TChad telephoned her thanks for a work well done.

When the final tally was taken, a record 500+ patients were seen. Over 1500 extractions were completed and multiple restorations were finished. We also passed out hundreds of bags of free medications to kill intestinal parasites.

It was closing time on the last day. She was our last patient. She was old and tired. She had waited the entire day to be treated by us. I was exhausted. I placed her in the chair and took her B/P—120/86. I peered into her mouth populated by multiple root tips and associated abscesses. That she was in severe pain was an understatement. I said a silent prayer and administered local anesthesia. As if in a trance, I began extracting the roots and draining the abscesses. After 30 minutes, I had finished removing all her teeth. I gave her clindamycin and an analgesic. A small tear welled up in the wrinkled corner of the eyes of this ageless old woman who was weathered by the sands of the Sahara Desert, as she gently took my hands in hers and uttered through the tinged gauze in her mouth, "Shoukran," or thank you for coming.

We left Ndjamena on January 1. On the plane, I fell into a deep sleep, my fingers stiff from seven days of relentless labor for the poor at 100 patients per day, but a heart overflowing with the joy of giving and the thrill of sharing a little of that which God has given to me.

Let me leave you with a closing thought. Life is fragile. We are here one day and gone the next. What one leaves behind does matter. Bless others as you have been blessed. Treat every day as though it may be last the day of your life.

Christmas in the Sub-Saharan desert was an event that will be etched in my mind for a long time. It was the greatest gift that we could have given ourselves. ▪

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How I Stopped Drowning in Student Loan Debt

By David Manzanares

My experience with student debt is a story that almost all new dentists today know well. I graduated from the UMKC School of Dentistry in 2009 with $220,000 in student loans. I consolidated my loans after my first year of dental school when the government was ending the practice of in-school loan consolidation and was able to lock in $50,000 at 4.75%. The rest of my loans were at an interest rate of 6.8%. However, I felt pretty lucky since I graduated from undergrad with no student debt because I had a full-tuition scholarship. In comparison, many of my classmates owed tens of thousands of dollars from undergrad.

After graduation, I went to work at a Federal Qualified Health Center (FQHC) in southern New Mexico. While I was earning a respectable starting salary, I found that I had to moonlight to help make ends meet. Initially, my loans were on the 10 year "standard" repayment plan. I had a monthly payment of more than $3,000. After a few months of barely managing to make ends meet, I switched to an income-based repayment plan. My monthly payments were more manageable, but that lengthened my repayment period to 25 years.

One of the reasons why I started working at an FQHC is because it allowed me to qualify for some of the loan repayment programs offered by the State and Federal Government. Unfortunately, many of the federal programs have cut back on their level of reimbursement or on the number of people that they accept into the program. Several state programs limit practice settings to FQHCs under very strict terms. For example, one program offered $50,000 spread over two years, but if employment with the FQHC ended a day early, the $50,000 had to be repaid at a very high interest rate (if memory serves me correctly, nearly 20%). Ultimately, I decided that the government repayment programs were not the right fit.

After a few years, I found work closer to home in the Albuquerque area and, after I became settled, about two years ago, I purchased a house in Albuquerque. To help facilitate my ability to obtain a reasonable mortgage, my banker advised that I pursue a student loan repayment plan that was spread out over 30 years, which would lower my debt-to-income ratio. My payments shrank to $1,600 a month; however, I tried to pay back more than that to pay it off faster. Over the past two years, I paid nearly $48,000 to the loan company, of which nearly $36,000 alone went to interest on the loans.

Writing that check every month and knowing that the vast majority of it would be going to interest, not paying down the principle (which, even when I was working at the relatively "low" wages of an FQHC, were not tax deductible) was financially devastating. The thought of continuing that pattern for most of my professional life, or at least the next 30 years of it, was incredibly discouraging.

Impact of student loan debt

I have held off on the purchase of a practice due to the amount of student debt that I have. I have been very aggressive in pursuing continuing education primarily because of its tax deductibility, whereas student loan interest is not. In many ways, my debt has stunted the development of my professional life—I truly wonder if I will be able to achieve the same financial achievements that my father did, having graduated from dental school 36 years ago. Graduating in the height of the Great Recession did not help my situation and many classmates have told me about the challenges that they encountered with a six-figure student debt load. I realize that having attended a public dental school, I have it much easier than many of the private school graduates who owe twice as much as I do. I also recognized that as a single man, a hefty debt load has less of a financial impact for me than for dentists who are married with children.

A solution

As soon as I heard about the opportunity to refinance my student loans through DRB, I was very excited. Truth be told, I did not know that refinancing student loans to a lower interest rate was even possible. Over the previous several months, I had received offers from different companies about refinancing options (in fact, I was receiving them as often as credit card applications), but I hadn't heard anything about these companies. I was cautious, not wanting to fall victim to some sort of scam. When I saw that this program was endorsed by the ADA, knowing the thoroughness of the research that they perform, I felt confident that this was a legitimate offer. I filled out the paperwork and went through the application process. The application was fairly straight-forward. The initial monthly payment that I was quoted was approximately $1,750 a month. This was done by lowering my interest rate to 4.75% from 6.8% (for all of the loans), and more importantly, this reduced my repayment plan to 10 years instead of 30. After speaking to DRB customer service, I was informed that I would have an additional 0.25% reduction for being an ADA member, as well as an opportunity to seek another 0.25% reduction in my interest rate if I open a checking account with DRB. This would bring my interest rate to 4.25%.

What a difference when you owe $165,000!

DRB states that dentists save $30,000 on average and according to my accountant, I will save a *lot* more than that. I honestly don't want to think about the amount of money I could have saved if this was available earlier in my career. To be presented the opportunity to be done with student loan repayments in 10 years instead of 30 is liberating. It is life-changing. Instead of the debt staring down at me, I am now staring it down and saying proudly, "I've got this."

What it means for you

I do not profess to be an expert on financial matters, but I believe that this program can make a true impact on the lives of new dentists. Student loan refinancing was the right decision for me. Not everyone will qualify for DRB's program — you will need to have steady income, a decent debt to income ratio, and good credit. When deciding whether this makes sense for you financially, you should consider the types of loans you have, their terms, and the amount you owe. You can also talk to a financial advisor to help with your decision. In the end, consolidating my loans through DRB was one of the best decisions I've made in my professional life and it could make a difference for you too.

