Year in Review

The Annual Association Guide

CDA

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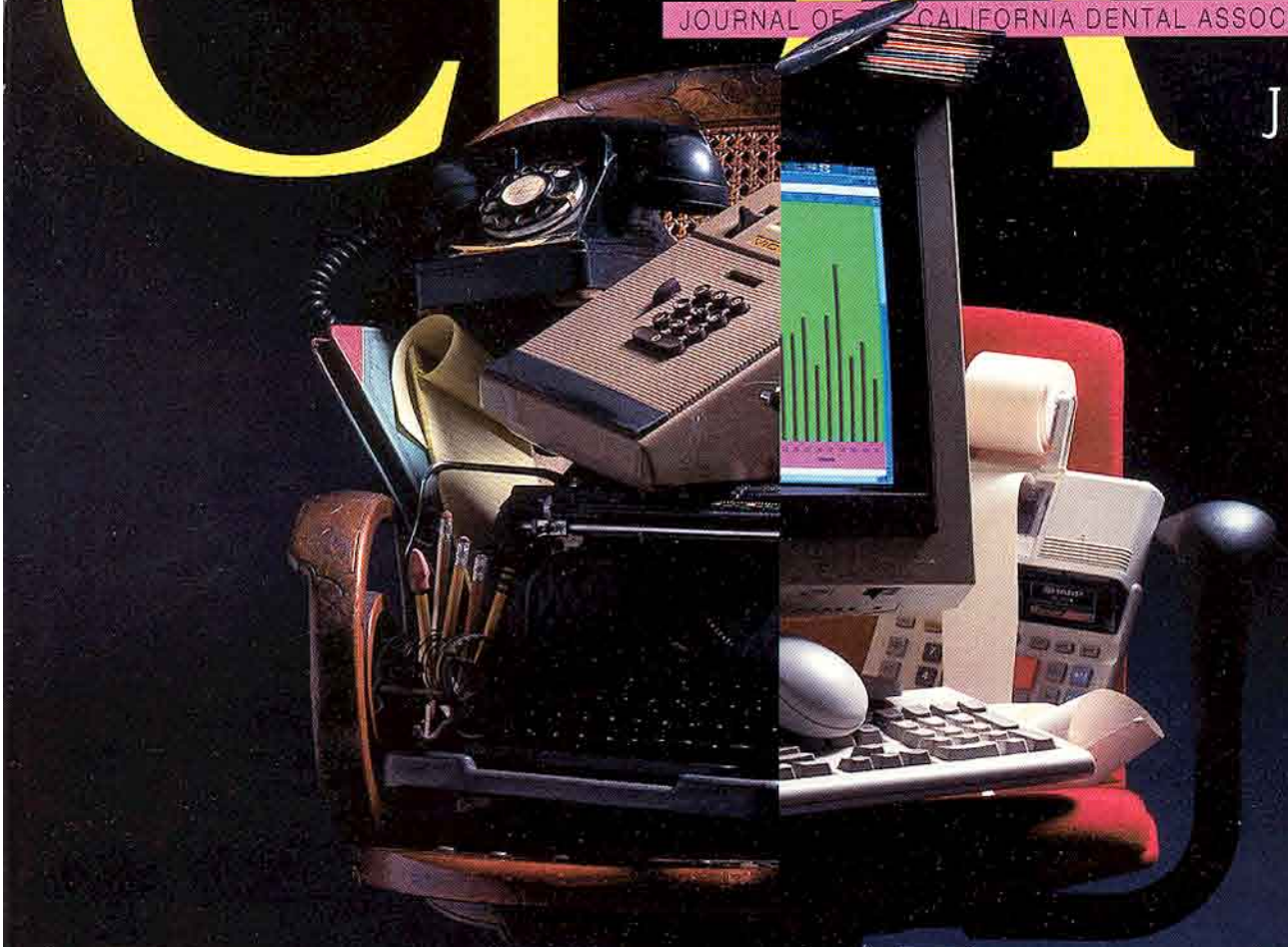

EVOLVING BUSINESS

David G. Jones

OF THE CALIFORNIA DENTAL ASSOCIATION
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DEPARTMENTS

FEATURES

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Another Black Eye

Jack F. Conley, DDS

In mid-November, the image of dentistry was dealt another glancing blow, this time via television. The good news is that the impact has been limited thus far to the area served by the Los Angeles television market. This TV report concerning Denti-Cal fraud didn't possess the coast-to-coast clout demonstrated by the massive circulation of Reader's Digest and its early 1997 report on discrepancies in dental treatment planning.

The concern here is that this report could still spawn the interest of television journalists in other markets to present additional reports like this one, which was factual in content but unbalanced to the extent that we believe it contributes to an unfair indictment of the dental profession at large.

It is either ironic or a coincidence that the Fox station in Los Angeles initiated its "undercover investigation" after the CDA Update published a report on the Denti-Cal fraud problem in the Sept. 17, 1997, issue.

It would be easy to pass this matter aside with the notion that only a few dentists are engaged in this activity and that it will not have significant impact on the image of the profession. However, review of some of the facts about the fraudulent activity and some details of how it was reported will be helpful to understanding why we believe that the impact of this report is a severe black eye for the profession! It will heal, but not without more conscious attention to the solution of the problem.

Our first realization that this form of organized fraud had been occurring was a telephone call from a dentist colleague in spring 1997. He reported that one of his dentist friends in Los Angeles had complained that patients with Denti-Cal coverage coming to his office were being paid $10 and supplied transportation to go elsewhere for their dental care.

A concern that we had with the November television report is that it focused on the fraud by dentists, their intermediaries, and the patients who were guilty of the crime. Only the state government and taxpayers were listed as the victims of this scam. There was no mention of the harm to the honest dentists who incorporate treatment of Denti-Cal patients into their practices, only to have their patients or potential patients stolen at the front door. It is unfortunate that the report failed to mention that honest dentists are victims of this crime as well.

A major problem with the report is one that frequently occurs with such media investigations. Not a single dentist was interviewed, nor was any representative from the profession offered an opportunity to comment on this problem, although efforts by CDA had been undertaken unsuccessfully once the association became aware that a program was being prepared. Other than the station's undercover work (with hidden cameras in some instances), the 11.5 minutes of this two-evening report was devoted to the reporter's voiceover on videotaped "capping" activity inside and outside of several dental clinics in Los Angeles and one in the suburb of Lynwood. Interspersed were clips of an interview with the director of the Medi-Cal Fraud Division.

The facts revealed in the report are as follows. A "marketer" ostensibly hired by the dentist, employs "cappers" to find the dentist patients and binds the cappers to a phony agreement in which they "agree"

not to pay those patients for coming to that dentist's office. If the capper encounters legal problems, the marketer will deny any business relationship with the capper. Under the terms of the agreement, the capper is paid as much as $2,000 plus per week, based upon the number of patients he or she steers to the dental clinics. Despite the phony contract, the capper makes payments to the patients ranging from $10 to $30 plus, in some cases, gifts from their proceeds. In one of the dental offices, the receptionist is filmed distributing "gift certificates" for a large supermarket chain while informing the patients that the coupons are good for anything they wish, from food to alcohol. There are obviously many incentives in the various schemes, with cell phones and pagers being among the premiums offered.

These schemes reportedly contribute to an estimated 10 percent of the annual Denti-Cal budget that is consumed by fraud. This was described as a pyramid scheme, where the person at the top, the dentist, makes money by overbilling for treatment that is never done, or for procedures that are unnecessary. The report described a patient that had 14 "fillings" placed in a short appointment that day. The reporter stated, "Greedy, unscrupulous dentists appear to be using others to become the richest link within the chain," and described the scenario whereby the dentists successfully distance themselves from the scam.

The cappers transport the patients to these offices from distances as far away as Bakersfield, according to the report. It was interesting to note that these cappers had vans clearly identified with painted signage proclaiming "Dental/Medical Transportation," but at the same time it was discouraging to find that ONLY dental scams were mentioned.

Another disheartening factor was that no specific information was provided to support how widespread this scam was (beyond its monetary contribution to overbilling fraud), although "widespread abuse" was the reference made by the director of the Medi-Cal Fraud Division in his interview. Neither was there any indication that there was a significant effort under way that would control or eliminate the problem. These factors taken together represented the most negative aspect of the manner in which this report was presented.

It was disturbing to have the viewing public told that "greedy, unscrupulous dentists" were masterminding a scam in which they were able to successfully distance themselves from the actual criminal activity (violation of Article 6, Section 650 of the California Business and Professions Code), which was putting from $400,000 to $900,000 in additional income into their pockets at the expense of California's taxpayer-supported public assistance program.

It would have been nice to hear that "a few dentists" were responsible and that progress was being made in eliminating this scam. Instead, the viewer was left with the impression that a significant amount of criminal activity by dentists, including overbilling, was victimizing this state program and the patients it serves, without resolution.

Perhaps it will take some ethical dental colleagues whose practices are being damaged by the activities of those involved in these scams to come forward with evidence that will be helpful in resolving an unpleasant public relations nightmare for the dental profession. Given the ease with which the TV crew was able to record activity and uncover evidence, resolution of the problem and healing of this wound seem overdue.

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Inventiveness Is a Useful Travel Partner

By David G. Jones

Deep into the hinterlands he treks, taking with him little more than his initiative, training, a armload of equipment and supplies -- and an ability to improvise.

Implicit as the animating facet for the travels and trials of Kenneth O. Crosby, DDS, is a desire to bring modern dental care to the world's technological backwaters.

The results of his forays into exotic realms such Nepal and Albania are people whose pain has eased and whose smiles have gained luster.

Since 1992, Crosby, a CDA member who practices in Fresno, Calif., has made four trips as part of a six-person team to provide dental care to people living in medical dark ages.

Crosby began his long-distance dental work when he was invited to join the team on a trip to Albania, where that country's people found their care provided by a corroded medical system reeking of communist obsolescence.

How bad was it? No anesthesia was used for fillings or root canals because none was available.

But when the team arrived, Crosby and his colleagues opened their suitcases, pulled out instruments and supplies, and set up shop on a local dentist's front porch.

"The local dentists couldn't believe these Americans could set up a whole clinic just out of a couple of suitcases," Crosby says. "One of the nice things about dentistry is that you can put everything you need for two or three weeks in the field into a couple of suitcases. And the work you do lasts for many, many years."

