CDA

Association Guide
New Officers
2004 Budget

JOURNAL OF THE CALIFORNIA DENTAL ASSOCIATION VOL.32 NO.1

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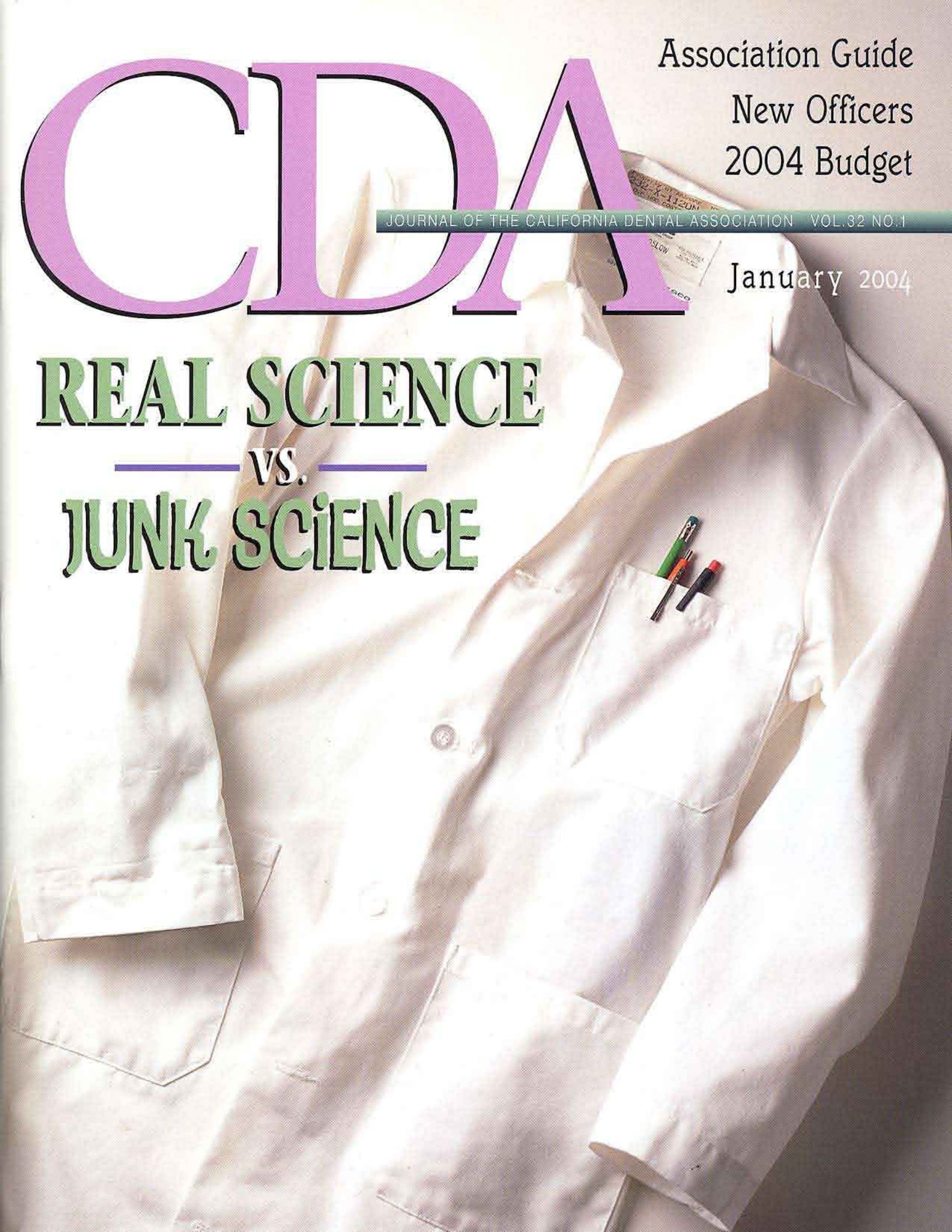
REAL SCIENCE vs. JUNK SCIENCE



OF THE CALIFORNIA DENTAL ASSOCIATION
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DEPARTMENTS

FEATURES

Jack F. Conley, DDS

Assessing The Membership Voice

This is the time of year when membership needs and wants are important topics of discussion by association staff and leadership. Not only is it a time when an assessment of ongoing initiatives and goals for the new year must of necessity be in the forefront, it is also a time when some members, for a variety of reasons, deliberate the question of their continued membership support. We find ourselves again in the annual membership renewal cycle. Perhaps some of the comments listed later in this column will provide convincing evidence that the California Dental Association is providing the leadership and benefits that the membership really needs and wants, despite some occasional rumblings to the contrary.

In mid-2003, CDA undertook a Member Survey, "Let Your Voice Be Heard" that provided some needed insight not only into member wants and concerns, but into the trends and attitudes of the many different segments in the membership universe. The difference in member opinions based upon groupings such as gender, ethnicity, new vs. old members, and high tech vs. low tech should be helpful in shaping future decisions and directions within the association to better meet the needs and expectations of the membership.

The summary findings of the consulting group that tabulated the data, confirm the changing trends in the makeup of the CDA membership. They stated that the trend in diversity brings "... an entirely new set of values and understanding" of the various segments of the membership. These insights should be very helpful in designing association initiatives to gain acceptance with the various groups of members. For example, the summary pointed out that "it is often difficult to realize that people of different gender and different ethnicity will see or hear something and end up with two different perceptions."

Our purpose here is not to go into detail about specific data, but to mention only a few general findings that might be of interest. For example, an understanding of, or a familiarity with longtime programs and services such as peer review and CalDPac, and the new entity, technology, were found to differ depending on ethnicity and years of practice. The "new" membership group with 15 or less years in the profession is composed of a greater percentage of minority members. Data showed that this group is less familiar with peer review and is over two times more likely to disagree when asked if there was a great deal of value in the peer review process when compared to the group with over 15 years in the profession. Similarly, the newer group was less likely to be familiar with CalDPac, which illustrates the need to adjust the communication and education to the different segments of the membership.

One "dynamic" that apparently did not differ between the new and old member groups in this survey is that both were in agreement regarding the value of the association's print publications, the CDA *Update* and this *Journal*. Both member segments were in agreement regarding the

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value of the print publications, and currently the new group does not have a preference for online vs. print delivery, expressing the want to have the content both online AND in print. This disputes a belief of some individuals who we have been hearing for sometime, that eventually all professional publications would be distributed online only.

The data also showed that "high technology" was positively correlated to the makeup of the new trend in CDA membership and is very similar across all groups (i.e. gender, ethnicity, etc.) Interestingly, those members classified as "low tech" were found to be more likely to disregard the value of the Peer Review process, disregard the value of CDA endorsed programs, less likely to be familiar with CalDPac, and, more likely to disregard the value of CDA for their dues dollar than the "high tech" group.