To learn more about the DRB benefit, visit student.drbank/ADA. Whatever interest rate you qualify for, your rate will be 0.25% lower for the life of the loan as long as you are an ADA member. ▪

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Dental Specialty Recognition

The Reiteration of an Old Paradigm

By Michael W. Davis, DDS

In January in a decision that will likely shape the future of dental practice in the United States, the United States District Court for the Western District of Texas, Austin Division, ruled that the Texas State Board of Dental Examiners could not prohibit two dentists, Drs. Jay E. Elliot and Monty Buck, from advertising themselves to the public as "specialists" in implant dentistry. Although Drs. Elliot and Buck had received credentials from the American Academy of Implant Dentistry (AAID), the Texas State Board, under Texas Administrative Code §108.54, had prohibited them from advertising as such because implantology was not among the nine officially recognized specialties of the American Dental Association (ADA). The court found §108.54 to be unconstitutional, as it violated the defendants' First Amendment rights to engage in truthful, non-misleading commercial speech.

The ruling was particularly significant in that it potentially weakened the scope of authority held by the ADA, the United States' largest and most prominent dental association. The Texas State Board had invoked the authority of the ADA to differentiate between legitimate and illegitimate specialties, but in his decision, Judge Sam Sparks found the dental board had an obligation to consider the authority of other associations representing non-ADA specialties.

In his ruling, Sparks wrote:

"While ostensibly promulgated to protect consumers from misleading speech, it appears from the dearth of evidence that Rule 108.54's true purpose is to protect the entrenched economic interests of organizations and dentists in ADA-recognized specialty areas. Indeed, Defendants have presented little more than industry bias in favor of the ADA to support the argument [that the] Plaintiffs' desired speech is deceptive, false, or misleading or that the State Dental Board can trust the ADA to carve out specialty areas without the need to make any substantive determination of whether the Plaintiffs' dental organizations are actually bona fide."

In addition to Drs. Elliot and Buck, plaintiffs in the case were the AAID, the American Society of Dentist Anesthesiologists (ASDA), the American Academy of Oral Medicine (AAOM), the American Academy of Orofacial Pain (AAOP), and three private dentists. The plaintiffs provided evidence that their represented groups required significant standards for membership credentialing, all seemingly equal to other ADA-specialty groups.

Defendants in the case included members of the Texas State Board of Dental Examiners and the Texas Society of Oral and Maxillofacial Surgeons (TSOMS), which intervened as a party defendant. TSMOS, a private organization representing the interests of oral and maxillofacial surgeons in an ADA-recognized specialty, held that the elimination §108.54 would harm its members and do a disservice to patients, who would be misled in their understandings of treatment quality.

Another important issue considered in the ruling was the protection of public welfare. In this area, the court found: "The issue here is not whether the state is entitled to protect consumers from misleading information by conditioning specialty advertisements on meeting some uniform standards of competency; the issue is instead whether the standards chosen by the state are immunized from constitutional review. In this case, it is clear they are not."

Furthermore, the court found the "[d]efendants have produced no evidence of actual deception associated with advertising as specialists in non-ADA-recognized fields, there is no evidence to suggest any of the Plaintiffs' fields are illegitimate or unrecognized, and there has been no accusation any of the Plaintiffs' organizations are shams."

The court seemed largely unimpressed with the case put forth by defendants: "For whatever reason, Defendants have been content not to offer any competent evidence and have instead essentially asked the Court to 'trust them' based their common sense and experience in the dental field. Such a meager showing cannot carry the day."

Michael Mashni, DDS, past president of the American Society of Dentist Anesthesiologists, who was active in a failed effort to pass dental anesthesiology as an ADA-recognized specialty within the ADA House of Delegates, issued this statement:

"As a dentist anesthesiologist, this decision allows me to advertise truthfully about my training, education, and experience. Every state mandates additional post-graduate training to provide general anesthesia, yet restricts me from advertising as a specialist in anesthesia solely because the American Dental Association does not recognize anesthesia as a specialty. The recently formed American Board of Dental Specialties (ABDS) has

approved anesthesia as a specialty based on training and testing validated by the American Dental Board of Anesthesiology. This decision will allow all dental specialties to advertise truthfully without limitations by the American Dental Association."

Frank Recker, DDS, JD, who served as lead counsel for the plaintiffs, was asked about future implications relating to the decision. Dr. Recker stated, "The decision was a victory for the First Amendment," and that there is "[a] change in the way the dental profession views 'specialties.' [This] must evolve from turf wars and economic protectionism to a free market place choice by consumers."

Dr. Recker also stated that the ABDS was formed to circumvent the problematic process of becoming an ADA specialty, and to make that process more fair and reasonable for doctors and the public alike. "I would hope that the changes needed in our profession are devised by our profession, not the FTC."

Jacquelyn Stanfield, DDS, a director with Concerned Dentists of Texas, an advocacy group of dentists seeking protections for the public interest noted, "After reading the decision, I was surprised at the lack of expertise the defendants brought to the table. While it may help implant dentistry, et. al, in the short term, be careful what you ask for." ▪

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Editor's Note: As mentioned previously in the NDAJ,[1,2] recent ADA HOD politically based specialty votes have done more than anything to legally eliminate the ADA as the arbiter of specialty status. Interestingly, prior to the ADA assuming responsibility for specialty recognition in 1948, states recognized specialties, such as Illinois, Michigan, Oklahoma, and Tennessee for Oral and Maxillofacial Surgery. In the foreseeable future, dental specialists will be recognized by the ABDS, states, the federal government, and for some the ADA will remain an option. The recent decision in Texas was legally predictable and something the ADA has been aware of, but has chosen to not address, for years. The lack of introspection by the ADA has resulted in dental specialty issues being controlled by third parties.

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Flashback on "Evidence-Based Medicine"

The Prussian Geheim Rath

By Hermann W. Børg, MD

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The paradigm of so-called evidence-based medicine has been elevated to the status of an obligatory "gold standard" of medical care. In discussions of this concept it may be useful to reflect on an interlude in German medicine and ask whether, at that time, medicine took a path similar to that envisioned by the votaries of EBM, in settings resembling current circumstances.