But inventiveness has been a necessary overseas companion. The team found that cardboard platforms passing for dental chairs became useless when wet, so Crosby went to work.

"I took some corrugated plastic and made a dental chair that weighs about five pounds, folds for travel in a suitcase, yet can hold up to 275 pounds," he says.

Crosby found many of the local dentists to be relatively well-trained, but they lacked supplies. Subsequently, the team gave the dentists supplies that had been donated for the trip such as 2,500 doses of anesthetic, burs, endodontic instruments and other basics. The team also exposed the local dentists to procedures that were unfamiliar or even unknown to them.

At least one bit of work done by Crosby in Albania gave a potential career boost to his patient.

"I had the opportunity to do composite fillings and crowns on teeth 4 through 12 for a television personality there," Crosby says. "You could see her cavities from across the room, but their television system is so grainy, I suppose viewers didn't see it on their sets.

"And doing a blue light composite was like walking on water to the local dentists."

Composites became a huge challenge on a subsequent trip to a remote area of Nepal which had no running water or electricity. To reach the village in the Himalayan foothills, the team crossed a rope suspension bridge -- " 'Indiana Jones' type," Crosby says.

Root canals were done with the assistance of handpieces powered by generators the team packed in, but only another extemporaneous adjustment by Crosby answered the composite question.

"I couldn't cure the composites, so I invented a solar-powered unit," he says.

Using an 11-inch Fresnel lens, Crosby focused 121 square inches of sunlight onto a quarter-inch spot and funneled the energy through a fiber optics bundle to a curing want fitted with a blue filter.

"It did the trick," he says.

The need in Nepal, where, as with Albania, he has twice traveled, was "mind blowing."

"We saw 745 patients in the (tent) clinic on this trip, and I personally saw 88 patients in one day," he says.

And the patients? Very grateful, very tough.

"To do root canals, we used 25-gauge needles to administer the anesthetic and didn't use any topical anesthetic, and nobody even said 'boo,' " Crosby said. "They had some teeth rotted off at the gum line, so it was no big deal."

But the goodwill -- not mention the spirit of help and useful improvisation -- left behind by the team and its supporters will be felt long after the anesthesia has worn off and the memory of long-endured pain subsides.

When Relief Becomes an Opportunity

By Marios P. Gregoriou

Designed primarily to reduce the federal deficit and balance the budget, the Taxpayer Relief Act of 1997 contains changes in tax law that could have a significant impact on an individual's financial strategy now and in the future.

The historic legislation contains provisions that affect a variety of financial goals, including: capital gains tax rates; retirement savings; education funding; home sales; estate taxes; and tax credits for many families with children.

The Act profoundly enhances investment opportunities for millions of Americans. Following are a few important provisions of particular interest to investors:

Significant reductions in capital gains tax rates: The maximum rate for long-term capital gains from the sale of stocks, bonds and most other investments has been lowered from 28 percent to 20 percent. The law also creates a new 10 percent capital gains rate for taxpayers in the 15 percent income tax bracket. The new 20 percent and 10 percent rates are

applicable to investments that have been held for longer than one year and sold after May 6, 1997, and before July 29, 1997. Investments sold after July 28, 1997, must have been held longer than 18 months to qualify for the new rates.

New and enhanced Individual Retirement Accounts: The Act enhances traditional IRAs and creates two new IRA alternatives, the Roth IRA and the Educational IRA.

Enhanced traditional IRA. When an individual participates in an employer-sponsored retirement plan, income limits for fully deductible IRA contributions will gradually be increased over the next several years, ultimately doubling the current limits to $50,000 for single tax filers by 2005 and $80,000 for joint tax filers by 2007. (For 1998, income limits for making fully deductible contributions will be $30,000 for individuals and $50,000 for people filing jointly.) In addition, spouses of active participants in employer-sponsored retirement plans who are not covered by their own plans can make fully deductible IRA contributions, regardless of whether they are wage earners, if the couple's adjusted gross income is $150,000 or less in 1998.

Also, the IRA account holders will be able to make withdrawals without penalties before the age of 59 if the funds are used to purchase a first home or to pay expenses associated with higher education. (The home withdrawal has a lifetime maximum of $10,000,)

Roth IRA. Eligible participants may make a contribution of up to $2,000 per year. All contributions will be non-deductible; however, earnings accumulate on a tax-deferred basis. Withdrawals will be tax-free if the account has been open for more than five years and the investor is at least 59 , is disabled or dies or the funds are used to finance a first-time home purchase ($10,000 lifetime maximum).

Any distribution not meeting the five-year rule and any of the other four requirements will be taxable to the extent distributions exceed previous contributions. The 10 percent premature distribution penalty will apply unless one of the exceptions to the penalty for distribution from traditional IRAs applies.

The adjusted gross income limits to determine whether investors are eligible for the Roth IRA begins at $95,000 for single taxpayers and at $150,000 for people filing jointly. Those whose income is above the limits to be eligible for a Roth IRA or to deduct a traditional IRA contribution can still make non-deductible contributions to a traditional IRA.

Eligible taxpayers can contribute to both types of IRA each year, but total contributions cannot exceed $2,000.

Educational IRA. This third IRA category will allow individuals who fall within certain income limits to contribute up to $500 per year per child to this account until the child reaches 18. Like the Roth IRA, contributions will not be tax deductible, but the earnings accumulate on a tax-deferred basis, and there will be no taxes on withdrawals, provided the funds are used to pay for the child's qualified higher-education expenses.

The legislation offers welcome tax relief and creates new opportunities for individual investors. For more information, contact your investment professional.

Mr. Gregoriou is an associate vice president for investments with Dean Witter. He can be reached at (800) 755-8041. Dean Witter is not a tax adviser, and investors should consult their individual tax advisers before making tax-related investment decisions.

Focus of IRS Can Be Taxing

The IRS may direct dentists nationwide to convert their accounting method from a cash to an accrual basis, if some recent incidents in Chicago have a national bearing, reports AGD Impact, the newsmagazine of the Academy of General Dentistry.

An Illinois dentist, who asked not to be named, was notified last year that the IRS would be examining his financial records for the 1995 tax year. He later learned that four other dentists in his town were also being audited.

The IRS concluded that the dentist should convert his accounting method from a cash to an accrual basis. Under the cash basis, income is taxable when the cash is received, while under the accrual basis, income is taxable when the service is performed.

The Illinois dentist believes the IRS may be planning to establish accrual-basis accounting for dentists nationwide. The change, while not necessarily resulting in more taxes being paid, would put the money in the IRS' hands sooner.

Honors

Robert Ibsen, DDS, of Santa Maria, the founder and president of Den-Mat Corporation, received the 1997 Dental Trade Industry Award by the Pierre Fauchard Academy.

Bill Harman, PhD, associated dean for Student Services at the University of the Pacific School of Dentistry was awarded honorary membership in the American Dental Association.

Rating Providers Spurs Them to Change

Giving consumers reports on health care providers not only helps patients and their families make informed decisions, but also prompts physicians and hospitals to make changes in their practices, according to an article in the Nov. 19 issue of The Journal of the American Medical Association, an issue devoted to quality of care.

Daniel R. Longo, ScD, from the University of Missouri-Columbia School of Medicine, and colleagues at the Missouri Department of Health examined consumer reports issued in 1993 to all Missouri hospitals providing obstetrical services. Like consumer reports for automobiles or home appliances, consumer reports for health care can provide information that can be used by consumers in deciding which physician or hospital to use. A survey of hospitals was conducted a year later to determine, among other things, what changes were made at Missouri hospitals following the release of the consumer report.

The authors write, "Consumer reports are gaining a great deal of attention from consumer groups, health care delivery organizations such as hospitals, and managed care organizations and physicians. They are included as a requirement in many state and national health system reform proposals. They are also being developed by managed care plans and some hospitals as a marketing tool to differentiate themselves based on both quality and cost."

Researchers found that hospitals with either low or average patient satisfaction quality indicators were more likely to have changed, or be planning to change, policies relating to those indicators than hospitals with high quality scores. However, only about 20 percent of those hospitals with low or average indicators expressed any consideration being given to changes in policies.

The researchers discovered hospitals that did not provide a service mentioned in the survey and that had a competitor in the same community were more likely to institute a service after the consumer report was published.

"It appears that although consumer reports were initially designed to assist patients in making better decisions about personal health care, they have been carefully evaluated by health care clinicians and delivery organizations," the authors write. "This phenomenon is fortuitous and should be explicitly taken into account by future consumer report releases."

Disinfectants Still Clean Up Against Bacteria

As bacteria become more resistant to antibiotics, they do not become more resistant to disinfectants, according to the American Journal of Nursing, November 1997.

The article cites researchers who tested the germicidal power of two disinfectants against 12 strains of seven bacterial pathogens.

The study pitted antibiotic-susceptible and -resistant bacteria against representative disinfectant products from two common classes (a phenol and a quaternary ammonium compound) at two strengths (recommended use-dilution and twofold concentrated solution in sterile distilled water).

The researchers found no correlation between antibiotic resistance and germicide resistance at either concentration. For five pathogens, they compared a susceptible and a more antibiotic-resistant strain. Only in one of 20 comparisons was the more antibiotic-resistant strain significantly more resistant to the germicide (Klebsiella pneumoniae, exposed to quaternary ammonium compound at use-dilution strength).

Current disinfection and housekeeping protocols don't have to be altered to account for antibiotic-resistant bacteria, nor do resistant bacteria need to be routinely monitored for susceptibility to disinfectants, the study authors conclude.

Given the tendency to use disinfectants at a much higher concentration than the minimum inhibitory concentrations, they say, even the more antibiotic-resistant strains should be controllable.

Ketoprofen Climbs Over the Counter

Ketoprofen, a nonsteroidal anti-inflammatory drug, has been approved as an over-the-counter analgesic at a 12.5 mg dosage.

In a study published in The Journal of Clinical Dentistry, Vol. VIII, No. 4, dental researchers explored the analgesic efficacy and safety of 12.5 mg of ketoprofen in patients experiencing pain following removal of impacted third molars.

Researchers found that ketoprofen has an analgesic onset of within one hour and an analgesic duration of nearly four hours. Somnolence was the most often reported side effect, experienced by about 13 percent of patients in the study group.