As to what the membership as a whole wants from CDA in terms of resource allocation, the top three benefits identified in this survey were legislative advocacy, marketing, and continuing education.

The overriding theme of the data from this aspect of the survey is that CDA will need to emphasize the value of some of the necessary member/professional benefits in order to overcome the differences of opinion between the various membership groups. As many in leadership know, staff and volunteer leadership consistently have made efforts to identify and address what are believed to be membership needs and wants. However, this survey does illustrate that the results of these efforts are not universally appreciated because their value (or their perceived value) is not always understood by some segments of the membership.

The final part of the survey asked for "additional comments" from the respondents. We usually find the open-ended responses revealing and useful. In my opinion, these comments fall into about five categories.

The first category I'll label **just plain critical**. Usually this member has had a negative experience with a sponsored insurance program or a negative experience at Scientific Sessions, or with a CDA- or ADA-sponsored activity. Staff and volunteers can learn from such complaints and generally remove the obstacle. However, we suspect the complainant may perceive this one event as typical of association management, perceiving it still to be true many months or years later, even though only experienced once.

Next is the **impatient complainant**. Because many of our colleagues practice solo and are used to controlling issues that arise with staff and patients with immediacy, they believe that CDA should be capable of resolving issues (such as the Dental Materials Fact Sheet, the Amalgam Controversy, and Denti-Cal funding). They may forget that the Legislature and the public they represent, regulatory agencies, and legal issues may be involved in the eventual resolution to a problem, making it highly impractical for CDA to bring about immediate closure.

Another category I shall label **uninformed and dissatisfied**. CDA staff members encounter this type of concern frequently, and some of this type of comment was present in this survey. Fortunately, some of these can easily be explained and resolved once the information is communicated. However, some perceptions may be developed from misinformation provided by uninformed colleagues and are therefore more difficult to overcome.

Moving forward, some members **offer suggestions** that will be helpful to them and their colleagues. These are positive and resolution oriented. While all comments are worthy of consideration, these are most helpful.

Finally, the **satisfied or complimentary category**. This observer was pleased to see a good number of these comments voiced in the survey. We believe these voluntary comments are reflective of the many positive efforts that are being made by California Dental Association on behalf of

the membership. In our opinion, publication of some of these comments might convince a member undecided about renewal that continued membership support is of sound benefit to the future of their practice. It is in that spirit that we share the following comments:

■ CDA is moving in the right direction. Strategic planning has been effective at tuning in better to members' needs. Glad to see the emphasis on auxiliary recruitment and on membership expansion.

■ As a recent dental school graduate, I have found the programs and services that CDA offers to be of great benefit as far as keeping me informed about 'new issues' that affect our profession on a daily basis.

■ Although CDA had questionable priorities a few years ago, great strides are now being made to support the members and serve the public. This is an extremely exciting time at CDA. The quality and commitment of volunteers is exceptional, and many opportunities await us.

■ I would have to say the CDA is a great benefit.

■ Overall, quite satisfied. Thank you!

■ CalDPac is doing a great job.

■ Please continue your hard work with state legislation and regulatory bodies.

■ CDA is a competent organization and is doing a fabulous job representing the profession by providing valuable services to members. Proud to be a member.

■ Peer review is one of the best things that we have.

■ As a former Dental Board member, I appreciate the watchdog role that CDA plays in monitoring and advocating dental health legislation. I have been proud of the ethics of CDA and appreciative of its stand on dental issues, even when I did not agree with or support its position. Any progress the Dental Board made during my tenure came about because of the leadership training and mentoring I received from CDA. Thank you.

■ I strongly support legislative efforts of GRO. We (CDA) are fortunate to have a well-organized and effective staff, and CalDPac

■ CDA is an excellent organization. I receive much more than I put in. Thank you!

■ I really enjoyed being a part of the Legislative Conference in May (2003). The CDA sets "the standard" for organized dentistry.

■ I love the CDA and the work that they do. I have always been a member and appreciate its programs and the quality of people that work with the CDA.

■ I see many new changes at CDA – all for the better. I am willing to spend more money for marketing dentistry by CDA.

For those who have not been watching closely, there have been many new and exciting changes occurring at CDA. We are pleased that some of the survey respondents have noticed and acknowledged the changes. The message is getting out! Gradual implementation of a carefully designed strategic plan that resulted from membership input is proceeding. An executive director, who has been carefully assessing the organization and its functions and has been reorganizing with efficiency in mind, demonstrates another current event that speaks volumes about the potential for increased benefits to the membership in the future.

The 2003 member survey provides your organization with some useful data about how it can better communicate and work with the membership in order to achieve mutually desired goals. Criticisms, suggestions, and the survey data about perceptions within various groups will help staff and volunteers to close existing gaps in communication. And finally, the unsolicited praise that was included in the member comments should help convince the doubters that membership in California Dental Association and the American Dental Association provides many values for them and for their patients. CDA

The top three benefits identified in this survey were legislative advocacy, marketing, and continuing education.

Illustration: Polly Powell

UCSF Awarded Contract to Study Sjögren's Syndrome

UCSF School of Dentistry recently received an $11.9 million contract to study Sjögren's Syndrome, an immunologic disease that affects the lacrimal and salivary glands.

The National Institute of Dental and Craniofacial Research and the National Eye Institute is funding the five-year study which also establishes the Sjögren's International Clinical Collaborative Alliance, a worldwide registry for the disease.

"Sjögren's Syndrome affects as many as four million Americans, approximately one in every 100 members of the adult population. Nine out of 10 affected by SS are women," said Troy Daniels, DDS, MS. He

and John Greenspan, DDS, PhD, are the two principal investigators.

Daniels added the alliance will benefit a significant number of Americans and others around the world suffering from the complications of Sjögren's and its associated chronic symptoms which include dry mouth and eyes.

In patients with primary Sjögrens, progressive damage to the glands can lead to the development of auto-antibodies in the bloodstream, oral or ocular infections as well as other complications. The systemic disease also may strike many organs such as the lungs, liver, kidneys, and in rare cases, advance to malignant lymphoma.

The immune mechanisms that cause Sjögren's are comparable to those that cause systemic lupus and rheumatoid arthritis. What's more, a secondary form of Sjögren's may develop in some patients already affected by those or related diseases.

The Sjögren's international allliance will create standardized diagnostic criteria for the disease, gather clinical data and biospecimens from patients and their families to establish a data and tissue bank to aid future research projects on the causation, mechanisms, prevention, and treatment of this disease.