The interlude occurred during the early Enlightenment. There are striking similarities between the culture of the early Enlightenment and today's post-modern digital revolution. The Enlightenment was brought about by rapid changes across society and the political structure, and also in philosophy, science, and culture. The changes in various areas reinforced one another and led to the rise of a new structure in culture, society, and politics. The feudal organization of society crumbled, and a new group, the bourgeoisie, started to acquire wealth, power, and more freedom. Repressive authority was weakened, opening the way for the flowering of a free pursuit of science and technology. Books, and thus knowledge, became widely available, allowing for those who had been powerless serfs to take charge of their lives and demand freedom.

This new spirit of freedom spread through Europe like wildfire. The freedom of individuals to chart the course of their own lives, and to decide their own fates, was perceived by those in charge as an increasing threat. Feudal monarchs and lords wanted to continue to dictate as before, to claim the lives and labor of others, and to be the ones to decide for others. Those in power were more interested in keeping and accumulating privileges, rather than in sharing power with the nascent middle class. Therefore, the privileged political class attempted to repress this rising tide of progress through the use of force. Their attempts were unsuccessful, and on many occasions backfired. Soon, the "royalty" and political aristocracy understood that in order to prevent loss of their power, it would be better for them to speak subversively and make some outward gestures as if they embraced the novel, popular ideas. Actually, they sabotaged and subverted the new ideas, surreptitiously misusing them to advance their goals. As a result, an "Enlightened Absolutism" was born.

Enlightened Absolutism affected virtually all European countries: from Spain to Russia. From the medical history point of view, the Prussian model of Enlightened Absolutism offers the most insight into the results of the injection of political power into medical practice. The Prussian political hierarchy was able not just to survive, but thrive, despite being surrounded by enemies who were more numerous, but not so well organized politically. The efficient and disciplined political-military organization that permeated virtually all aspects of life in Prussia played a very important role in this success. Prussians have never forgotten this important historical lesson. Unfortunately, in their enthusiasm for political hierarchy and all things military, they overlooked that even the most elegant single formula cannot solve, or even explain, all the complexities of life.

At the outset, however, the single universal formula seemed to work very well. The creator of Prussian Enlightened Absolutism, Frederick the Great, made the Prussian way of ruling even more efficient. He combined the old and proven Prussian administrative model with the new French bureaucracy concepts inspired by Enlightenment philosophy.[1] Frederick's work was continued by his descendants, who also had a keen understanding of methods of sabotaging ideas of freedom in the service of maintaining the status quo.[2]

A prime example of that Machiavellian way of ruling was continuation of German feudal systems of power by simply giving them an updated form and designating a modern "enlightened" purpose for them, while underneath they remained the same old feudalism.

Some interesting hybrids were created. Those hybrid positions had the stated purpose of improving the lives of the Prussian citizens (consistent with Enlightenment philosophy), but their hidden, real function was maintenance of the supremacy of the ruling political elites. Such was the distinctively Prussian position of Geheim Rath (modern spelling: Geheimrat). Geheim Rath can be translated as secret, or more precisely confidential adviser to the king or emperor.[3] This was a position similar to the English privy councilor. Historically, Geheim Rath was the title given to the feudal lord (an aristocrat by birth) who served as a member of the royal council (Königliche Geheimer Rath). This council was charged with advising the anointed ruler (prince, king or emperor) in the Holy Roman Empire of the German Nation. The "Holy Roman Empire" came into being circa 800 A.D. It included much of Europe, including Italy and parts of France. It was named the Roman Empire, but in 1157, Frederick Barbarossa added the word "holy" to reflect his ambition to dominate Italy and the Papacy. The "Holy Roman Empire" dissolved after its defeat by Napoleon at Austerlitz on August 6, 1806.

After the fall of the empire, the councils ceased to exist, and Geheim Rath became an honorary title given to loyal political adherents who were aristocrats by birth. Subsequently, Enlightenment philosophy emphasized the merit of the individual rather than his political and family connections. Therefore, the Geheim Rath title was often given to individuals who achieved a high level of expertise and proficiency (i.e. "excellence") in professional fields such as law, medicine, commerce, etc. In keeping with this the Geheim Rath had to be addressed as Exzellenz (His Excellency). Many well-known luminaries of science and arts were honored by the Geheim Rath title, for instance Johann Wolfgang von Goethe and Gottfried Wilhelm von Leibniz.

In many professional areas the designation of Geheim Rath simply denoted excellence in some field. However, in medicine the title of Geheimer Medizinal Rath (Geh. Med.-Rath) evolved into an extremely powerful position that changed the way Prussian medicine was practiced.[4] Unfortunately, despite all the stated good intentions, this change was for the worse. Historical analysis of the evolving role of the Geheimer Medizinal Rath can be very instructive in the context of current attempts to reform the practice of medicine

Accurate medical knowledge was almost non-existent in medieval times, due to the difficulties of studying biological systems. Medical care was ineffective. Physicians were held in low esteem. Satirical poems and plays were directed at sincere but inept doctors.[5] In the early Enlightenment this criticism increased, as illustrated by comedies of Molière such as Imaginary Invalid or The Doctor in Spite of Himself.

Medical study was a major focus during the Enlightenment. In many other areas such as engineering and agriculture, early scientific methods showed spectacular results. Industrial and agricultural advances were prime examples of the positive impact of the philosophy of the Age of Enlightenment. However, the field of medicine lagged behind, to the dismay of Enlightenment theorists. Philosophers had a very hard time explaining the discrepancy. Perhaps the idea that treating patients cannot be compared to making machines or farming did not occur to them. After all, experience is always a better teacher than theory.

The Kingdom of Prussia took the most decisive approach to reforming the medical profession in accordance with the teachings of Enlightened Absolutism.[6] Prussia had many useful tools for such reforms, including a robust academic system and the position of Geheim Rath. Prussian academic medicine operated according to a militarized structure.[7] However, militarism is not what is needed for scientific study. Lack of scientific knowledge cannot be cured by force. The militaristic organization of Prussian medicine allowed for easy implementation of any type of novel doctrine, without much opposition and with a high degree of compliance. However, academic centers were not spread evenly throughout the country. Moreover, some academics, even Prussian ones, might occasionally show less than expected enthusiasm for the ideas promoted by the Crown. The position of Medizinal Geheim Rath was considered a possibility to remedy those problems. Medizinal Geheim Rath was not an academic appointment but a political one; it was a state function. Therefore, the person who held this position had powers both inside and outside of academia, and did not need to be based at an academic institution. He was given authority in the medical field comparable to the authority held by the Komtur (local commander) of the Teutonic order.