The study concluded that 12.5 mg of ketoprofen is a safe and effective analgesic for relief of postsurgical dental pain. The researchers noted that they found the overall efficacy of the 12.5 mg dosage impressive for an over-the-counter analgesic.

Wooden Nickels Accepted Here

Dr. William Robinson, an orthodontist in Sherman, Texas, has rewarded his patients with wooden nickels for such things as good oral hygiene and keeping appointments. Patients save and redeem the nickels for prizes including toys, notebooks, compact discs and telephones.

An article in The Bulletin, from the American Association of Orthodontists, July/August, reports that Robinson's

treatment coordinator explains the program to new patients, who receive three tokens on their first visit. Robinson estimates the program costs from $300 to $400 a month, but the cost has been balanced by increased patient compliance and cooperation. The nickels also serve as a marketing tool: Each one has Robinson's name and address printed on the back.

It's Progress But Not Parity

Women seem to be making consistent progress in higher education, according to the Bulletin of Dental Education of the American Association of Dental Schools, September 1997.

The number of women presidents of colleges and universities has more than tripled, from 148 in 1976 to 453 in 1996. The number of women faculty members has also increased, and women now receive 54 percent of all bachelor degrees and 38 percent of all doctorates. Sixteen percent of all top leaders in U.S. higher education institutions are women.

However, in the United States, only six medical school deans are women, with only 4 percent of medical school chairs being women. In the 55 U.S. dental schools, there is only one acting female dental dean. Nearly half of U.S. dental schools lack women at the assistant and associate dean level; only 6 percent of department chairs are women.

Though there is data indicating progress, little has been done to understand the social, cultural and psychological dynamics that influence the advancement of women. Often biases and assumptions about women in positions of authority go unexamined and unaddressed.

The Bulletin article suggests a need to understand the dynamics in institutions and how the social and professional climates influence women and their development.

ITMD Linked to General Health

Several studies have revealed that temporomandibular disorders and general health are associated.

In 1992, Marjaana Kuttila, DDS; Seppo Kuttila, MD; Yrsa Le Bell, DDS, PhD; and Pentti Alanen, PhD, began analyzing the relationship between need for treatment of temporomandibular disorders, sick leaves, and use of health care services in a study population of 441 adults.

The authors' findings, published in the Journal of Orofacial Pain, Vol. 11, No. 3, 1997, indicated that these were strongly associated, suggesting that stomatognathic disorders are one link between medicine and dentistry in health care.

The study showed that subjects with TMD were on sick leave more often, visit physicians often and use much medication, physiotherapy or massage. Limited awareness of the physician to diagnose and treat TMD often leads to unnecessary radiographs, antibiotics and pain medications.

The authors believe that proper treatment for TMD patients would be referring the patient to a stomatognathically experienced dentist to minimize suffering and total cost.

The clear association between TMD treatment need and the use of health services emphasized the necessity of comparing different treatment modalities in chronic pain conditions in the head, neck and shoulder areas, the authors concluded.

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The Honor of Serving

KENNETH E. LANGE, DDS

As I was being installed by Dr. Valentine, a quote by Warren G. Harding came to mind. He said, "I am a man of limited talent from a small town. I don't seem to grasp that I am president."

Well, I have grasped it now; and I, indeed, am extremely honored to be installed as president of the California Dental Association. Very few dentists have the opportunity to serve in this role. I am grateful to all of you -- my colleagues, my family and my friends -- who have supported me and placed confidence in me through all the years of my involvement in organized dentistry. I thank you so very much.

Challenge equals opportunity, and CDA is there today. The California Dental Association has faced many challenges since unification of the Southern California Dental Association and the California Dental Association in 1973. For the following 24 years, that fledgling organization grew into one of the premier professional organizations in the country.

The association has always had the vision and tenacity to recognize new directions and pursue its goals. Achieving them was not always easy, but as Napoleon said, "Victory is won by the most persevering," and that exemplifies CDA.

Dr. Sekiguchi faced and endured major challenges this year. He is to be greatly admired and truly appreciated for the dedication and sacrifice he put forward for this association. Gene, this association owes you thanks almost beyond expression. Thank you.

I now have the responsibility to lead this association up that hill of change and transition as the search begins for a new executive director. The business of the association for the benefit of our members and the public we serve will go forward in a planned, proactive manner. Dr. Sekiguchi is doing a yeoman's job in working with the executive staff to administer the operation of the association as we proceed through this interim period. CDA staff is very dedicated and talented, and I have full confidence that the association will remain an example of excellence as we transition through this period.

The theme of this year's strategic planning session was "communication, trust and commitment." These three premises embody what CDA must mean to our membership. I believe in these ideals and will see that CDA builds on them during my presidency.

Change in dentistry has accelerated during the past several years. Dr. Miller

said two years ago that, "Change is coming in modes of practice, communication with members, the public, third parties and the government, in education and systems of licensure. Change can be painful for those who are inflexible and unwilling to negotiate. For them, the future represents a frightening place."

How right he was! The increase in managed care plans is incredible. There is ongoing pressure for fragmentation and independent practice of auxiliaries, as well as pressures from regulatory agencies and movements toward common licensure. These are all major challenges about which CDA must be proactive. The leadership will respond by providing direction for these challenges and representing the interests of dentistry before the appropriate agencies.

The issue of change may not be comfortable for all dentists, but these changes are real. Licensure, continued competency and diversity are and will be ongoing issues this association will need to address. The demands for licensure change are being studied across the country. CDA will be a player in this dialogue. CDA must represent all dentists. With the changing diversity of our state, an emphasis on encompassing and welcoming cultural differences is a priority for CDA. This is truly a grassroots member effort, and I encourage each of you to help enrich your component through diversity.

CDA undertook a very comprehensive and proactive legislative agenda this year. The strategy and effort proved to be very successful. Next year will bring additional challenges, one of those being MICRA. CDA cannot rest on its laurels, and I assure you that our government relations agenda will remain full next year.

Coalition building will take a prominent role in delivering dental care to the underserved and solving access problems. CDA is and will be forming more coalitions through the efforts of our special projects director. CDA will work closely next year with Oral Health America on sealants, spit tobacco, mouth guards and special athletes special smiles programs. Fluoridation and donated dental services programs are other examples of the necessity of coalitions and the cooperation needed to achieve results. CDA's components have numerous instances in which coalitions have been formed to provide access to care. Please keep up these wonderful endeavors.

As CDA moves forward to examine new and somewhat controversial concepts, we may very well stumble and have to retreat a bit to heal and find a new path. This happened with a good, forward-thinking idea that ran too fast. The concept was continued competency. A voluntary self-assessment tool is the appropriate path for now. The expansion of this concept can be saved for future development as needed. As Franklin D. Roosevelt stated, "It is common sense to take a method and try it. If it fails, admit it frankly and try another, but above all try something." So it is with continued competency.

CDA has an impressive record of achievements, but in addition to the aforementioned challenges, we must continue to seek new horizons. To do that, we must look hard at old traditional programs for their continued relevancy so we can expand to new programs. For that reason, CDA will do an operational audit of the entire association to provide membership with the most cost-effective organization possible. This process will start upon hiring the new executive director. The results should be presented to the 1998 House of Delegates.

CDA's subsidiaries have been very successful, providing not only quality services, but also dividends to augment the operation of the association. Due to their success, dues have been stable for more than 10 years. As CDA moves into new challenges, funding sources will need to be identified, and the audit will be important in that development.

The CDA Holding Company has not grown to its full potential. I intend to guide that growth this year. For CDA and its for-profit subsidiaries to remain competitive in the marketplace, the information technology area needs to be expanded and upgraded. The ongoing expansion of TDIC into new products and states along with the impressive Esquire Place project and the possible formation of new member services opportunities from TDC will allow the Holding Company to expand its business responsibilities.

CDA needs to maintain excellence, not just provide the basics. A longtime favorite of mine, W.C. Fields, said, "Ah, yes, my little chickadee, we lived for days on just food and water." CDA will provide more than food and water to our members and will excel at superior customer service.

I believe the vision for CDA has been established by the impressive leadership of my predecessors. To coin a phrase, "To be the best that you can be" exemplifies what I expect of CDA. The foresight to build a solid asset base and develop sound profitable subsidiaries that provide quality services and products to the membership speaks to the proud history of the family of CDA.

This association is stronger for having made the hard and difficult decision to preserve the heart and soul of CDA. I thoroughly understand the past and I am committed to taking a cohesive CDA family into the future. In closing, I again want to sincerely thank you for the honor of serving as your president.

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The Challenge of Leadership

By Eugene Sekiguchi, DDS

When I accepted the honor and challenge of leading the California Dental Association one year ago, I trusted that I was prepared for anything.

Now, as I offer my thanks to you for allowing me my time as president of this organization, I reflect upon the year that has become another benchmark in the association's history. Clearly, it was a year during which anything could happen, and nearly everything did.

With our desire to consistently bring to the people of this state excellence in dentistry while offering our members an organization steeped in the tradition and spirit of service as catalyst, we, together, won battles, sought and found compromise, made the best of change and continued to thrive, both as an association and as a profession that rightly commands the public's respect.

As I consider the significant achievements of the past 12 months, I am compelled to acknowledge that what has been and continues to be accomplished is the result of effort on CDA's behalf by innumerable individuals who share a belief that our work has meaning and our goals are honorable.

I respectfully emphasize that none of this year's accomplishments would have been possible without gracious help from all corners. Nothing would have been possible were it not for the CDA staff, council members, your Board of Trustees and the Executive Committee. Their planning, commitment, deliberation and advice planted ideas and gave those ideas a chance to take root and flourish.

And I must thank others behind the scenes, the most important people in my life, my family, beginning with my wife and true love, Claire, and my children, Steven, Dr. Kevin and Dr. Jill. They are the foundation upon which all else is built.

Our most-visible and far-reaching successes came in the halls of government this year, where CDA's legislative agenda gained support and our new way of doing business found favor that translated into new laws that buttress the profession of dentistry. As a member of the Council on Legislation in 1996, I seeded the notion that our association become an active rather than reactive participant in the legislative process and saw that the Government Relations Office is the best machine to work with the "new" rules and legislative tenures.

Bill Emmerson, as chairman of the Council, has provided leadership this year to make that vision reality, and Liz Snow has shown through her direction of Government Relations how effective we can be in shaping debate and building consensus while keeping our ultimate goals in plain sight.