Daniels and Greenspan have worked together for many years. The Sjögren's international alliance builds on more than three decades of work in UCSF's Sjögren's Syndrome Clinic, which Daniels co-founded in 1972, and on more than 20 years of specimen-banking work by Greenspan and his team, who established in 1982 the UCSF AIDS Specimen Bank.

Sjögren's patients will be admitted to the registry at five participating clinical centers throughout the world. These clinics will collect data and specimens and transfer them to the UCSF project coordinating center.

"With this approach, groups of scientists across the world will end up using the same ways of approaching this surprisingly common disease," Greenspan said.

"The patient benefits from SICCA (Sjögren's international alliance) will come from having improved diagnostic criteria to better identify this disease, and from research projects that will be supported by the availability of this clinical data and biospecimens," said Greenspan.

> "With this approach, groups of scientists across the world will end up using the same ways of approaching this surprisingly common disease."
>
> **John Greenspan, DDS, PhD**

Joining Greenspan and Daniels on this project are Judy Borland; Yvonne De Souza, MSc; Deborah Greenspan, BDS, DSc; Richard Jordan, DDS, PhD; Caroline Shiboski, DDS, PhD; and Dr. Ava Wu, DDS of the UCSF School of Dentistry. Additional particpants from the UCSF School of Medicine are Esteban Burchard, MD; Lindsey Criswell, MD, MPH; Kenneth Sack, MD; Stephen Shiboski, PhD; and Jack Whitcher, MD, MPH.

Lead collaborators from the participating international clinics are Hector Lanfranchi, DDS, PhD, University of Buenos Aires; Yi Dong, MD, Peking Union Medical College; Morten Schiødt, DDS, PhD, Copenhagen County University Hospital; and Susumu Sugai, MD, PhD, Kanazawa Medical University, Japan.

Stephen Pflugfelder, MD, Baylor University; Austin Mircheff, PhD, University of Southern California; Kathy Moser, PhD, University of Minnesota are external consultants.

Impaired Recovery Linked to Smoking

Smokers have reduced body defense mechanisms that affect their recovery following dental procedures, said Swedish researchers in the *Journal of Periodontology*. Even recovery from non-surgical periodontal therapy may be impaired if the patient continues to puff away.

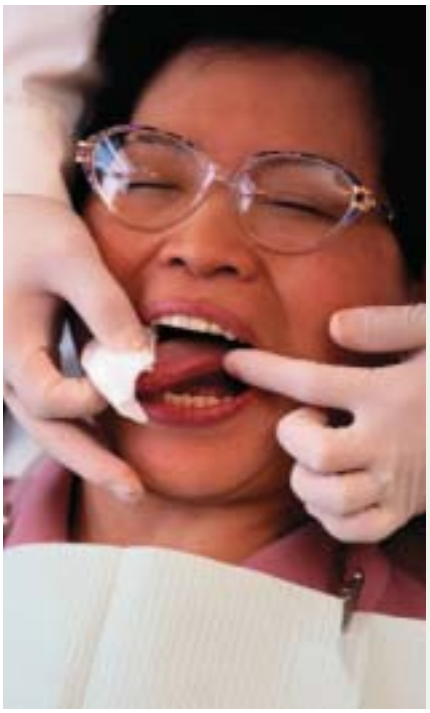
"In this study we investigated the relationship between tobacco smoking and the inflammatory response in smokers who consumed 10 to 20 cigarettes per day," said Michael P. Rethman, DDS, MS, and president of the American Academy of Periodontology.

"What we found in tobacco smokers is that the body's defense mechanism was weakened, whereas the defense mechanism in non-smokers promoted a more favorable healing response."

Additionally, research showed that smoking tobacco releases enzymes that may advance the development of periodontitis, a bacterial infection of the gums, bone and attachment fibers supporting teeth and hold them in the jaw. Oral health improves once the smoker quits.

"Patients who want to quit smoking are urged to increase brushing and flossing their teeth and gums," Rethman said. "It's suggested that the fresh clean feeling a person feels in the mouth after brushing and flossing may curb the urge to smoke. Ironically, these simple tips also help to prevent periodontal diseases."

Joining forces with the Great American Smokeout last November, the American Academy of Periodontology created a special section on its web site, www.perio.org, to inform people about the impact of tobacco on periodontal health. Dental care professionals can request a free brochure of *Tobacco and Gum Disease* online at the above web site or call (800) FLOSS-EM.



Oral Cancer Tops List for Diagnostic Concerns

The single most important diagnostic issue facing dentists is oral cancer, said Gary C. Coleman in the June 2003 issue of *Texas Dental Journal*.

An estimated 30,000 cases of oral cancer are diagnosed annually in the U.S. with roughly half ending in death. An effective diagnosis is based on recognizing associated findings or "suspicion factors" that suggest malignant neoplasia, Coleman said.

Association of one or more of these suspicion factors with an oral lesion could be weak evidence of squamous cell carcinoma or other oral malignancy. However, Coleman said, a mixture of several suspicious factors may justify for definite diagnosis by incisional or exclisional biopsy.

In the article, Coleman discussed the suspicion factors including clinical feature of the lesion, possible causes such as alcohol or tobacco use, age, surface character, delineation, distribution, pain, palpation, location, clinical course and rate of change.

Clinical presentation of oral cancer varies among patients. Luckily, he said, many of the oral lesions exhibiting suspicious factors are reactive lesions or benign. The challenge for dentists is to accurately read the secondary characteristics related with a white patch or ulcer to correctly recognize lesions that support reasons for the discomfort and cost of a definitive diagnostic biopsy procedure.

Since early detection and treatment are key to surviving oral cancer, Coleman said diagnosis is the single most important factor for dentists.

Can you edit one line from this please?

No Link Between Asthma and Periodontal Disease

There is no evidence to support the association between asthma and periodontal health in adolescents, said researchers at Baylor College of Dentistry and Goldman School of Dental Medicine, Boston College. Their report appeared in the May/June 2003 *Pediatric Dentistry*.

Of the 1,596 youths between the ages of 13 and 17, 16 percent were asthmatics. The teens were examined for bleeding on probing, subgingival calculus, supragingival calculus, probing depth greater than or equal to 3mm, and loss of periodontal attachment greater than or equal to 2 mm.

None of the periodontal measures was associated with asthma severity or with the use of anti-asthmatic medicines, the authors reported. They did note that the finding possibly may be because of inherent limitations of cross-sectional studies, lack of knowledge about the daily dose of anti-asthmatic medication and the compliance level with therapeutic methods.

Six previous studies, the authors noted, examined the association between asthma and periodontal diseases and none showed consistent findings when taken as a group. Complicating the interpretations of these studies are factors such as treating asthmatics involves using medications that affect immune response and inflammation.