The methods of reform of the Prussian medical system were harsh, but its stated goals appeared to be very noble and benevolent. The main stated objectives were to improve the quality, effectiveness, and affordability of medical care throughout the kingdom. This was supposed to be done by elimination of "nonscientific" treatment methods through leveraging the expertise of accomplished physicians. It was the classic "the ends justify the means" scenario. Unfortunately, as in many similar situations, those reforms were ill-advised, and carried out by people who did not have any appreciation of unintended consequences.

Medicine in the Enlightenment was a great source of income. Not surprisingly, competition was fierce. In addition to formally trained physicians, the medical field was swarming with self-educated barbers/surgeons, midwives, and druggists. Many of those characters were mere charlatans. However, some of the government physicians were also charlatans, since this was before the age of germ theory. Some of the medical practitioners not anointed by the government achieved a surprising level of professional success, as measured by patients' satisfaction. They were becoming formidable rivals of the officially anointed doctors. Moreover, independent self-made wealthy men do not make ideal loyal subjects. They tend to

Continues on page 20 ➲

question the political and economic status quo. The supposedly merit-based Geheim Rath system assured prompt elimination of non-government-anointed physicians.

As noted by Jane Orient, "The trend to rely on expert committees suggests…we are moving toward the Prussianization of American medicine, adopting a system…like the Geheim Rath (secret council) system in Prussia at the close of the 19th century. The Geheim Rath set the standard of care, and none of his younger colleagues wanted to disagree with him."[8]

She notes, "There is a lot of pressure to restrict physicians' treatments to practice guidelines and to methods that have been shown to be both safe and effective in double-blind controlled trials. If we were to insist on this across the board, a huge number of medical treatments that physicians rely on would be ruled out."[8]

Ordinary medical orthodoxy and peer pressure can have similar deleterious effects, even without committees writing "evidence-based" guidelines. Ignaz Philipp Semmelweis thought cleanliness was important for physicians delivering babies, especially if they had just performed an autopsy. He instituted a hand-washing policy, and the rate of fatal puerperal fever fell from as high as 25–30% to 1–2%. Ridicule was heaped on him, and he was dismissed from his hospital in Vienna, and rejected by his fellow physicians there. In 1861 he published his major work, on the etiology, concept, and prophylaxis of child-bed fever, but the general reaction was adverse: "weight of authority stood against his teachings." His dismay and outrage caused him to be committed to a mental hospital, where he died just 14 days later.[9]

In our own day, the Australian physicians Barry Marshall and Robin Warren showed that Helicobacter pylori is the cause of most peptic ulcers, overturning medical orthodoxy that declared that peptic ulcers were caused by spicy food, stomach acid, stress, and so on. Dr. Marshall relates, "I had a colleague, Dr Warren…. It was difficult for him to get any of his colleagues to take this seriously,… the idea that bacteria could survive in the stomach, when the medical books said they couldn't survive in the stomach." Marshall stated, "It was a campaign. Everyone was against me. But I knew I was right."[10]

Modern communications helped him. "One of the top ulcer specialists in the world was in Amsterdam…. I visited him…. He had hinted that there were some funny things going on in the ulcer treatment story that didn't add up to [it all being] caused by acid…. I visited Stanford…and Dallas…epicenters…of the ulcer business. Although they were very skeptical, they did go out and start testing the hypothesis." He also writes, "It's fun to have the rejection letter after all these years."[10]

Thousands of patients have been spared years of drinking chalky ineffective liquid, and undergoing vagotomies and Billroth operations. Marshall and Warren were awarded the Nobel Prize in Physiology or Medicine in 2005.

Who knows what will happen if the "evidence-based" guideline-writing drill sergeants take over?

In the past, the results of the Geheim Rath system were dismal. Instead of improving medical care, this method of government administration and policing of the medical field caused chaos. It fostered corruption and exploitation of young physicians, who became the indentured servants of Geheim Räthe. The Geheim Rath system promptly became fossilized and interfered with any innovations, especially those contradicting government dogma. The only beneficiaries of this system were the political classes of Prussia and their obedient servants. With the dissolution of the second German empire and the downfall of the old elites at the beginning of the 20th century, the position of Geheim Rath was abolished. Soon after, German medicine experienced its renaissance.

The idea of "evidence-based" medicine ignores the obvious evidence that when people do have reliable evidence and the means to obtain it, the evidence will prevail over conjecture, deductions derived from flawed premises, and prejudice. After all, we do focus on sterile technique because of evidence supporting germ theory, and we are no longer treating peptic ulcers with vagotomy and antrectomy because of the evidence that Helicobacter pylori causes peptic ulcers.

Is comparing Geheim Rath-based medicine to EBM a justified analogy? The proponents of EBM would claim that their method is the total opposite of such a system. EBM relies on "objective" evidence, thus outwardly eliminating the highly subjective expert opinions upon which the Geheim Rath model was based. However, careful comparison between those two outwardly different schemes reveals many common denominators. In both systems, the decision-making process is being out-sourced. It is removed from the individual patient-physician interaction. The old Prussian principle of "one elegant formula can solve all the problems" is used as a guiding principle of EBM. It is quite ironic, since most of the EBM enthusiasts have not declared themselves to be endorsers of Prussian militarism.