Our posture helped harness the efforts on our behalf of Sen. Jim Brulte and Assemblyman Fred Keeley. Brulte, a Republican, authored Senate Bill 1014,

which makes it unprofessional conduct for a patient to be treated before having been examined, diagnosed and having a treatment plan completed by a dentist. Keeley, a Democrat, was author of Assembly Bill 1116, establishing uniform educational standards for dentists seeking licensure in California and eventually eliminating the restorative techniques exam. Much credit for this bill must go to members of the forum -- a roundtable of leadership from the ethnic dental societies who formed the coalition to move this bill. The signing of these bills into law in October by Gov. Pete Wilson was a testament to our new effectiveness as a political force.

Before becoming CDA president, I made a commitment to attend all meetings of the Board of Dental Examiners, and to encourage more association members to attend and participate, especially volunteer leadership. This presence established, I believe, our desire and ability to be engaged and provide strong, good-faith input to the board. This attention led to the thawing of what had been chilled relationships between CDA and the BDE, which allowed us to become a trusted party that now works well with the Board. The bonus of our improved relations brings added luster to accomplishments in that arena, which include elimination of the definition of surgical procedures in infection control regulations. Our efforts to bring together prominent scientists and research experts on the matter of dental unit waterlines gave the board information necessary for reaching a sound decision. We have encouraged the Board to use science-based information to make decisions rather than rely on anecdotal information and emotion. Dental Affairs Director Judith Babcock and Assistant Director Terry Fong have been a significant presence and force in our successes with the BDE.

I speak with pride of another concept that has broadened the table upon which ideas are laid and helped us look into dentistry's future -- the dental think tank. The think tank sessions have brought together deans of California's five dental schools with leaders from our association and the Board of Dental Examiners. The enthusiasm for establishing and supporting more rewarding relationships among the participants and organizations represented has been notable. Also significant is the building of better understanding among all parties sharing common goals and individual insights relative to issues facing dentistry. These are facets of this new enterprise. Support of the think tanks by the Executive Committee is a clear example of that body's desire to open important lines of communications and to think ahead, another example of pro-activity by CDA.

Access to care for the children of our state's "gap" population is being addressed by Gov. Wilson's Healthy Families program. The program creates a government-subsidized funding partnership with the insurance industry to pay a portion of the cost of care. CDA's Special Projects Director Dr. Teran Gall, who boasts a long background in addressing access issues for underserved people, is leading CDA's involvement in the program.

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Proudly, I point to our advancements in a far-reaching area that is defined by progress. Having emphasized our need to build our information technology into a formidable presence and tool, I am gratified to be part of the modernization of CDA's computer capabilities and the expansion of its possibilities. Val Szyntar's efforts as director of the association's Information Technology Department have galvanized our determination to claim IT as major factor in our future success -- this is our backbone and spinal cord. A subsidy program offered by CDA has given component societies an opportunity to build their computer capabilities and enhance their ability to participate with CDA in the ADA's ambitious Tripartite Association Management System. Thanks to the ad hoc Information Technology Committee for its guidance.

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The Challenge of Leadership

By Eugene Sekiguchi, DDS

When I accepted the honor and challenge of leading the California Dental Association one year ago, I trusted that I was prepared for anything.

Now, as I offer my thanks to you for allowing me my time as president of this organization, I reflect upon the year that has become another benchmark in the association's history. Clearly, it was a year during which anything could happen, and nearly everything did.

With our desire to consistently bring to the people of this state excellence in dentistry while offering our members an organization steeped in the tradition and spirit of service as catalyst, we, together, won battles, sought and found compromise, made the best of change and continued to thrive, both as an association and as a profession that rightly commands the public's respect.

As I consider the significant achievements of the past 12 months, I am compelled to acknowledge that what has been and continues to be accomplished is the result of effort on CDA's behalf by innumerable individuals who share a belief that our work has meaning and our goals are honorable.

I respectfully emphasize that none of this year's accomplishments would have been possible without gracious help from all corners. Nothing would have been possible were it not for the CDA staff, council members, your Board of Trustees and the Executive Committee. Their planning, commitment, deliberation and advice planted ideas and gave those ideas a chance to take root and flourish.

And I must thank others behind the scenes, the most important people in my life, my family, beginning with my wife and true love, Claire, and my children, Steven, Dr. Kevin and Dr. Jill. They are the foundation upon which all else is built.

Our most-visible and far-reaching successes came in the halls of government this year, where CDA's legislative agenda gained support and our new way of doing business found favor that translated into new laws that buttress the profession of dentistry. As a member of the Council on Legislation in 1996, I seeded the notion that our association become an active rather than reactive participant in the legislative process and saw that the Government Relations Office is the best machine to work with the "new" rules and legislative tenures.

Bill Emmerson, as chairman of the Council, has provided leadership this year to make that vision reality, and Liz Snow has shown through her direction of Government Relations how effective we can be in shaping debate and building consensus while keeping our ultimate goals in plain sight.

Our posture helped harness the efforts on our behalf of Sen. Jim Brulte

and Assemblyman Fred Keeley. Brulte, a Republican, authored Senate Bill 1014, which makes it unprofessional conduct for a patient to be treated before having been examined, diagnosed and having a treatment plan completed by a dentist. Keeley, a Democrat, was author of Assembly Bill 1116, establishing uniform educational standards for dentists seeking licensure in California and eventually eliminating the restorative techniques exam. Much credit for this bill must go to members of the forum -- a roundtable of leadership from the ethnic dental societies who formed the coalition to move this bill. The signing of these bills into law in October by Gov. Pete Wilson was a testament to our new effectiveness as a political force.

Before becoming CDA president, I made a commitment to attend all meetings of the Board of Dental Examiners, and to encourage more association members to attend and participate, especially volunteer leadership. This presence established, I believe, our desire and ability to be engaged and provide strong, good-faith input to the board. This attention led to the thawing of what had been chilled relationships between CDA and the BDE, which allowed us to become a trusted party that now works well with the Board. The bonus of our improved relations brings added luster to accomplishments in that arena, which include elimination of the definition of surgical procedures in infection control regulations. Our efforts to bring together prominent scientists and research experts on the matter of dental unit waterlines gave the board information necessary for reaching a sound decision. We have encouraged the Board to use science-based information to make decisions rather than rely on anecdotal information and emotion. Dental Affairs Director Judith Babcock and Assistant Director Terry Fong have been a significant presence and force in our successes with the BDE.

I speak with pride of another concept that has broadened the table upon which ideas are laid and helped us look into dentistry's future -- the dental think tank. The think tank sessions have brought together deans of California's five dental schools with leaders from our association and the Board of Dental Examiners. The enthusiasm for establishing and supporting more rewarding relationships among the participants and organizations represented has been notable. Also significant is the building of better understanding among all parties sharing common goals and individual insights relative to issues facing dentistry. These are facets of this new enterprise. Support of the think tanks by the Executive Committee is a clear example of that body's desire to open important lines of communications and to think ahead, another example of pro-activity by CDA.

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The Year in Review

By Brian L. Blomster

The unavoidable metal-on-concrete whack of a pile driver doing its work next to CDA headquarters as winter fell on California offered what might be a fitting metaphor for the just-finished year.

Even as its pounding shook the surrounding landscape, work on the foundation of Esquire Plaza -- a project in which CDA through The Dentists Insurance Company has financial interest -- has been necessary preparation for building something bigger, better.

And for CDA, 1997's trials and triumphs provided plenty of opportunity for growth. The association got some big wins in the Legislature and took a couple of punches in court. A longtime leader in the organization called it quits, and the new executive director who had been on board little more than a year chose to leave. Victory came in a long-disputed issue before the Board of Dental Examiners, but the fate of two extensively debated subjects -- direct reimbursement and continued competency assessment -- remained high in the association's policy-making consciousness.

Elsewhere, Western Dental Plan was slapped with a huge fine and other sanctions, and Denti-Cal fraud fired concern up and down the state.

But, despite the questionable intentions of a Reader's Digest article, dentists and dentistry continued to enjoy an esteemed place among the country's professionals, even as they worked to maintain a degree of control in an atmosphere fogged with concerns about access to care, fair compensation and the proliferation of underfunded capitated programs.

Politics, regulation and the vexations of being a highly visible target for the occasional critical dart could not slow progress within the profession. The association added muscle to its frame by creating positions for a director of Information Technology and a director of Special Projects, the former charged with turning a sagging system into a high-powered tool, the latter bringing a well-trained ear to the long-heard call for access for the state's underserved populations.

The industry enjoyed a bit of a jolt when the federal Food and Drug Administration approved marketing a laser for use on hard tissue procedures.

No, it was not a year without an occasional discouraging word, but shouts for achievement, progress and plain good dentistry left 1997 with an echo worth listening to.

Transition Continues

As sometimes happens in corporate America, when change comes, it comes in stages. CDA is facing another such stage as a search begins to find a new executive director.

In July 1996, Kenneth L. Zakariasen, DDS, came out of academia to replace Dale F. Redig, DDS, who had been the association's top staff person since 1978. Zakariasen brought in a philosophy that depended heavily on giving executive staff members the power and flexibility to make decisions and pursue projects that previously had been under tight control by the executive director's office.

But by late summer of 1997, although CDA's Executive Committee embraced the concept of staff empowerment, differences in management style and association direction led Zakariasen to resign.

CDA President Eugene Sekiguchi, DDS, accepted an interim appointment by the Executive Committee to replace Zakariasen, and he subsequently appointed a search committee, which may bring forward candidates for the permanent position by March.

"We will continue to move forward," Sekiguchi vowed.

Other significant change visited the association's Sacramento headquarters. Hoping to close a technology gap and improve the capabilities of CDA and component societies, association leaders OK'd creating the position of director of Information Technology, a position filled by Valerian Szyntar. Szyntar immediately began rebuilding IT throughout CDA and its subsidiaries, beefing up his staff and laying the groundwork for a complete overhaul and upgrade.

Another need was met with creation of the position of director of Special Projects and filling the spot with Teran Gall, DDS. A practicing dentist, Gall is overseeing such ongoing concerns as direct reimbursement and continued competency assessment, while pouring energy into securing funding for fluoridation projects and access for underserved populations.

Goodbye, Dr. Gaynor

Never the retiring type, J. David Gaynor, DDS, refused to call it quits. Instead, he left CDA after an almost three-decade relationship as a volunteer and staff member to start a new career.