Researchers said asthma has become more prevalent since the 1980s and affects people of all ages, racial groups, genders, especially children. From 1980 to 1994, asthma among U.S. youths between the ages of 5 and 14 has increased by 174 percent.

The authors said ensuing studies should be longitudinal. Researchers used health interview data and oral examinations from the 1988-1994 Third National Health and Nutrition Examination Survey.

Study Looks at Infants and Bacterial *S. mutans*

Researchers in Brisbane, Queensland, Australia, found that the colonization of *Streptococcus mutans* increased as the infant aged, so that by the toddler's second birthday, 84 percent of the children in the study had the bacteria.

The same researchers previously determined that before tooth eruption, more than 50 percent of the infants already were infected with *S. mutans*. The recent report, using the same infants in the first study, found the colonization of S. mutans following tooth eruption.

Researchers followed 312 infants—93 pre-term; 219 full term—every three months from the children's birth until age 2. In eight of the infants who developed caries, *S. mutans* was initially detected at the median age of 18 months, according to the report.

Additionally, infants who had their teeth regularly brushed by their first birthday showed decreased signs of harboring S. mutans than those who had not brushed. Researchers said these findings support and extend the work of others who promote early dental care.

Causes of *S. mutans* colonization, according to the report, include child-rearing habits ranging from adult to child sharing food and utensils, and close contact such as breastfeeding and the child sleeping beside the mother.

In eight of the infants who developed caries, S. mutans *was initially detected at the median age of 18 months.*

Diagnosing Cracked Tooth Syndrome

Since fractures or splits are the third-most common cause of tooth loss in industrialized countries, researchers recommend early reinforcement of at-risk teeth.

According to researchers at the University of Washington School of Dentistry and the Medical University Hannover, Germany, cracked tooth syndrome is often associated with bizarre symptoms that can complicate diagnosis and therefore the condition may persist for several years.

Accidental trauma is the leading cause of incomplete fractures, researchers said. For example, inadvertently biting with a hard force a small and very dense object, such as a seed, may immediately generate an excessive load due to the small contact area. As a result, the loaded tooth may split or fracture.

The study, published in the June 2003 *Quintessence International*, defined cracked tooth syndrome as an incomplete fracture of the natural crown of a pre-molar or molar. Incomplete splits typically run in a mesiodistal direction. While most of those teeth are restored, the share of caries-free and non-restored teeth is between 13 and 35 percent.

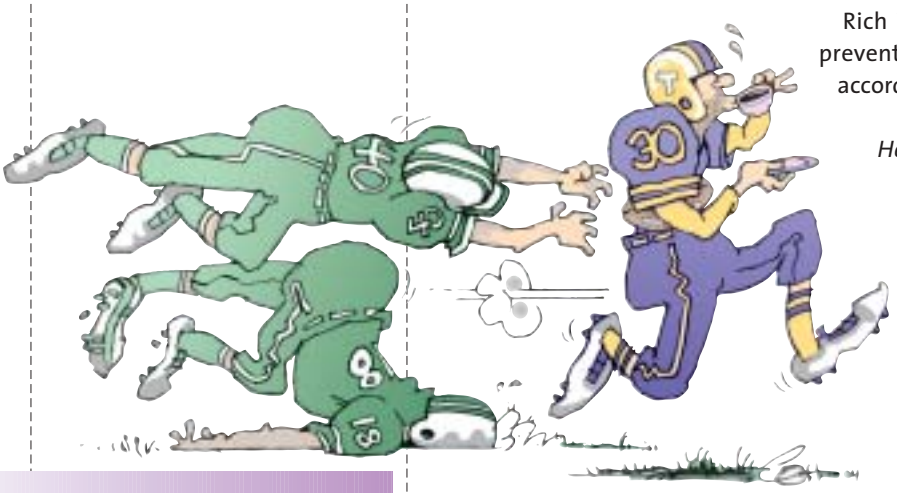
Researchers said diagnosis is simple as viewing a cracked tooth. Unfortunately, the most common mesiodistal cracks are microscopic.

Because a split typically runs parallel to the plane of the film, radiographic examination seldom improves the diagnosis of a crack. However, researchers noted, the radiologic findings of a localized periodontal breakdown in an otherwise periodontally healthy dentition may signify a troublesome tooth.

Sharp pain on chewing tough or hard foods can be telling diagnostic evidence of a fractured tooth. To confirm a case of a split, patients should be asked to bite on an orangewood stick or similar hard object, and then release the pressure quickly, researchers recommended.

Illustration: Matt Mullin

Popular Beverage May Fit You to a Tea



Rich in antioxidant flavonoids called catechins, tea may prevent cancer, heart disease and help keep bones strong, according to preliminary research.

In the Mayo Clinic's September 2003 newsletter, *HealthQuest*, a study found that people who consumed six cups of black tea had a 50 percent lower risk of developing coronary artery disease as compared to those who didn't drink the beverage.

Additionally, laboratory studies showed that green tea helped prevent or delay cancer development in breast, colon, liver and prostate cells. A previous study found that regularly consuming black or green tea over a decade may improve bone mineral density by up to five percent.

No endeavor that is worthwhile is simple in prospect; if it is right, it will be simple in retrospect.

Edward Teller

Upcoming Meetings

2004

Jan. 22-23	Sacramento District Dental Society 24th annual Midwinter Convention and Expo, Sacramento, (916) 446-1211.
Feb. 15-21	Barbados Dental Association 16th annual Midwinter Convention, Barbados, www.barbadosda.org
March 2-3	Academy of Laser Dentistry Certification Program, Standard Proficiency and Advanced Proficiency, Palm Springs, (954) 346-3776, www.laserdentistry.org.
March 3-6	Academy of Laser Dentistry 11th Annual Conference, Palm Springs, (954) 346-3776, www.laserdentistry.org.
March 5-8	Academy of Laser Dentistry 10th Anniversary Conference and Exhibition, Destin, Fla., (954) 346-3776, www.laserdentistry.org.
April 15-18	CDA Spring Scientific Session, Anaheim, (866) CDA-MEMBER (232-6362).
April 27-May 2	American Academy of Cosmetic Dentistry's 20th annual Scientific Session, Vancouver, British Columbia, www.aacd.com.
Sept. 8-11	International Federation of Endodontic Association's sixth Endodontic World Congress, Brisbane, Queensland, Australia, www.ifea2004.im.com.au.
Sept. 10-12	CDA Fall Scientific Session, San Francisco, (866) CDA-MEMBER (232-6362).
Sept. 30-Oct. 3	ADA Annual Session, Orlando, Fla., (312) 440-2500.

To have an event included on this list of nonprofit association meetings, please send the information to Upcoming Meetings, *CDA Journal,* P.O. Box 13749, Sacramento, CA 95853 or fax the information to (916) 443-2943.