The objectivity of EBM is dubious. The "evidence" itself does not magically write the clinical guidelines. The "expert committees" do. These committees consist of experts who, as human beings, carry their own biases. One could argue that the final product of writing of clinical guidelines is in fact a result of consensus between variously

Continues on page 22 ➲

biased experts' opinions. That is precisely what EBM claims not to be. This is even more ironic, since virtually all EBM promoters would like to enthusiastically endorse the following famous statement about "consensus science":

Let's be clear: the work of science has nothing whatever to do with consensus. Consensus is the business of politics. Science, on the contrary, requires only one investigator who happens to be right, which means that he or she has results that are verifiable by reference to the real world. In science consensus is irrelevant. What is relevant is reproducible results. The greatest scientists in history are great precisely because they broke with the consensus.[11]

Like EBM, the Geheim Rath system was presented to the public and to the medical profession as the quintessence of the new enlightened progressive philosophy. It was supposed to be a benevolent and rational quality assurance system based upon objective merit. In reality, it was a stealthy tool of political, economic, and ideological control. One can only imagine what possible feats of medical progress could have been produced by the talented and hardworking Prussian physicians if only they had been afforded freedom in their pursuit of medical arts and science.

From a historical perspective, the Geheim Rath model failed to deliver its purported public benefits. It served the political and economic elites very well, though. What the historical outlook on the EBM will be remains to be seen. But based on the evidence of history, it belongs in the trashcan. ▪

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Are Refunds Reportable to the NPND?

Guideline from the NPDB Insights March 2016

By Daniel L. Orr II, DDS, MS (anesth), PhD, JD, MD

A patient complains to her practitioner about an adverse reaction from an injection she received, and the practitioner offers the patient a refund for the office and injection fees. Is this refund reportable to the NPDB? Whether this is a medical malpractice payment (and is therefore reportable to the NPDB) depends on the following criteria:

- If the payment was a result of a written complaint from the patient, it should be reported to the NPDB — malpractice payments must be the result of a written complaint or claim demanding monetary payment for damages.
- If the doctor simply waives the fees, it should not be reported to the NPDB. There is nothing to report, as a waiver of a debt is not considered a "payment" — malpractice payments are limited to exchanges of money.
- If a payment was made by a practitioner out of personal funds, it should not be reported to the NPDB. However, if the practitioner's malpractice insurer reimburses the practitioner for her out-of-pocket expenses, the insurer must report the payment.

Editor's Note: Further questions may arise after reading this NPDB guideline. For instance, does the written complaint need to be made to a third party? Do corporate practice refunds count as personal funds?

In any case, it is prudent to contact one's liability insurance carrier in the event of any questions and before unilaterally attempting to resolve such issues.

If one does decide to refund fees, a restricted endorsement on the check can be considered. A restricted endorsement before negotiating the check may further elucidate the negotiation at a later time as needed. An example of a restricted endorsement would be: "By endorsing this check I acknowledge I am completely satisfied with my treatment by Dr._____"

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Exciting times here at SNDS! We've made changes to the format of our monthly dinner meetings to improve the atmosphere and interaction amongst members and our corporate partners. Each month, we're doing a different theme. Our Academy Awards Night was a blast! We had a record turn-out, had lots of awards and prizes for our members and a lot of laughs were had. The SNDS Executive Board have the hardest working people I've ever seen. We're really trying to bring a new energy to the Society.

We have partnered with UNLV School of Dental Medicine to bring you Botox 1 on March 24–25, 2016. Please make sure to contact the SNDS office to register for the class as seating is very limited. We're excited to be working with the dental school again, and plan on bringing more top choice continuing education choices to you.

We're planning our annual shredding day. It will be held in April. More information to come soon.

We're working on some new dentist events, so be on the lookout for an invitation from Dr. Emily Ishkanian soon.

Our C.E. premier Series continues on March 18, with Dr. Ross Nash, "An Overview of Esthetics & Cosmetic Dentistry for the General Dental Practice," and on April 22 with Dr. Michael Block, "Treatment of Dental & Implant Complications in the Esthetic Zone." Each course is 6 CEU's. As always, the courses will be held at the Gold Coast Hotel & Casino.

Give Kids A Smile is going to happen! We had to postpone the event due to the transition in the SNDS office, but we've got a date of May 21 set. Please contact our office if you're interested in volunteering.

If you haven't already renewed your membership for 2016, please contact either the NDA or SNDS office and we'll get that taken care of for you.

Our March dinner meeting will be held on Thursday, March 17, and our speaker will be John Hunt, attorney for the NSBDE. It's going to be a very informative meeting, and we'll have some fun things planned for you that night. It's also St. Patrick's Day, so wear your green, or you may get pinched! ▪

Handing off the Baton

JB White, DDS

I had three primary goals when I stepped in for my year as president. I wanted to change our dinner meetings to Thursday evenings, evaluate the current venue, and implement strong leadership with common core values. Those were just a few of the issues that would come to pass.

The dinner meetings are the opportunity for our dental community to come together, celebrate, share ideas, gain knowledge, and build friendships. I wanted to do everything possible to make it easy for the membership to attend and also worthwhile. Significant energy and planning has gone into recent meeting and the switch from Tuesday to Thursday evenings has significantly improved attendance. The feedback from the themed meeting as well as the raffles and door prizes has been positive.

We also wanted to increase value to our sponsors and exhibitors. To show our appreciation for their continued support, we moved them from the perimeter of the room to center stage. We felt they didn't get enough foot traffic and one on one time with our members, so the room was set up around them. We also wanted to give them a chance to introduce themselves and announce any current programs or specials. Each table is given a few minutes of microphone time at the beginning of each meeting.

The SNDS has held the majority of their events at the Gold Coast for as long as I can remember. In an effort to attract our largest group of non-members, new dentists (dentists who have been out of school ten years or less), and to give the society an updated aura, a search for a new venue ensued. It was important to keep a central location that was easily accessible both by vehicle and didn't require a long walk once inside. Quotes were received from several options, but the Palms was willing to work with us and gives us the best opportunity. We held two events, Community Night and our first CE Premiere Series at the Palms. When the SNDS is fiscally secure, a permanent move to the Palms is likely.

I am also proud to announce Mr. Anthony Ferreri as our interim Executive Director. Many of you know Anthony as he has been the Executive Assistant for the Nevada Dental Association. The Executive Board and Mr. Ferreri have set out to restore the integrity of the society and rebuild interactions with our community. Noteworthy effort has been made to increase working relationships with the NDA, Northern Nevada Dental Society, UNLV School of Dental Medicine, Nevada State Board of Dental Examiners and the ADA.

The SNDS has taken action that has led to an advisory opinion from the NSBDE that allows dentists in the state of Nevada to administer Botox and dermal fillers. The SNDS has partnered with UNLV School of Dental Medicine Continuing Education Department to develop curriculum and put together a three-part course for dentists wanting to implement injectables into their practice.