Leaving his post as president and executive director of The Dentists Company and The Dentists Company Insurance Services after 15 years, he joined MBNA America as a senior account executive in San Francisco. He had been a CDA trustee and was president of the association in 1980. Blunt and outspoken, Gaynor's legacy includes successful practice as a pediatric dentist, leadership in the fight to fluoridate California and start-up -- from scratch -- of TDC and TDCIS.

Gaynor was succeeded as head of the two companies by Roger R. Kittredge, CPA, MBA, CDA's longtime chief financial officer. Laura Catchot, CPA, MBA, who had served as the association's comptroller under Kittredge, was appointed as CFO.

Taking the Lead

1997 was the year CDA changed the way it played politics, and the result was a string of legislative successes and the prospect for more good things to come.

Under an aggressive new philosophy coming from the Council on Legislation and Government Relations Director Liz Snow, CDA saw six bills it sponsored or supported signed into law by Gov. Pete Wilson, addressing a range of issues important to dentistry and the public's health.

Among notable victories were bills involving uniform educational standards for foreign-trained dentists and proper diagnosis for new patients. Both issues had long occupied the association's attention.

Coalition building and compromise were keystones for success, but even more important was the association's new-found ability and desire to help set the legislative agenda rather than react to bills put forward by others.

"We made a conscious effort to be proactive rather than reacting to someone else's legislation," said William J., Emmerson, DDS, chairman of the Council on Legislation.

Grassroots participation also received credit for CDA's showing at the Capitol.

"Dentists were involved locally," Snow said. "They were engaged from the beginning of the process. Legislators saw that these had support from our members and that it all wasn't just coming from association headquarters. ... Lawmakers saw the faces of our membership."

BDE Strikes Definition

The California Board of Dental Examiners struck from its infection control regulations a definition for "surgical procedures," a move that met with wide CDA approval.

The definition -- "entries into normally sterile areas of the body" -- had been taken to mean anything from extensive work on soft or hard tissue to an injection.

Laboring under that definition, dentists had been required to use sterile techniques for many procedures that they would not have otherwise. Supporters of eliminating the definition say that move allows dentists to use their professional judgment in determining when to use sterile gloves and/or coolants and irrigants.

"It makes treatment more effective, since it lets the doctor decide when the extra precautions should be used," Sekiguchi said, adding that the real issue was that the definition did nothing to further patient safety.

BDE President Peter C. Hartmann, DDS, said his board's action helps clarify when dentists need to use sterile irrigants and coolants and ultimately improves infection control regulations.

"It streamlines it somewhat," he said.

Judith R. Babcock, CDA's director of Dental Affairs, who has been involved in the association's support of eliminating the definition for years, was pleased.

"We've gone from no regulations to regulations that were really onerous and cumbersome to regulations that were clearer," she said. "These regulations are reasonable, providing for patient and office staff safety while not unduly burdening the dentist."

Court Sides with FTC

The Federal Trade Commission won the latest round in its legal fight with CDA when the Ninth Circuit Court of Appeals in October supported the FTC's determination that the association's restrictions on advertising constitute an illegal restraint of trade.

The court also affirmed that the FTC has jurisdiction in the matter.

The long-running dispute will end up before the Ninth Circuit Court en banc -- before the entire court -- if CDA's petition for rehearing is granted. The most recent ruling was before a three-judge panel from the court and favored the FTC 2-1.

If the Ninth Circuit Court again rules against CDA, the association will appeal to the U.S. Supreme Court.

In its review of the FTC's ruling that the advertising limitations appearing in CDA's Code of Ethics are illegal, the appeals court found that "The advertising rules of the CDA, as applied to truthful and nondeceptive advertisements, violate Section One of the Sherman (Antitrust) Act and Section Five of the Federal Trade Commission Act."

The appellate court agreed with the FTC that CDA's guidelines not only restrict false and misleading advertising, but could also restrict truthful and nondeceptive advertising for such things as money-back guarantees, special offers on dental procedures, senior citizen discounts and discounts for new patients.

The court also ruled that the FTC has jurisdiction over some nonprofit entities, a point CDA continues to dispute.

"CDA is firm in its conviction that the FTC lacks the authority to regulate nonprofit entities and that the Ninth Circuit ruling violates a fundamental congressional limit on FTC jurisdiction," said CDA legal counsel Raoul Renaud.

State Gets Tougher on Denti-Cal Fraud

A California law prohibiting dentists from offering inducements for referral of Denti-Cal patients gained widespread attention and continues to affect unprincipled practitioners as well as dentists who aren't well-versed in the statutory restrictions.

Of greatest concern to law enforcement are dentists who reward third parties for rounding up people eligible for Denti-Cal benefits and bringing them to their offices. The third parties -- often called "cappers" -- are paid a flat fee or by the head and promise that the dentist will give Denti-Cal beneficiaries anything from cash to items such as sneakers or even toasters.

That is the extreme end, but even dentists who offer rebates or discounts are operating outside the law. The state Business and Professions Code prohibits any form of rebates, commissions or discounts for patient referrals.

So, even a dentist who sends a favored patient flowers for referring another patient for treatment is violating the code.

Therein lies part of the problem, and that is, many dentists are unaware of the strictures they work within relative to referrals.

But the state's biggest concern is for those who are trying to grab a bigger chunk of the Denti-Cal pie and are willing to pay for the chance.

"People who have participated in this have told us they've received running shoes, blenders, toasters and other items," said Ann Kensey of Delta Dental's Surveillance and Utilization Review Department. Delta Dental administers the state's Denti-Cal program.

Law enforcement officials say the problem is growing.

"We have witnesses complaining that people are being solicited for this scheme and picked up from the San Joaquin Valley area as far north as Fresno and taken to Los Angeles," said Victor Telles, a state Attorney General investigator supervisor.

Ann Emery, coordinator of CDA's Council on Dental Care, said that although the Denti-Cal fraud is troubling, relatively few dentists are participating.

"Based on the information we have, it appears that a small percentage of providers are participating in this illegal activity, and they are targeting a particularly vulnerable population -- Hispanic Denti-Cal patients -- where language is a barrier," she said.

Beam Us Up

A much-anticipated step into the future occurred to the cheers of some and restraint of others when the Food and Drug Administration approved for marketing a laser for use on hard tissue in adults.

Available for several years for use on soft tissue, the latest advancement gives lasers new credibility as an effective tool. With a price tag of about $39,000, it also gives its producer a nifty payoff.

While the new tool's applications are limited to very specific types of procedures, it is a step toward lasers that someday may be used for root canal surgery and cutting and shaping of bone, according to Colette Cozean, chair and chief executive officer for Premier Laser Systems Inc., the laser's maker.

The laser approved for marketing is called the Centauri Er:YAG, which stands for erbium, yttrium, aluminum and garnet. Erbium is the crystal that generates the wavelength, while yttrium, aluminum and garnet are metals and crystals that help control the laser beam. The handpiece looks like a standard dental drill and uses water or air to cool and clean the tooth during treatment.

Richard T. Hansen, DMD, is a UCLA faculty member who participated in clinical tests on the laser. He said test results and other patient studies "underscore the fact that a laser for hard-tissue procedure writes a new page in dental history."

"I believe it's a development patients have been waiting for, especially considering the public's familiarity with the success of medical lasers," Hansen said.

He also listed benefits for practitioners.

"We can pinpoint and excise diseased hard tissue with great precision, preserving the tooth's overall integrity," Hansen said. "We can eliminate nonproductive time spent during the day waiting for anesthesia to take effect, and we find the laser ideal for the newer tooth-colored restorative materials dentists increasingly use."

Long Year for Direct Reimbursement and Continued Competency

Two programs that have been scrutinized, retooled, criticized, picked over, lionized and, ultimately, dusted off and told to keep going continue to search for their places in the hearts and minds of the association's leadership and members.

Direct reimbursement, which supporters say preserves the idea and practice of fee-for-service dentistry and helps maintain the dentist-patient relationship, was given new marching orders by CDA trustees during their March meeting. A resolution that would have pumped another $150,000 into the program was defeated, ending a study being conducted for the association by the consulting firm of Johnson & Higgins. A report presented by Johnson & Higgins representatives indicated that to gain a greater share of the market, DR would have to undergo modifications that trustees rejected.

Some discussion called for the DR program to be terminated. But, instead, trustees instructed the Direct Reimbursement Committee to place new emphasis on CDA staff working directly with employers in an attempt to gain a greater market share.

The 1997 CDA House of Delegates in December was to consider a resolution restructuring the association's DR program to reflect the new direction.

"Regardless of your personal feelings about the amount spent on DR promotion in California or the use of CDA staff resources, it should be realized that this is the best dental benefit option that assures complete freedom of choice for patients and practitioners alike, while making the best use of the dental care dollar," wrote DR Committee Chairman Russell E. Chang, DDS, in June.

Delegates at the House also were to consider the latest version of voluntary continued competency assessment presented by the ad hoc committee that has pursued the issue.

Renamed "QUIL3" -- Quality Improvement through Lifelong Learning -- the program is a result of assessment of field tests at both Scientific Sessions and ongoing give and take between the committee and the Board of Trustees.

The committee calls the program put before delegates an "education-based, voluntary, self-administered program designed to assist the participating dentist in assessing his or her skill, knowledge and judgment in a contemporary dental environment."

The assessment can be done in privacy, and no in-office audits are part of the program.

Committee Chairman Steven Schonfeld, DDS, said in May that "CDA is acting to do something that (organized dentistry) can live with."

The program is needed, he said, to help ward off state-mandated testing and to give legislators direction and a blueprint from which to work if they decide state oversight of continued competency testing is necessary.

State Nails Western Dental

In an 11th-hour settlement between California's Department of Corporations and Western Dental Services, the Orange County-based dental HMO agreed to pay a $1.7 million fine.

The June 30 settlement was reached just one hour before a hearing during which a Superior Court judge would have decided the fate of Western Dental. In addition to the fine, the largest ever levied against a health plan by the DOC, the settlement called for appointment of joint monitors and required implementation of 23 corrective actions.

The settlement stemmed from a lawsuit filed by the DOC against Western citing 27 areas needing corrective action, ranging from quality assurance and accessibility to plan administration and organization.

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Originally, the DOC sought a fine of $3 million.