CDA Code of Ethics

Adopted by the California Dental Association House of Delegates Nov. 16-18, 2001

With the adoption of the Principles of Ethics and Code of Professional Conduct of the American Dental Association, it became necessary for the Judicial Council to rewrite CDA's Code of Ethics. In so doing, the council took the opportunity to rearrange the code into three significant groupings. In the revised version of the code printed here, the association's most important statements regarding ethical conduct can be found in the beginning sections. Thus, the first group pertains to service to the public; the second discusses the promotion of a dental practice; and the third portion concerns daily ethical conduct in the dental office.

PREAMBLE

The Code of Ethics of the California Dental Association consists of the principles stated herein.

The CDA Judicial Council may, from time to time, issue advisory opinions setting forth the council's interpretations of the principles set forth in this code. Such advisory opinions are "advisory" only and are not binding interpretations and do not become a part of this code, but they may be considered as persuasive by the trial body and any disciplinary proceedings under the CDA Bylaws.

The association's Code of Ethics, although presented in the form of general guides, clearly suggests the conduct which a dentist is expected to follow in carrying out professional activities whether they be related to patients or to fellow practitioners.

Problems involving questions of ethics should be solved within the broad boundaries established in this Code of Ethics and within the meaning and interpretation of the Code of Ethics and Bylaws of the constituent and component societies. If a satisfactory decision cannot be reached, the question should be referred, on appeal, to the Council on Ethics, Bylaws and Judicial Affairs of the American Dental Association, as provided in Chapter XII of the Bylaws of the American Dental Association, and also in Chapter XI of the Bylaws of the California Dental Association.

Dentists should constantly remind themselves that the ethics of dental practice, the basic system for self-regulation of the dental profession, grow out of the obligations inherent in the practice of a profession. The dentist should reflect constantly upon the professional characteristics of the dental occupation, which are:

1. The provision of a service (usually personal) which is essential to the health and well-being of society.
2. The necessity of intensive education and training to qualify as competent to provide the essential service.
3. The need for continuing education and training to maintain and improve professional knowledge and skills.
4. The need for joining with professional colleagues in organized efforts to share new knowledge and new developments of professional practice.
5. Dedication to service rather than to gain or profit from service.
6. Leadership in the community, including all efforts leading to the improvement of the dental health of the public.

Section 1. Service to the Public

Service to the public is the primary obligation of the dentist as a professional person.

The dentist's primary obligation of service to the public shall include the delivery of quality care, competently and timely, within the bounds of the clinical circumstances presented by the patient.

In their service to the public, dentists shall conduct themselves in such a manner as to maintain or elevate the esteem of the profession.

In serving the public, a dentist may exercise reasonable discretion in selecting patients for the dental practice. However, a dentist may not refuse to accept a patient into his/her practice or deny dental service to a patient solely because of the patient's race, creed or national origin.

Wherever "standards of care" or "quality services" are undefined by state or federal law, such standards or services shall be defined by the California Dental Association or such agency as designated by the association.

It is unethical for a dentist to render, or cause to be rendered, substandard care.

It is unethical to mislead a patient or misrepresent in any material respect either directly or indirectly the skills, training, identity, services, or fees of the dentist who performs a procedure.

Except as exempted by state law, a dentist has the obligation to obtain the fully informed consent prior to treatment, or the use of any identifiable artifacts (such as photographs, X-rays, study models, etc.) for any purpose other than treatment.

A dentist who submits any billing for services rendered or to be rendered which is fraudulent, deceitful, or misleading is engaged in unethical conduct.

Advisory Opinions:

1. Dentists shall not represent the care being rendered to their patients or the fees being charged for providing such care in a false or misleading manner.

A dentist who accepts a third party[1] payment under a copayment plan as payment in full, without disclosing to the third party[1] payer that the patient's payment portion will not be collected, is engaged in overbilling. The essence of this ethical impropriety is deception and misrepresentation; an overbilling dentist makes it appear to the third party[1] payer that the charge to the patient for the services rendered is higher than it actually is.

2. Solicitation of children on any private or public school grounds by the use of dental health programs (e.g., dental screening, mouth guards, sealants, etc.) for the purpose of generating referrals or for the financial benefit of the dentists participating in such programs is deemed not to elevate the esteem of the dental profession. For purposes of this advisory opinion, solicitation includes, but is not limited to, dissemination of business cards or any other materials intended to promote the dentist's practice.

3. Dentists shall fully explain proposed treatment, reasonable alternatives, and the risks of not performing treatment. Treatment should be explained in a manner that allows patients to be involved in decisions affecting their oral health.

4. Dentists shall not allow or cause patients to believe that they are providers for the patients' third party[1] payor when, in fact, they are not. Additionally, dentists shall not allow or cause patients to believe that services being offered are benefits covered by the patients' third party1 payor if, in fact, they are not. Dentists should make a bona fide attempt to determine these facts before committing patients to a financial obligation.

Section 2. Government of a Profession

Every profession receives from society the right and obligation to regulate itself, to determine and judge its own members. Such regulation is achieved largely through the influence of the professional societies, and dentists have the dual obligation of making themselves a part of professional society and of observing its rules of ethics.

Any member convicted of or pleading guilty to any felony or misdemeanor involving malpractice or unprofessional conduct (as defined by the Dental Practice Act or the California Dental Association) is in violation of the Code of Ethics, and may be disciplined by the association.

Any member who makes a statement in any document filed with the California Dental Association, its component societies, or the American Dental Association, which statement is fraudulent or false in a material respect, or which omits to disclose any material fact or matter, has engaged in unethical conduct. For the purpose of this section, the word "material" shall mean "not insubstantial" or "of significance" with respect to reasons for which the document is filed.

Section 3. Cooperation with Duly Constituted Committees

It is the duty of the member to comply with the reasonable requests of a duly constituted committee, council or other body of the component society or of this association necessary or convenient to enable such a body to perform its functions and to abide by the decisions of such body. In the event a member is employed by another dentist, it shall be the duty of the member to provide satisfactory written assurance from the employer that the employed dentist will be able to meet this duty of compliance. Any violation of this duty constitutes unethical conduct.

Section 4. Court Action and Association Discipline

Dentists who are members of the California Dental Association shall comply with the laws of the state of California relating to the practice of dentistry. Any dentists who shall be reprimanded, disciplined, or sentenced by final action of any court or other authority of competent jurisdiction, pursuant to the laws of the state of California governing the practice of dentistry, or who are found by final action of any court guilty of a crime reflecting unfavorably on dentists or the dental profession, shall thereby render themselves liable to discipline by the association.