As I hand the baton off to Dr. Tina Brandon-Abbatangelo, I am proud of what the SNDS has been able to accomplish in my tenure. I'd like to thank the officers who I've had the privilege to work alongside as well as the many dedicated Delegates. I have confidence in the leadership that will follow, and I'm looking forward to assisting in your efforts. ▪

Upcoming SNDS Events

April

7	*New Dentist CE—All on 4 Restorative Nobel*
15	*UNLV End of Semester*
21	*SNDS Dinner Meeting @ Gold Coast 5:30*
22	*Seminar Dr. Michael Block*
30	*New Dentist Social—Hike/BBQ*

May

19	*SNDS Dinner Meeting @ Gold Coast 5:30*
21	*GKAS*

June

16–18	*NDA Summer Meeting Napa Valley, California*

ADMISSIONS AND STUDENT AFFAIRS

The Office of Admissions and Student Affairs has received approximately 1,950 applications for the 2015–16 application cycle. The selection for the Class of 2020 is still underway with interviews taking place through February. Acceptances will continue to be sent until the class is filled with 80 students.

Preliminary results for acceptances to a specialty/residency for the Class of 2016 are:

- Oral and Maxillofacial Surgery....2
- Orthodontics.....5
- Anesthesiology.....1
- Pediatrics.....5
- Endodontics.....1
- GPR /AEGD 1

The UNLV School of Dental Medicine Scholarship Committee selected first-year dental student Adam Marina as the recipient of the Delta Dental Scholarship Opportunity Award. Mr. Marina will receive $10,000 annually throughout his tenure at SDM.

Each year the student chapter of the American Dental Education Association hosts a Dental Simulation Course. This 2-day course is organized by SDM students who present lectures on dental anatomy and restorative dentistry. The second day features a hands-on component where attendees are able to take and pour impressions, prepare and fill typodont teeth with composite and amalgam as well as wax teeth under the supervision of Faculty and Students. This is a valuable course for predental students who are exploring the field of dentistry as well as providing insights into the life of a dental student. This year's Simulation Course will take place on June 3–4 at the School of Dental Medicine.

IMPORTANT DATES

Spring Break	March 14–18
Spring Semester Ends	April 15
Summer Semester Begins	May 9
Class of 2016 Senior Gala	May 11
Class of 2016 Convocation	May 13
Class of 2016 Commencement	May 14
2016-17 Application Cycle	June 2
Summer Semester Ends	August 17
Class of 2020 Orientation	September 6–9
Fall semester Begins	September 12

ADVANCED EDUCATION IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS RESIDENCY PROGRAM

Orthodontic screening appointments are available at SDM on Main located in the Student Wellness and Recreation Center on UNLV's Main Campus. Patients may call 702-774-7108 to schedule an appointment. The Orthodontic program has a website designed for new and existing patients. Visitors to the site can learn about the program, meet the Faculty and Residents, and get general information about insurances accepted and costs of treatment. The website link is: www.unlvorthodontics.com.

OFFICE OF RESEARCH

The UNLV SDM Dean's Symposium and 14h Annual Student Research Day was held on February 29. We were honored to have Dr. Edward Lynch, Head of Dentistry from the Warwick Medical School Coventry as our guest speaker and Student Research Day judge.

Dr. Lynch is a specialist in three disciplines including Endodontics, Prosthodontics and Restorative Dentistry and a Consultant in Oral Surgery. Over the course of his career, Dr. Lynch has been awarded a total of 94 research grants, has more than 500 publications, including chapters in books and refereed abstracts, and has more than 4,000 citations in citation index. He is Chairman of the European Experts group on Tooth Whitening and he is actively seeking to change European Union (EU) legislation to legalize Home Bleaching as evidenced by presentations on tooth whitening to the EU parliament on two occasions.

In 2010, Dr. Lynch was accredited with the prestigious membership of The American Society for Dental Aesthetics and awarded the Outstanding Achievement Award at the Dentistry Awards. In 2012, he was awarded the Fellowship of The American Society for Dental Aesthetics and was the first UK Dentist to achieve this prestigious fellowship. In 2013, he received the Lifetime Achievement Award for Services to Research and Teaching at the International Oral Health Research Dentistry conference in Las Vegas. Dr. Lynch was the first dentist to ever have been awarded the University of Warwick (Warwick Awards for Teaching Excellence) prestigious award for his teaching. On May 9, 2014, Dr. Lynch was voted by his peers to receive the Lifetime Contribution Award in Dentistry.

COMMUNITY SERVICE REPORT

The Give Kids A Smile event sponsored by the Southern Nevada Dental Society will take place from 7:30am – 1:00pm on May 21.

The UNLV School of Dental Medicine (SDM) has been actively participating in various community events including health fairs, career days and the school-based sealant program (Seal Nevada South). Preventive services have been offered to children, adults, teens and seniors. From the middle of November of 2015 to the middle of February of this year SDM attended 23 events with a total of 1,196

participants. Screenings were completed on 193 children and five adults. A total of 465 sealants were placed.

From November 8, 2015 to February 11, 2016, an estimated $18,265 (SDM fees) in donated services has been offered in school-and community-based events (excluding SDM specialty clinics).

INTERNATIONAL VISITORS

From January 18 – February 14, the School of Dental Medicine hosted five visiting scholars from the Stomatological Hospital of Nankai University in China. These visitors were here to develop a general understanding of the United States dental educational system. They also gained an understanding of the educational program of the UNLV SDM predoctoral dental curriculum, including sequencing, length, content, competencies, assessment, and teaching methodologies.

Dean West was pleased to host a meeting with faculty from the "G. d'Annunzio" University of Chieti Pescara, Department of Medical, Oral and Biotechnological Sciences (Italy). Professor (Dean) Sergio Caputi, MD, DDS and Drs. Trubiani, Traini, Diomede, and Sinjari presented the University of Chieti-Pescara educational and research goals and some of their research initiatives. Areas of possible collaboration, including student and faculty development opportunities and research projects, were discussed.