"We are content that a settlement has been reached between the DOC and Western Dental," said CDA President Eugene Sekiguchi, DDS. "Although the penalty is lower than the original proposed fine, this is a step in the right direction to ensure quality dental care for Western Dental patients and consumers in California."

Magazine Article Takes Shot at Dentistry

Gaining its share of publicity but faltering under its own paucity of sound research, an article published in Reader's Digest questioning the integrity of dentistry was more smoke and noise that bombshell.

The story was based on visits by its author to 50 dentists in 28 states. To select the dentists, the author consulted the Yellow Pages. He wrote that examinations of his dental condition conducted by the various dentists resulted in proposed treatments that ranged in cost from about $500 to nearly $30,000.

The author's conclusion was that dentistry is being driven in large part by dentists trying to push more expensive treatments rather than address a patient's real needs.

CDA offered a positive message in response, saying that the author's methodology was rudimentary and unscientific but that the story raised the valid question of how best to choose one's dentist. The association emphasized accepted ways to select a dentist; the Dental Bill of Rights; how to determine quality dental care; and reasons why diagnosis, treatment options and dental costs vary.

From the Ground Up

Work began in June on a project that will turn a pair of old theaters and an empty, weed-covered lot into a wellspring of economic opportunities for CDA.

Construction of Esquire Plaza, an ambitious development next door to CDA headquarters in Sacramento, eventually will produce a 22-story Class A office building and an IMAX theater. The Dentists Insurance Company, one of CDA's for-profit subsidiaries, is investing $9.7 million in the project. TDIC will be the owner in a limited liability company.

"This is a way to continue to diversify our asset base," said TDIC Chairman Bruce Valentine, DDS. "TDIC investments are heavy in stocks and bonds but only a little in real estate. This allows us to take a more diversified approach to our investing."

Mike Brassil, TDIC's chief financial officer, said the company expects "steady long-term asset growth" and further strengthening of the company's investment portfolio. TDIC's chief executive officer, Frederick E. Knauss, said the development "is an investment like any other TDIC makes," although the projected 10-year rate of return of 17 percent makes it even more attractive.

Honors

The contributions of two California lawmakers who were instrumental in CDA's success at the Capitol in 1997 were recognized by the association in September.

Sen. Jim Brulte, R-Rancho Cucamonga, and Assemblyman Fred Keeley, D-Santa Cruz, were the first recipients of the George F. Baker Award.

Baker, who died in May, had been an active CDA volunteer and member of the Board of Trustees. He helped develop and was a charter member of CalDPAC, helping CDA move squarely into the realm of influencing state politics on behalf of its members.

Brulte was honored for authoring and helping to get passed into law SB 1014, which placed into statute the requirement that an examination, diagnosis and treatment plan be completed before treatment is provided to patients.

Keeley was recognized for authoring AB 1116, which is meant to ensure uniform standards for dental licensure.

"Honoring both a Republican and a Democrat this year, we believe (reflects) the bipartisan nature of Dr. Baker's legislative networking," Sekiguchi said.

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Evolving Business

Keeping Up With the Profession Is the Challenge

By David G. Jones

Think of a dental practice as an iceberg. Above the waterline is the practice of dentistry, where dentists, young and older, employ their clinical training and experience to provide quality oral care to patients. Below the waterline lurks the other side of dentistry, the business side. There, the bulk of the iceberg lies in practice management issues such as accounting, salaries, insurance, managed care, new equipment and supplies, computerization, and other overhead costs and issues, all leading to the bottom line.

Consider a practitioner, imbued with a high degree of clinical dental education and with some level of experience, but with very little formal training in practice management. The practice can be akin to the Titanic on her maiden voyage. It was the part of the iceberg below the surface that did the Titanic in.

A thorough knowledge of practice management is the key to operating a successful dental practice. But how does a dentist get there? And what are dentists experiencing as they manage their practices on a day-to-day basis? The first obstacle to successful practice management rears its head when students enter dental school.

"I defy you to find any students entering dental schools with any prior business knowledge," said Robert S. Gartrell, DDS, chairman of CDA's Council on Dental Care and a part-time practice management professor at the University of the Pacific School of Dentistry. He said that dental schools, while they have done a much better job with practice management education than in the past, must emphasize it more in the dental curriculum to bring students more knowledge of the business aspect of dentistry.

Gartrell, emphasizing the importance of business education, said of current practice complexity, "It's not getting any easier. I think the schools seriously should consider the business of dentistry as important, then they should set curricula accordingly, because dental practice management is getting more and more difficult."

Gartrell admitted that dental school curricula are already crowded, so putting more business courses in will be difficult. It's the crowded clinical curriculum that makes it difficult for students to concentrate on practice management.

"In our senior year at USC, fighting all the requirements to get through clinic, the last thing on our minds was the business aspect of dentistry," said Cyrus Tahmasebi, DDS, a general practitioner in the La Jolla area who graduated from the University of Southern California in 1991. "At that moment, it had very little impact on us."

"It's a fact that the emphasis (in school) is on clinical skills and how to get through the requirements for certification," said Arthur S. Wiederman, a CPA who also lectures on practice management to dental students at USC and Loma Linda University.

A recent graduate of UOP, Laura Van Roy, DDS, agreed that business education in dental school is minimal. She said she received about 20 hours of business education, "mostly in the areas of insurance, capitation plans, and starting up a practice," before graduating in 1995.

Gartrell, who graduated from dental school in 1974, emphasized that dentists then didn't need a lot of business training to become successful.

"It didn't take a lot of business acumen, and banks were ready to help finance new practices," he said. But today, the marketplace is much more complex.

"When I graduated, there was only one insurance product available, traditional indemnity insurance," he said. "Now, so many plans and products are on the marketplace, a dentist must be capable of making sophisticated business decisions."

While graduating dental students today accumulate little business education, they gather a mountain of debt that experts say averages from $100,000 to $150,000 -- and more for those who attend private schools. That is a factor that causes some graduates to choose working for someone else to ensure a steady income to pay down the school debt. Others ignore it and press on into practice ownership.

Tahmasebi took the latter route.

"After graduation, I had about $80,000 in student loan debt, lower than average, but still significant," he said. He was working in the practice he purchased nine months after graduation, and, "whatever I made went to paying off loans or attorneys and accountants involved in buying the practice. The first year was very difficult," Tahmasebi said.

Even with school debt and the added burden of the practice purchase loan,

Tahmasebi stayed upbeat.

"My advice to young dentists is that focusing on the debt load is a negative way to look at things," he said. "If you can get into a practice that pays well, don't be concerned with the liability."

He tempered that statement with the admonishment "to use an accountant to weigh the possibilities carefully."

But Wiederman put his accountant's hat on to take issue with Tahmasebi's advice.

"There are finance companies out there that will finance a student and fund their practice, but new dentists instead should hope to find a private practice dentist to mentor under to learn how to deal with patients, vendors, staff and all the other practice management issues," he said. "To buy a practice, while a young dentist is just getting started and a significant amount of earnings are going to debt service, doesn't leave you much to live on."

Even so, like many graduating seniors, Tahmasebi wanted to start his own practice.

"Working for someone else would have been an easier decision because it would have provided a safety net to pay off debt," he said.

Van Roy took the other path and works as an employee in a group practice owned by a dental corporation.

"I would like to have gone into a partnership in private practice, but the cost of starting my own practice was a perceived obstacle," she said.

She wanted to stay in her geographical area of choice, and "this job was available and the only position I could find in the area."

"It's not a situation I want to be in permanently. When I leave, I'll be in less debt but still starting from scratch later with no established patient base and no additional practice management experience."

While Van Roy is satisfied for now with her situation, seeking an immediate income stream to pay down debt carries with it its own set of problems, according to past CDA President Richard Lewis, DDS.

"I know that their (new dentists') indebtedness forces many of them into accepting salaried positions with dental practices they would otherwise avoid, practices that demand 'production' above all else and where the quality standards learned in school are unknown," Lewis said.

Operating a successful dental business, once business knowledge is gained through years of practice, involves myriad details. Many more-experienced dentists run the business side of their practice using computers and sometimes CPAs to help balance the books. Some don't.

"Unfortunately, some dentists manage their practices by seeing how much they have in their checkbooks and hope they can make their payroll," Wiederman said. He used his experience providing accounting services for more than 100 dental practices in California to provide an overview of operating expenses and overhead ranges dentists should fall within to be successful (see accompanying chart for breakdown).

"Salaries should run 18 to 20 percent of total office production, not including associates, hygienists, fringe benefits or payroll taxes," Wiederman said. "If it's less than that, it means you have an efficient staff or are underproducing for your level of staff. If the number is too high, it means you are overstaffed and are paying too much."

Gartrell explained the issue of staff salaries further.

"Probably the single largest cost in any practice is labor, which has risen as a matter of time and cost of living," he said. "The good news is a dentist then keeps staff members over the long term, but the bad news is that pay must be raised over time, so salary costs rise as a percentage of gross revenue."

Wiederman warned dentists not to be afraid to hire new staff when indicated.

"We find many dentists who are reluctant to hire a new staff person due to cost," he said. "But if the office is understaffed, the collection percentage is lower because you don't have time to make financial arrangements or follow up on claims or insurance."

An integral part of any dental office is the hygiene staff. Wiederman said to figure out hygienist salaries, look at this cost as a percentage of hygiene production.

"In a perfect world, about 42 percent of the gross hygiene income should be paid to the hygienist(s), and the other 58 percent used to cover other office expenses," he said. "Also, look at the percentage of hygiene as a percentage of total production. In a practice doing $50,000 a month gross, usually 20 to 25 percent is hygiene and 75 to 80 percent is dentistry."

Another personnel expense, payroll taxes, should run 2 percent to 3 percent of total production, Wiederman said.

And "never get behind on taxes," he said, emphasizing that he knows of some dentists who have lost their houses because of tax problems. Other personnel-related expenses include benefits, such as medical insurance, uniforms and education. "This should run at 1 to 2 percent of production, higher if a pension plan is included," he said.

Wiederman said a typical office used to use 10 percent to 12 percent of production for lab costs, but now it's about 8 percent to 10 percent.

"This is due to fierce competition with labs, so many times dentists can ask for fees to be cut."

Gartrell provided another perspective.

"If you look at a practice primarily treating managed care patients, lab costs are at or below 10 percent due to cost containment being a major pressure," he said. "Dentists who do more ideal forms of dentistry can go to 15 to 16 percent."