Section 5. Unprofessional Conduct and Violation of State Law

A member may be disciplined for unprofessional conduct as it is defined by the Dental Practice Act, and for violation of any law of the state of California relating to the practice of dentistry.

Section 6. Education Beyond the Usual Level

The right of dentists to professional status rests in the knowledge, skill and experience with which they serve their patients and society. Every dentist has the obligation to advance his/her knowledge and keep his/her skills freshened by continuing education throughout his/her professional life.

Section 7. Use of Professional Titles and Degrees

A dentist may use the degrees conferred upon him or her by diploma from a recognized dental college or school legally empowered to confer the same, the letters "D.D.S." as permitted by state law, and/or the titles, Doctor and/or Dentist and any additional advanced academic degrees earned in health service areas on cards, letterheads, announcements and advertisements. A dentist who has been certified by a national certifying board for one of the specialties approved by the American Dental Association may use the title "diplomate" in connection with that specialty on cards, letterheads and announcements.

If dentists use a title or degree in connection with the promotion of any dental or other commercial endeavor, such usage must not be false of misleading in any material respect.[2]

Advisory Opinions:

1. A dentist using volunteer position titles and association and/or component society connected experience in any commercial endeavor may be making a representation which is false or misleading in a material respect. Such use of volunteer position titles and association and/or component society connected experience may be misleading because of the likelihood that it will suggest that the dentist using such is claiming superior skills. However, when such usage does not conflict with state law, volunteer position titles and association and/or component society connected experience may be indicated in scientific papers and curriculum vitae which are not used for any commercial endeavor. In any review by the council of the use of volunteer position titles and association and/or component society connected experience, the council will apply the standard of whether the use of such is false or misleading in a material respect.

2. The phrase "any additional advanced academic degrees earned in health service areas" is interpreted to mean only those degrees that are earned after a member graduates from dental and/or medical school. Use of a degree earned prior thereto could be misleading in a material respect because of the likelihood that it will indicate to the public the attainment of specialty status or advanced dental education. A member may list degrees only in the order received. A certificate or license is not a degree and shall not be listed with professional titles or degrees.

3. A dentist may append either the letters D.D.S. as permitted by state law, or the letter abbreviation(s) representing the degree(s) conferred upon him or her by a recognized dental college or school legally empowered to confer the same, when indicating successful completion of a dental educational program. The simultaneous use of these abbreviations, however, may be making a representation which is false or misleading in a material respect as it implies completion of an increased level of dental education. In any review by the council of the use of letter abbreviations, the council will apply the standard of whether the use of such is false or misleading in a material respect.

Section 8. Announcement of Specialization and Limitation of Practice

This section is designed to help the public make an informed selection between the practitioner who has completed an accredited program beyond the dental degree and a practitioner who has not completed such a program.

The special areas of dental practice approved by the American Dental Association and the designation for ethical specialty announcement and limitation of practice are: dental public health, endodontics, oral pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics.

A dentist who chooses to announce specialization should use "specialist in" or "practice limited to" and shall limit the practice exclusively to the announced special area(s) of dental practice, provided at the time of the announcement the dentist has met in each approved specialty for which he/she announces the existing educational requirements and standards set forth by the American Dental Association.

A dentist who uses eligibility to announce as a specialist or a limitation of practice to make the public believe that specialty services rendered in the dental office are being rendered by qualified specialists when such is not the case is engaged in unethical conduct. The burden of responsibility is on the specialist to avoid any inference that general practitioners who are associated with the specialist are qualified to announce themselves as specialists or limitations of practices.

General Standards: The following are included within the standards of the American Dental Association for determining the education, experience and other appropriate requirements for announcing specialization and limitation of practice:

1. The special area(s) of dental practice and an appropriate certifying board must be approved by the American Dental Association.

2. The dentists must have successfully completed an educational program accredited by the Commission on Accreditation of Dental and Dental Auxiliary Education Programs, two or more years in length, as specified by the American Dental Association Council on Dental Education or be diplomates of an American Dental Association recognized certifying board.

3. The dentist's practice shall be limited exclusively to the special area(s) of dental practice in which the dentist has announced.

Standards of multiple specialty announcements: Educational criteria for announcement as a specialist or limitation of practice in an additional recognized area(s) are the successful completion of an educational program accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs in each area for which the dentist wishes to announce.

Dentists who completed their advanced education in programs listed by the American Dental Association Council on Dental Education prior to the initiation of the accreditation process in 1967, and who are currently ethically announcing as specialists or limitation of practice in a recognized area, may announce in additional areas provided they are educationally qualified or are certified diplomates in each area for which they wish to announce. Documentation of successful completion of the educational program(s) must be submitted to the appropriate constituent society. The documentation must assure that the

duration of the program(s) is a minimum of two years except for oral and maxillofacial surgery, which must have been a minimum of three years in duration.

Advisory Opinion:

1. A dentist who is qualified to announce specialization under this section may not announce to the public that he or she is certified or a diplomate or otherwise similarly credentialed in an area of dentistry not recognized as a specialty area by the American Dental Association unless:

1. The organization granting the credential grants certification or diplomate status based on the following: a) the dentist's successful completion of a formal, full-time advanced education program (graduate or postgraduate level) of at least 12 months' duration; and b) the dentist's training and experience; and c) successful completion of an oral and written examination based on psychometric principles; and

2. The announcement includes the following language: [Name of announced area of dental practice] is not recognized as a specialty area by the American Dental Association.

The Advisory Opinion applies to any credential in an area of dentistry not recognized as a specialty area by the American Dental Association, including, but not limited to, "certified," "accredited," "diplomate," "fellow" or "master." It does not apply to a statement of membership in an organization as long as the statement does not express or imply specialization or special qualifications which cannot be substantiated.

Nothing in this Advisory Opinion affects the right of a properly qualified dentist to announce specialization in an ADA-recognized specialty area(s) as provided for under Section 8 of this Code or the responsibility of such dentist to limit his or her practice exclusively to the special area(s) of dental practice announced. Specialists shall not announce their credentials in a manner that implies specialization in a non-specialty interest area.

Section 9. General Practitioner Announcement of Services

General dentists who wish to announce the services available in their practices are permitted to announce the availability of those services so long as they avoid any communications that express or imply specialization. The dentist shall also state that the services are being provided by a general dentist. No dentist shall announce available services in any way that would be false or misleading in any material respect.

Advisory Opinions:

1. Since the advent of the accreditation process leading to ADA approved specialties, the phrase "practice limited to" has taken on a secondary meaning referring to a dentist who is a specialist in an ADA approved specialty. The public and profession have been secure in the knowledge that a dentist using this longstanding phrase has received two or more years of postdoctoral specialty training in an ADA accredited specialty education program. Use of this phrase by a specialist also carries with it the understanding that the specialist devotes 100 percent of his or her time to the specialty and does not provide any general dental services.