CONTINUING EDUCATION

Courses being offered at the UNLV School of Dental Medicine include the following:

- "Cone Beam (CT) Radiography: A Certification Program for Dentists" will be the focus of a course presented by James Mah, DDS, MSc, DMSc and Robert Danforth, DDS on April 1– 2.
- Roger Sanger, DDS, Ray Stewart, DMD, Bill Waggoner, DDS, and Stephen Wilson, DMD will present "ICPPD: Fundamentals of Pediatric Dentistry" on April 29 and 30. Registration is available through the Institute for the Clinical Practice of Pediatric Dentistry.
- Mr. Daniel R. Watkins, JD, BS will discuss "An Overview of Risk Management Principles for Dentists" on April 27.
- "Infection Control for the Dental Office" will be presented by Ed Herschaft, DDS on April 30 and May 21.
- Real World Endo® in conjunction with the School of Dental Medicine presents "Restorative Endodontics: A Modern Standard of Care for Long-Term Success" with Alex Fleury, DDS, MS on May 21.

To register for any of these courses or for more information on Continuing Education at SDM, please visit unlvdentalce.com.

Lori Benvin
nnds@nndental.org

It's Children's Dental Health month and the NNDS New Dentist Committee along with our Healthy Smile Healthy Child/NNDHP program hosted the 6th Annual Give Kids a Smile event at Community Health Alliance dental clinic. Thank you to Community Health Alliance administration who generously allowed this event to take place at their dental clinic on Wells Avenue in Reno.

There were 94 children served, with close to $50,000 in donated dental services February 6 with 52 families who we will now be qualifying for continued dental care through Healthy Smile Healthy Child (HSHC) or Community Health Alliance to find them a dental home. HSHC, one of the programs of the Northern Nevada Dental Health Programs, has been helping at-risk northern Nevada children since early 1980. Some of our dental providers prefer to volunteer their time by participating in GKAS events, like this one, instead of providing care all year long. For more information about NNDHP and how you can get involved, please contact me or go to our new website at nndhp.org

I'd like to thank the multitude of volunteers who made this year's GKAS event such a success.

A Special Thanks

- Monica Vazquez, HSHC Program Supervisor
- The staff of HSHC
- Dr. Erin Anderson, Chair of the NNDS New Dentist Committee.

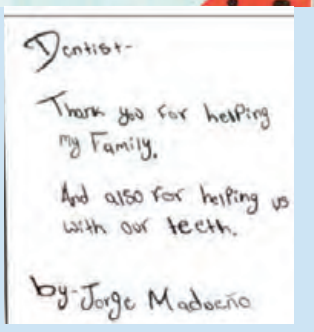
I'd also like everyone to thank the following volunteer dentists who provided the pro-bono care;

- Dr. Brad Davis
- Dr. Cariann Champagne
- Dr. Carol Lee
- Dr. Cyrus Kwong
- Dr. Garrett Swanson
- Dr. Jason Champagne
- Dr. Jennifer Rearrick
- Dr. Justin Kiggins
- Dr. Katy Wallace
- Dr. Kevin Olson
- Dr. Mat Stewart
- Dr. Morrigan Drew
- Dr. Nick Anastassatos
- Dr. Paul Brosy
- Dr. Staci Owens
- Dr. Summer Kleidosty
- Dr. Emily Whipple
- Dr. Katie Foster
- Dr. Whitney Garol
- Dr. Alec Fillmore
- Dr. Jim Garol
- Dr. Ryan Falke
- Dr. Jacqueline Delaney
- Dr. Erin Anderson

We appreciate all of you who give back to our community.

The NNDS continues to host top-notch speakers with some excellent opportunities for you to get continuing education right here in Reno. Please check our website www.nndental.org or watch for our mailed fliers and emailed newsletters. We offer these courses for low costs to our members because you are valued for your continued membership. ▪

6th Annual Give Kids a Smile



Brandi Dupont, DMD

The NDA annual midwinter meeting was held in January in Las Vegas. It was a very productive meeting, and there was much discussion on the top dental legislative issues that the NDA hopes to address in the coming legislative year.

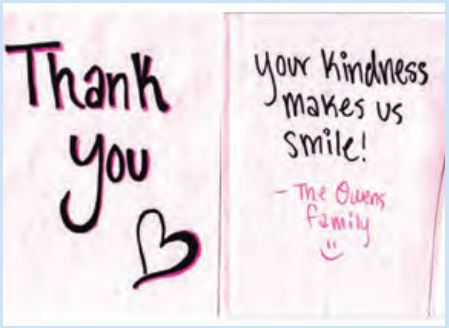
The Northern Nevada branch of the ADA's Committee on the New Dentist held its 6th annual Give Kids a Smile event on Saturday, February 6 at Community Health Alliance Community Health Center. The event provided free dental care to over 90 children in need in northern Nevada. Dr. Erin Brosy organized the event with members of the Committee on the New Dentist and help from the Northern Nevada Dental Society. Thank you to all of the dentists, hygienists, dental staff members, students and other volunteers who made the event successful!

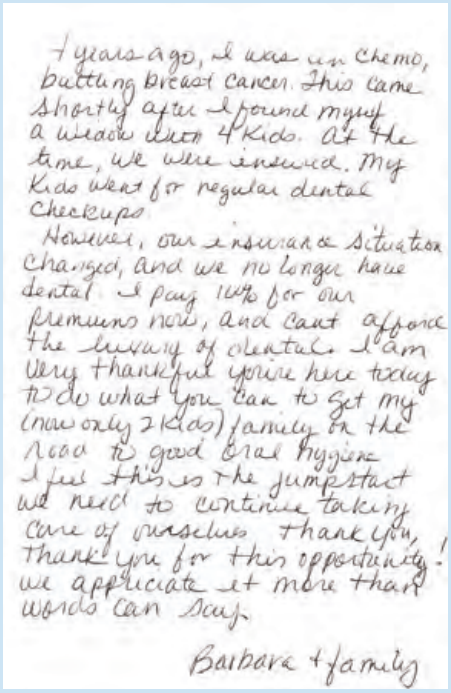
As Spring arrives, we have a multitude of continuing education programs coming up. First in March, we have renown speaker, Dr. Lee Ann Brady, presenting on "Mastering Anterior Implant Esthetics" at our dinner meeting on the 10th, and then providing an all-day CE opportunity on the 11th on "Today's Top Clinical Tips." In April, we will not be holding the Mario Gildone awards night this year, but will be holding another dinner meeting and CE opportunity, and on May 6, the NNDS will hold its annual OSHA/Infection Control Course. This year's NDA Annual Summer meeting will be held in Napa, California from June 16 to the 18, and I encourage our members to attend.