Another overhead item is supplies, at about 5 percent to 6.5 percent of total office production. Wiederman and others indicated that supply costs are now a little higher because of OSHA requirements. In fact, he said that, "the average dental office pays an extra $1,000 to $2,000 per month due to OSHA and HIV. In addition, the average practice pays from 1 percent

to 5 percent of the gross for practice development, including printed brochures, advertising, marketing, referral services, newsletters and coupons."

Another big-ticket item, rent, averages about 5 percent a month. Wiederman says he has found some dentists who have overbuilt and offered advice especially useful for new dentists.

"If you're just starting out, don't spend $200,000 to build an office," Wiederman said. "Rent at first until you have an income stream to pay for it."

All that constitutes major operating expenses that make up 50 percent to 55 percent of the gross. Minor expenses include bank charges, accountants, attorneys, pension administration, office supplies, telephone, utilities, maintenance, insurance and taxes, totaling about 8 percent to 10 percent. A big computer system or use of a management consultant will boost that figure.

The bottom line? Operating overhead total should be at 60 percent to 65 percent, Wiederman said. The rest pays debt service and the dentist's salary.

Ideally, every dental practice should fall within those parameters, experts say, but dental practices aren't all alike. A look at some actual practices provides a more realistic appraisal of what it takes to operate a dental office.

Norman R. Ball, DDS, is a general dentist who has practiced in Eureka for 31 years. He says wages and supplies have always been the big-cost items associated with running his practice, and supply costs are rising dramatically.

"In the last 10 years, supplies, as a percentage of gross receipts, have risen from 5.6 to 9.5 percent of my gross production -- that's nearly a 70 percent increase," he said.

Agreeing with Wiederman, he said, "This is due in part, I believe, to the advent of HIV and infection control costs and OSHA compliance."

Ball's total overhead expense in 10 years has increased from 59 percent to 66 percent of gross receipts, so while his total production has increased yearly, his profit is getting smaller.

The former CDA president, Lewis, also has seen overhead rise significantly over the years.

"I've been in general practice for 38 years. When I started, overhead costs were in the 50 percent range, and they're now around 75 percent," said Lewis, a 1959 graduate of USC.

Lewis says the largest increase has been in salaries, and rent is another factor that outpaces the Consumer Price Index. Other costs, he says, aren't out of line with the CPI, including lab costs and costs for services and supplies. Finally, a periodontist, Steve Schonfeld, DDS, says expenses are squeezing his profit.

"Expenses are increasing faster than income -- income is thus going down," he said. "This is, in large part, due to insurance companies applying pressure to keep costs down, but the overhead is unquestionably increasing faster than my gross."

Schonfeld, as a specialist, has a lower overhead than a typical general dentist. His overhead is about 54 percent, as opposed to a general dentist's average of 65 percent. This is typical because lower overall lab costs for most specialists using diagnostic labs reduces overhead below the level for general practitioners who use prosthetic labs.

Insurance companies continue to affect the ability of dentists to charge for services, while holding down both costs and profits. Tahmasebi uses this fact to find creative ways to keep overhead costs down and profits up.

"Given the pressures that are put on us by the insurance companies to lower our fees, I feel that it is necessary for us to ask our dental labs and suppliers to share in our efforts to cut costs," he said. "I have signed a contract with our dental supplier to keep our supply bills bellow 5 percent of our production, and my dental lab has agreed to keep my lab cost at 9 percent."

Lewis explained the effect of insurance programs in another way.

"Insurance companies are holding down fees," he said. "When one of the biggest went from the 90th percentile to the 80th for filing of new fees, it effectively forced me to reduce some fees at the same time my costs were increasing. The only reason I continue as a provider with this company is that patients of 'non-par' providers pay a significantly higher co-payment, and I am not comfortable adding to my patients' out-of-pocket costs."

Managed care, especially in California, has lowered profits for many dentists. It has, as one veteran provider said, caused trouble especially for new dentists.

"The managed care situation has been a paradigm shift that has caused untold hardships on California dentists, especially the newly licensed dentist," said Eugene R. Casagrande, DDS, a Los Angeles-based practitioner.

Gartrell helped to flesh out Casagrande's paradigm.

"Managed care exerts pressure on dentists to contain costs, but many dentists may not be astute enough business managers to do that," he said. "As a result, cost containment hasn't occurred in many dental offices, and net income drops. To increase net income, dentists must become better managers of dollars. Those very successful in managed care have learned those skills and can contain costs without affecting greatly their net income."

Richard A. Simms, DDS, a longtime consultant to CDA's Council on Legislation, put it another way.

"HMO/DMO and insurance programs are not holding down your costs, but they're holding down your profit," he said. "They hold down their cost by telling you how much they will pay you."

Managed care can also exert pressure on dentists to treat patients differently than they might in fee-for-service offices.

"If you're cost containing due to managed care, you may not recommend a procedure you would otherwise ask for under an ideal treatment program," Gartrell said. "Let's say a three-surface amalgam may suffice where the ideal may be a three-surface inlay, but the cost is

significantly higher. In cost containment, and looking at what is appropriate for the patient, both are appropriate, but the inlay may be the longer-lasting restoration and thereby more ideal."

While managed care may not work for some, others have had success with it. Scott Jacks, DDS, is one example.

"I've participated in managed care for more than 10 years," said the member of CDA's Council on Dental Care. "It has, however, been a mixed experience."

He said he left some plans he initially worked with because of low reimbursement levels and poor working relationships. Ultimately, he says, that's the best way to analyze a plan.

"If you're contemplating joining a panel, sign on to a plan and see how it goes. Watch the numbers to see if it's working to improve overall profitability of the practice. If it's not working, get out."

Jacks emphasized that the decision about joining a managed care plan depends on the needs of the community. His practice in a suburb of Los Angeles is in a heavily blue-collar area where the majority of patients have switched to some form of managed care (PPO/HMO). He had to accept managed care or lose patients from the community.

"If you have excess capacity and empty chairs, it makes sense to fill them with managed care patients," Jacks said. "If you have a full practice, why replace the fee-for-practice patients with lower-rate ones?"

He says that in a small town, with a low supply of dentists, many practitioners have little excess chair capacity, so they don't have the need to sign up. In areas with many dentists, the reverse is true, and managed care helps those dentists fill their chairs with patients.

From a purely business standpoint, Jacks says a majority of those plans are underfunded so, "I don't know if you can operate a dental practice on 100 percent of these patients. But to supplement a practice with these managed care patients can help. It's a business decision and should be made from a pragmatic context."

He also said that managed care is hard work.

"Each plan has different exclusions, limitations and fee schedules. It's more work for less money," Jacks said. "But you have to deal with the economic realities of your community. It's very easy for someone in a community or area where they're doing great without managed care to say 'don't do it.' It works for some but not others."

Schonfeld, in the small Northern California town of Eureka, is one of the others.

"I live and work in a rural community, and the impact of closed panels (managed care) is still minimal," he said. "Most of the dentists here have established practices, and they all got passing grades in arithmetic. They see the poorly funded plans for what they are and eschew participation."

Another area of practice management lies in the very value of a dental practice, which experts say is also on the decline. Gartrell, who has been doing practice management and sales for more than 20 years, explains.

"In the late '70s, if you sold a practice, you could get 60 to 65 percent of gross revenues, plus accounts receivable," he said. "Now, it's 50 to 55 percent plus receivables. So there is a decline, but the forces that play on practices are complicated."

One reason he offered is that the number of dentists practicing is beginning to fall, so the theoretical value of a practice should steady out. In urban areas, where many dentists practice, the value may go up. Another reason practice values are changing relates to managed care.

"In the Los Angeles basin, practices that don't have managed care contracts may be valued less than one that does," Gartrell said. As an example, he points to Lockheed.

"When they went to managed care, dentists that didn't have contracts with those providers lost out."

Lewis offered a different perspective on practice value.

"Practice owners, except possibly owners of large clinics or groups, are not realizing a return on their investment equivalent to what could be realized 20 or 30 years ago," he said. "If all costs are factored in (education, purchasing a practice, and other capital costs), I would not recommend dentistry as a profession to someone seeking maximum appreciation on capital investment."

There are, however, entities that are buying up dental practices for that very reason -- capital appreciation.

"I am disturbed by the trend toward corporate ownership of dental practices," Lewis said. "The venture capitalists who put these groups together value only the return on their investment. They will state that they must offer value in order to stay in business. Unfortunately, most of the public is not sophisticated enough to recognize the difference between 'good enough' and better or high quality. The entrepreneurs take advantage of the public's lack of knowledge."

While the number of those corporations represents a small percentage of dentistry, the impact is growing nationally.

"I know a young man who is a venture capitalist back in Georgia who is making a lot of money putting together these large group dental practices," Lewis said. "They buy practices, then hire the dentist back as a manager on salary. The dentist gets that guarantee, but it is less, and it puts him under pressure to hire other dentists to work for him at greatly reduced salaries."

This trend is just starting to affect California, according to Jacks, who says that some dentists will do well with it, while others won't.

"It's a little like saying you think you will do well in the stock market," Jacks said. "If a dentist is considering selling a practice to these companies or working with them, investigate thoroughly first."

Another trend having more and more of an impact on dentistry in California and the rest of the country is the use of computers in practice management.

"Four years ago, we computerized our office," Ball said. "At the time, we were all computer illiterates, and the learning period was difficult and frustrating at times. Now things run rather smoothly, and we wonder how we got along without it."

One area in the use of computers in dental practices that is gaining acceptance is electronic claims submissions to insurance companies.

"Once we got past some software problems, this has been one of the real bright spots in modern office management," Ball said. "Turnaround times have improved dramatically. Where through the mail it could take a month or more to get paid, we are now getting paid in half the time. Our record turnaround time is now four days. I would encourage any dentist with a computer to get going with electronic claims submission."

Not all dentists have been as successful using computers as Ball and his staff.

"As far as paperless (electronic) claims, we're not there yet," Simms said. "But we do have a computer. It makes some things in the office easier, like keeping records and appointments and doing mailings and accounting, but not necessarily cheaper."

Schonfeld doesn't use electronic claims, "as a lot of our treatment (such as radiographs and periodontal charting) requires additional documentation. Since these have to be submitted via 'snail-mail' after the electronic claim is filed and the insurance company requests it, we still see no advantage to e-claims for our practice."