An announcement by a general dentist that services available are restricted or limited to a particular area of dentistry could be misleading to the public because of the likelihood that it will imply that the dentist has received the same type of education and training which an ADA approved specialist receives. In order to avoid the likelihood of such misconceptions, a general dentist may only announce a practice limited to a particular area of dentistry if all of the following are strictly adhered to:

a. Other general dental services are not provided;

b. One hundred percent of the dentist's time is devoted to the particular area of dentistry; and

c. It is clearly stated that the services are being provided by a general dentist in a font as prominent as that used to announce the limited practice.

In addition, if the area of practice is not a specialty recognized by the ADA, the following or a substantially similar disclaimer must be used in conjunction with the announcement of limited practice and displayed in a clear and visible manner:

(Area) dentistry is not a specialty recognized by the American Dental Association.

Failure to adhere to these provisions would make the announcement false or misleading in a material respect. For instance, if any general dental services are provided, the announcement would be false because the dentist is not truly limiting his or her practice to a particular area. Similarly, if 100 percent of the dentist's time is not devoted to the particular area, the announcement would also be false. If "general dentist" is not prominently displayed, the announcement may lead the public to mistakenly believe that the dentist has attained ADA approved specialty status. If the disclaimer is not used, the announcement may lead the public to mistakenly believe that the particular area of dentistry is one that the ADA has found to be appropriate for specialization.

2. A general dentist may not announce to the public that he or she is certified or a diplomate or otherwise similarly credentialed in an area of dentistry not recognized as a specialty area by the American Dental Association unless:

1. The organization granting the credential grants certification or diplomate status based on the following: a) the dentist's successful completion of a formal, full-time advanced education program (graduate or postgraduate level) of at least 12 months' duration; and b) the dentist's training and experience; and c) successful completion of an oral and written examination based on psychometric principles;

2. The dentist discloses that he or she is a general dentist; and

3. The announcement includes the following language: [Name of announced area of dental practice] is not recognized as

a specialty area by the American Dental Association.

This Advisory Opinion applies to any credential in an area of dentistry not recognized as a specialty area by the American Dental Association announced by a general dentist, including, but not limited to, "certified," "accredited," "diplomate," "fellow" or "master." It does not apply to a statement of membership in an organization as long as the statement does not express or imply specialization or special qualifications which cannot be substantiated.

Fellowships or other credentials earned in the area of general dentistry may be announced so long as they avoid any communications that express or imply specialization and the announcement includes the disclaimer that the dentist is a general dentist. The use of abbreviations to designate credentials shall be avoided when such use would lead the reasonable person to believe that the designation represents an academic degree, when such is not the case.

3. "Family Dentistry" and "Restorative Dentistry" are considered synonymous with "General Dentistry" and can be used to state that services are being provided by a general dentist. General dentists who choose to announce the services available in their practices shall announce those services in a manner subordinate to the statement that services are being provided by a general dentist. Otherwise consumers may falsely assume some services, including but not limited to aesthetic dentistry, cosmetic dentistry, implant dentistry and laser dentistry, are among the nine special areas of dental practice approved by the American Dental Association for ethical specialty announcement and limitation of practice.

Section 10. Advertising

Although any dentist may advertise, no dentist shall advertise or solicit patients in any form of communication in a manner that is false or misleading in any material respect. In order to properly serve the public, dentists should represent themselves in a manner that contributes to the esteem of the profession. Dentists should not misrepresent their training and competence in any way that would be false or misleading in any material respect.[2]

Advisory Opinions:

1. A member shall not disseminate, permit or cause to be disseminated, or participate in the benefits from any form of advertising containing a statement or claim which is false or misleading in any material respect, for the purpose of, directly or indirectly, soliciting patients or inducing the rendering of dental services.

2. A statement or claim is false or misleading when it:

a. Contains a material misrepresentation of fact;

b. Is materially misleading because the statement as a whole makes only a partial disclosure of relevant facts;

c. Is intended or is likely to create false or unjustified expectations of favorable results;

3. Any member who compensates or gives anything of value to a representative of the press, radio, television or other communication medium in anticipation of, or in return for, professional publicity must make known the fact of such compensation in such publicity.

4. A member may not use any professional card, professional announcement card, office sign, letterhead, telephone directory listing, dentists' list, dental directory listing or a similar professional notice or advice if it includes a statement or claim that is false or misleading in any material respect.

5. A dentist shall not issue or cause to be issued through any medium, a public statement expressing or implying official sanction of the American Dental Association, California Dental Association, or any of its component societies, without due consent of the governing body of said organization. Upon receiving such authorization, the member shall ascertain that any public statement is scientifically correct and complies with the Code of Ethics.

6. Advertising claims shall be avoided that contain a material, objective representation, whether expressed or implied, that the advertised services are superior in quality to those of other dentists, if that representation is not subject to reasonable substantiation.

Subjective statements about the quality of dental services can also raise ethical concerns. In particular, statements of opinion may be misleading if they are not honestly held, if they misrepresent the qualifications of the holder, or the basis of the opinion, or if the patient reasonably interprets them as implied statements of fact. Such statements will be evaluated on a case by case basis, considering how patients are likely to respond to the impression made by the advertisement as a whole. The fundamental issue is whether the advertisement, taken as a whole, is false or misleading in a material respect.

Section 11. Cards, Letterheads and Announcements

A dentist may utilize professional cards, announcement cards, recall notices to patients of record and letterheads when the style and text are not false or misleading in any material respect.[2]

Section 12. Office Door Lettering and Signs

A dentist may utilize office door lettering and signs provided their style and text are not false or misleading in any material respect.

Section 13. Directories

Dentists may permit the listing of their names in a telephone directory, community directory or guide, dental list or dental directory, or in a membership roster, membership directory or other membership list of a service club, charitable organization, fraternity, school alumni association or business, professional or trade association to which they belong, provided such listing is not false or misleading in any material respect.[2]

Section 14. Name of Practice

As the name under which a dentist conducts a dental practice may be a factor in the selection process of the pa-

tient, the use of a trade name or an assumed name that is false or misleading in any material respect2 is unethical. Use of the name of a dentist no longer actively associated with the practice may be continued for a period not to exceed one year.