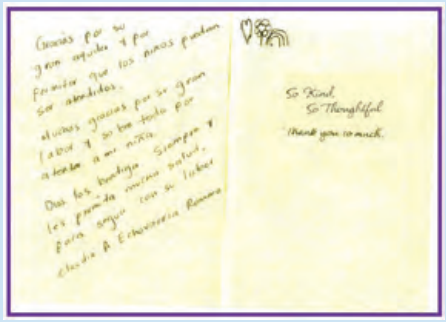
The Northern Nevada Dental Health Program (NNDHP) has rolled out its new website. Please visit the website at NNDHP.org to learn all about their programs and volunteer opportunities. As always, we want to thank our volunteer dentists who give so much of their time to the patients seen through the NNDHP programs. We really appreciate you!

I would like to thank the membership of the NNDS for their continued support of our programs. We have a great profession and a great professional community in northern Nevada, and I look forward to continued fellowship moving forward into Spring. ▪

Thank you notes from children and families who attended







NDA 2016 Meeting Calendar

3/9(Wed.)	NDA Executive Meeting Video Conference	6pm
5/4(Wed.)	NDA Executive Meeting Video Conference	6pm
6/8(Wed.)	NDA Executive Meeting Video conference	6pm
6/16-18	NDA Summer Meeting, Napa Valley, CA	TBD
8/4-6	Western States President's Conf., Honolulu, HI	TBD
8/10(Wed.)	NDA Executive Meeting Video Conference	6pm
9/9-11	Caucus 1, Phoenix, AZ	TBD
10/20-25	ADA Annual meeting, Denver, CO	TBD

NNDS Calendar of Events

APRIL 2016			
Tuesday, 4/12	**NNDS Executive Committee Meeting**	5:45 pm	161 Country Estates Cir, #1B, Reno
Thursday, 4/14	**NNDS General Membership Dinner Meeting**	6:00 pm	Atlantis Casino Resort Spa, Reno
Thursday, 4/21	**AGD Dinner Meeting**	6:00 pm	tbd
MAY 2016			
Friday, 5/6	**OSHA, Infection Control & Bloodborne Pathogens CE**	8:00 am	Atlantis Hotel Casino Spa, Reno
Tuesday, 5/10	**NNDS Executive Committee Meeting**	5:45 pm	161 Country Estates Cir, #1B, Reno
JUNE 2016			
June 1	**NEW NNDS OFFICERS TAKE OFFICE**		
Tuesday, 6/14	**NNDS Executive Committee Meeting & Delegate PreMeeting**	5:45 pm	161 Country Estates Cir, #1B, Reno
June 16-18	**NDA Annual Summer Meeting**		Napa, California
JULY 2016			
Tuesday, 7/12	**NNDS Executive Committee Meeting**	5:45 pm	161 Country Estates Cir, #1B, Reno
AUGUST 2016			
Tuesday, 8/9	**NNDS Executive Committee Meeting**	5:45 pm	161 Country Estates Cir, #1B, Reno
TBD	**NNDS Annual Open House Picnic**	5:30 pm	Bartley Ranch Regional Park
SEPTEMBER 2016			
Tuesday, 9/13	**NNDS Executive Committee Meeting**	5:45 pm	161 Country Estates Cir, #1B, Reno
TBD	**NNDS Spouses Night/ Mystery Bus Trip**	5:30 pm	??
Friday, 9/16	**NNDHP/Joel F. Glover 14th Annual Charity Golf Tournament**	8:00 am	Lakeridge Golf Club, Reno
OCTOBER 2016			
Tuesday, 10/11	**NNDS Executive Committee Meeting**	5:45 pm	161 Country Estates Cir, #1B, Reno
Thursday, 10/13	**NNDS General Membership Dinner Meeting**	6:00 pm	Atlantis Casino Resort Spa, Reno
Tuesday, 10/20	**AGD Gen'l Membership Dinner**	6:00 pm	tbd
NOVEMBER 2016			
Thursday, 11/10	**AGD Dinner Meeting**	6:00 pm	tbd
Tuesday, 11/15	**NNDS Executive Committee Meeting**	5:45 pm	161 Country Estates Cir, #1B, Reno
Thursday, 11/17	**NNDS General Membership Dinner Meeting w/ Dr. Harel Simon**	6:00 pm	Atlantis Casino Resort Spa, Reno
Friday, 11/18	**All Day Continuing Education Course with Dr. Harel Simon**	8:00 am	Atlantis Casino Resort Spa, Reno
Saturday, 11/19	**Hands-on CE with Dr. Harel Simon**	9:00 am	nSequence Dental

ADA-Affiliated Products

We are pleased to announce that the NDA and ADA have combined the purchasing power of dentists to gain discounts on a large variety of products and services. Call the company or the NDA to learn more.

CareCredit
Patient financing
800-300-3046 x4519 www.carecredit.com

InTouch Practice Communications
877-493-9003
www.intouchdental.com/ada

TDIC
Professional liability
800-733-0633 www.tdicsolutions.com

Wells Fargo Practice Finance
888-937-2321 www.wellsfargo.com/dentist

NDA-Affiliated Products

These companies and their products have been evaluated by the NDA and are recommended for use in running your practice. Let us know if you have any feedback or would like to recommend a product or service for affiliation.
For a weblink to each company, go to www.nvda.org/affiliatedproducts.shtml.

Best Card, LLC
Credit card processing
877-739-3952 www.bestcardteam.com

The Dental Record
Digital record keeping
800-243-4675 www.dentalrecord.com

EBSCO
Subscription service
800-527-5901 x1652 www.ebsco.com/errss

FedEx
Shipping services
800-636-2377 or 1-800-MEMBERS

Fletcher Jones Imports
Mercedes-Benz leasing
866-628-7232 www.ada.org/mercedes

HP (Hewlett Packard)
800-243-4675, mention ADA
www.hp.com/ada

IC System
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