Overall, though, many practices have at least attempted to file claims electronically, although not always successfully.

"A lot of people try to do electronic insurance billing, and there have been glitches on both ends," Gartrell said.

He added that, "Certainly those using it find that it works well -- when it works. Benefits include reduced labor and mailing costs and faster turnaround when it works right."

Gartrell also said that the process of filing e-claims is improving.

As many dentists wrestle with the increasing use of technology in practice management, perhaps the new generation of dentists leaving school in the past few years with more computer literacy will find it easier going.

"Years ago, I would ask dental students how many were familiar with computers, and a few would put up their hands," Gartrell said. "Now almost everyone raises their hands."

Over time, dentists, like most other types of business people, will become more computer literate and dependent, perhaps one day leading to the paperless office.

"For now, though," Gartrell said, "dental practices are using computers, but mostly as an accounting tool. More computer literate people are using them as a marketing tool, but computers are still way underutilized."

Some dentists, particularly specialists, are using computers as clinical tools, using programs that allow input of procedures and treatment plans.

"Of all the specialties, orthodontists are as a group using more of the clinical programs and some periodontists, too," Gartrell said. "From 50 to 65 percent of orthodontists are now using computerized charting and treatment programs."

Another tool some dentists are using to help manage their practices is outside experts, or "outsourcing," to handle some business functions. One such dentist is Tahmasebi.

"We have hired a public relations firm to market our practice, and they have been instrumental in introducing to the public all of the advances made in our practice," he said.

"I also have a law firm representing me in my dealings with insurance companies and an accounting firm handling every financial aspect of my practice. Although all of this sounds costly, and it is, their vision and advice have at times been invaluable."

Not many dentists rely on outsourcing most of their business functions. Those who do utilize it in the form of external marketing, Gartrell said. Another factor working against outsourcing for many dentists is the loss of control they would experience.

"A high degree of control, especially in the accounting area, is an important issue for dentists. So outsourcing may not be a good idea for many of them," Gartrell advised.

With so many options and so many demands to meet, developing an understanding of and appreciation for what is necessary to effectively and successfully work in the modern world of small business is yet another challenge in an already challenging profession.

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Participating in an Era of Change

By David G. Jones

The year was 1944, and World War II was raging across Europe and the Pacific. As the Allies pushed toward victory, a young Charles Wilson began his push to become a dentist. Now, 54 years later, he looks back on the history of a profession that, in his own way, he has helped shape.

Wilson began his dental career as a student in the Navy. But when the war ended, he finished his dental training in 1947, using the G.I. Bill at a private dental school at the University of Kansas City, forerunner of today's University of Missouri, Kansas City.

He took his DDS degree to the far northern reaches of California, coming to rest in a small rural community just south of the Oregon border.

"Tulelake, California, was the place," Wilson said, naming one of the state's more remote towns.

There he "leased a building for $45 a month, bought some equipment, put a sign on the door, and waited for the patients to line up."

In those days, small, faraway towns boasted few dentists, so patients were easy to find and no marketing was needed. Other things were simple, too.

"We had no dental insurance to deal with, and my records at that time were on 5 by 7 cards," Wilson said.

Each card had a diagram of the patient's teeth, and cavities were marked on the diagrams. The office secretary filled in the procedures, dates and costs; and at the end of the month, she would send out a bill that presented the total cost but wasn't broken down by procedure. Then, Wilson would wait for patients to pay.

"If not," he said, "the office secretary doubled as the bill collector."

In 1950, Wilson and his wife (NAME?) moved south to the more populous Solano County town of Fairfield, then with about 5,000 people.

"My dental supply man knew business was good in Fairfield," Wilson said. "A dental office was just being built, so we moved in there. The day I opened, I was booked for two weeks solid without people even knowing who I was."

He said that getting patients without marketing or advertising was easy until the mid-1970s.

The general practitioner abandoned his solo practice in 1956 and occasionally worked with an associate over the years to share expenses.

Those expenses, Wilsons said, have changed little relative to the bottom line in intervening years. Salaries then, like today, were the highest single expense in the office budget. The relative costs of supplies and equipment are similar to today's.

To ensure overhead didn't eat into profit, Wilson simply determined what the overhead was annually and adjusted

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fees accordingly. He worked alone in the beginning so he only had to equip one operatory.

"The whole setup -- including chair, X-ray system, lab equipment, and the 'unit' (consisting of motor, handpiece, spittoon, water and air) -- cost about $6,000," he said.

The "unit" was the most expensive portion of the operatory. It featured an electric motor that operated the handpiece by a pulley system.

Dental assistants, then educated in a three-month school, didn't need state certification; and many offices then had one woman who doubled as the office assistant and dental assistant. The dentist performed all hygiene functions.

In his first few years of practice, Wilson earned an annual average of $50,000 gross and kept a little more than half of that. Not bad for a well-qualified dentist who had been underprepared to operate a business.

"We had no knowledge of the business side of dentistry at all," Wilson said.

As a dental student, he didn't get any course work on practice management,

"but we were exposed to part-time faculty members who had practices. They passed along some tidbits."

The biggest challenges Wilson faced in the early years were related to areas not covered by his dental education. He took continuing education courses to learn some business practices and new clinical issues.

His practice prospered, and over the years he became active in his local dental society. In 1971, he was elected president of CDA.

As late as 1978, Wilson's staff still kept appointments in an appointment book and maintained patient's records on cards. Then, after he began a 12-year run as CDA speaker of the house in 1978, a sea of change was poised to sweep over practice management. The computer age for the dental profession loomed on the horizon.

In about 1980, Wilson bought one of the first computer systems to appear in a dental office in Solano County. After he and his staff overcame the initial learning curve, they immediately put their training to work tracking patient accounts and insurance and procedure codes.

"It cost $20,000 and printed statements at the end of each month, already inside their envelopes and sealed," Wilson said. "After we used it for a while, we didn't know how we ever got along without it," he said.

Managed care didn't exist in the early years of Wilson's practice. In later years, he was barraged with almost daily requests to sign up with plans, but stayed with fee-for-service and indemnity insurance plans until his retirement in 1992.

After Wilson retired, he started another career in which he seeks to incrementally lower a number which signifies success. His golf handicap is 18.

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Buy It, Treat It or Chew It

Robert E. Horseman, DDS

Back in the Glory Days of dentistry (March 11 and 12, 1969), it was not uncommon for at least one or two salesmen from dental supply companies to appear at my office on a weekly basis. We may laugh at this primitive marketing system now, but in those days it served us well. Most of the knowledge of dentistry we gained after dental school came from these weekly visits, particularly when the supply salesman was accompanied by a manufacturer's representative radiating bon homie and demonstrating the latest in materials and technology. This was before manufacturers smote their collective foreheads with the heels of their hands upon discovering that the proper way to showcase new products was to give seminars and charge admission.

But that was then and this is now. Call an 800 number and a disembodied voice exuding all the warmth of Robbie the Robot suggests that if you want the order department, press 3. Another voice, equally congenial, announces that all the order reps are busy, but if you will hold while they play the entire score from "Phantom of the Opera," your call will be answered in the order in which it was received, possibly even this week.

Those of us who are au courant, of course, order our supplies online. This way, we can eliminate personal contact with any creature, living or electronically generated, and don't have to apologize to anyone for not needing anything this week. The salesman and his samples are gone. I miss him. I'm sorry and it's my fault.

A common phenomenon known to all dentists, but never fully explained by Dear Abby or paranormal researchers, is that of the "phantom toothache" and its relation to the telephone. It works like this: Patient rings the office complaining of a toothache. "Been bothering me all night," he moans. "I need to see the doctor." An appointment is made and one of two things ensues:

1. The patient never shows up for the appointment.

2. The patient does appear, but is embarrassed to confess that the toothache has disappeared. This happens so frequently that at least two independent studies are under way to investigate the relationship of pain, real or perceived, to the physical act of lifting the telephone to make a dental appointment.

We called Professor Vladimir Zoronsky at Duke University, who confirmed that, yes, his department had received a government grant of $800,000 to study the phantom toothache phenomenon.

"Ve round up as many toothache complainers vhat ve can find," he told us. "Zen ve put zem vun at a time in room viz only

telephone and tell zem to call zere dentist for appointment. Vun of us highly trained researchers viz a geschtoppenvatch zen records how long before ze toothache disappears."

"And?"

"Ninety-six percent of ze toothaches wanished between 45 seconds and vun hour after lifting ze phone."

"Wanished?"

"Yes!"

"Why do you think this occurs?"

"Ve haven't ze faintest idea," he admitted, "but ve have applied for anodder grant to find out vy I have zo many Vs and Zs in my speech."

Professor Zoronsky concluded that dentists should definitely install a dedicated telephone line connected to an answering machine that will give "phantom appointments." "Zis should solve ze whole furshlugginer problem," he said. "Have a nize day!"

It is curious that America's vast counterculture that has so enthusiastically embraced nearly every toxic substance known to medical science, including Twinkies and Ding-Dongs, has not become addicted to one of the most popular products used by about half of the rest of the world.

I speak of betel nut chewing. Betel nut is prohibited from use or import in Canada, which should make it wildly popular there, but so far the United States seems to have ignored it. Betel nut is not a commercial spinoff of a certain defunct British rock group, but seems to be a product of a thin coconut palm tree called areca.

Chewing these hard nuts is a permanent feature of the cultures of the Pacific, used as casually as a wad of Wrigley's Spearmint in this country. Word is that betel nut chewing is an acquired habit, somewhat more complicated than the more familiar tequila, lime and salt routine favored by enthusiasts in the Western world. A dedicated betel nut chomper, who can easily be identified by his colorful red saliva and Cajun-blackened teeth, will dust his nut with powdered lime and then wrap it in the green betel leaf before giving himself over to the pleasures of the cud.

The nuts are chewed and harvested by millions of people in India, Vietnam, Sri Lanka, Indonesia, the Philippines and American Samoa, who seem to agree that the mild, stimulating results are worth the trouble, even though "it can jangle your nerves a bit."

Betel nut contains a toxic substance, arecoline, which has been linked to esophageal cancer. Just the ticket to entice our subculture, under 30 folks to give it a whirl along with the traditional booze/tobacco/pharmaceutical delights already at their disposal. I pass.