Advisory Opinion:

1. The use of a trade name or an assumed name could mislead laymen concerning the identity, responsibility and status of those practicing thereunder. Therefore, it is improper to mislead a patient or misrepresent the skills, training, identity, services or fees, either directly or indirectly, through the use of such a trade name or assumed name in any way or manner. Except as permitted by state or federal law, a dentist shall practice only under one of the following: 1) his/her own name; 2) the name of a dentist employing him/her who practices in the same office; 3) a partnership name composed only of the name of one or more of the dentists practicing in a partnership in the same office; or 4) a corporate name composed only of the name of one or more of the dentists practicing as employees of the corporation in the same office. Whenever any assumed or trade name of the practice is used, it must be conspicuously accompanied by the name of the dentist as licensed to practice dentistry.

Section 15. Emergency Service

Dentists shall be obliged to make reasonable arrangements for the emergency care of their patients of record. Reasonable arrangements shall be defined in accordance with the standards established by the component dental society. Failure of the component society to establish such standards shall not excuse the dentist from the duty to provide emergency care to all patients of record.

The dentist shall be obliged when consulted in an emergency by a patient not of record to make reasonable arrangements for emergency care. If emergency treatment is provided, the dentist, upon completion of such treatment, is obliged to return the patient to the dentist of record, unless the patient expressly reveals a different preference.

Section 16. Consultation and Referral

A dentist shall be obliged to seek consultation, if possible, whenever the welfare of the patient will be safeguarded or advanced by utilizing those who have special skills, knowledge and experience. When a patient visits or is referred to a specialist or consulting dentist for consultation:

1. A dentist has a duty to make reasonable inquiry to determine whether a prospective patient is currently the patient of another dentist.

2. A specialist or consulting dentist upon completion of the care shall return the patient, unless the patient expressly reveals a different preference, to the referring dentist, or, if none, to the dentist of record for future care.

3. A specialist shall be obliged, when there is no referring dentist and upon completion of the treatment, to inform the patient when there is a need for further dental care.

Section 17. Use of Auxiliary Personnel

Dentists have an obligation to protect the health of their patients by not delegating to a person less qualified any service or operation which requires the professional competence of a dentist. Dentists have the further obligation of prescribing and supervising the work of all auxiliary personnel in the interest of rendering the best service to the patient.

Advisory Opinions:

1. Hygienists' duties are to support the dentist in the delivery of dental care. The duties should never be performed independently of the dentist's professional judgment or a separate treatment procedure performed outside of the dentist's supervision. Hygienists' services are dental treatment. Therefore, the diagnosis for dental treatment and subsequent delegation of duties to registered dental hygienists must be made by a dentist.

2. The state of California provides for both general and direct supervision of registered dental hygienists. General supervision means supervision of dental procedures based on instructions given by a licensed dentist but not requiring the physical presence of the supervising dentist during the performance of those procedures. Direct supervision means supervision of dental procedures based on instructions given by a licensed dentist who must be physically present in the treatment facility during performance of those procedures. Duties shall not be delegated to the registered dental hygienist by the supervising dentist until the patient has been initially examined and diagnosed by the dentist.

3. After the initial examination and diagnosis by the supervising dentist, additional examinations of each patient shall be completed by the dentist as determined by the customary practice and standards of the dental profession. Registered dental hygienists may not perform any additional dental treatment other than that which is contained in the written treatment plan until the supervising dentist has re-examined the patient and provided new or additional instructions.

Section 18. Third Party[1] Practice

A dentist may enter into an agreement with individuals and/or organizations to provide dental health care provided that the agreement does not permit or compel practices which lead to unethical conduct.

In the performance of such contracts the dentist is required to deal fairly with the public and fellow practitioners in the locality.

A dentist who submits any billing for services rendered or to be rendered which is fraudulent, deceitful, or misleading is engaged in unethical conduct.

It is unethical for dentists to contract for services under conditions that make it impossible to render service to their patients in a timely and reasonable manner.

Section 19. Justifiable Criticism

Dentists shall be obliged to report to the appropriate reviewing agency instances of gross and/or continual faulty treatment by another dentist. Patients should be informed of their present oral health status without disparaging comment about prior services.

Advisory Opinions

1. It is the duty of a dentist to report instances of gross and/or continual faulty treatment. However, this section is entitled "Justifiable Criticism." When informing patients of the status of their oral health, the dentist should exercise care that the comments made are justifiable. This would include finding out from the previous treating dentist under what circumstances and conditions the treatment was performed. A difference of opinion as to preferred treatment should not be communicated to the patient in a manner which would imply mistreatment.

2. If comments are made which are obviously not supportable, and, therefore, unjustified, such comments can be the basis for association disciplinary proceedings against the dentist making such statements.

Section 20. Expert Testimony

Dentists may provide expert testimony when that testimony is essential to a just and fair disposition of a judicial or administrative action.

Dentists shall avoid placing themselves in a position where personal or professional interests may conflict with their duties as expert witnesses. Dentists shall also avoid using information learned as expert witnesses for personal gain or advantage.

If a dentist accepts a request from an attorney to provide an expert opinion about a person who is not a patient of the dentist, the dentist shall not accept that person as a patient into his or her practice until the litigation or other proceeding, if any, involving that person has concluded.

A dentist has the right to speak out against any policies espoused by organized dentistry, provided the dentist does not misrepresent such policies. It is unethical, however, for dentists to represent their views as those of the dental society or as those of the majority of the dentists of the community when, in fact, those views are opposed to those of the society or the majority of dentists in the community.

A dentist has the right to make fair comment with respect to dental health subjects, including dentists and the quality of dental care delivered and costs related thereto. However, it is unethical to publish, cause to be published or encourage the publication of comments on such subjects if the dentist does so without having sufficient information that would justify a reasonable dentist to believe the comments to be true. The burden shall be on the commenting dentist to produce the evidence upon which he/she based those comments and to establish therefrom that a reasonable dentist would be justified in believing the comments to be true. For the purposes of this section, the word "publication" means any form of communication, including, without limitation, the press, radio, television and lecture.

Section 21. Rebates, Split Fees and Other Fee Arrangements

A dentist may not accept or tender "rebates" or "split fees." Other fee arrangements between dentists or other persons or entities of the healing arts which are not disclosed to the patient are unethical.

Section 22. Discoveries, Patents and Copyrights

Patents and copyrights may be secured by a dentist provided that such patents and copyrights shall not be used to restrict research or practice.

Section 23. Health Education of the Public

A dentist may participate in a program of health education of the public, involving such media as the press, radio, television, and lecture, provided that such programs are in keeping with the dignity of the profession.

1. A third party is any party to a dental prepayment contract that may collect premiums, assume financial risks, pay claims, and/or provide administrative services.

2. Notwithstanding any ADA Principles of Ethics and Code of Professional Conduct or other standards of dentist conduct which may be differently worded, this shall be the sole standard for determining the ethical propriety of such promotional activities. Any provision of an ADA constituent or component society's code of ethics or other standard of dentist conduct relating to dentists' or dental care delivery organizations' advertising, solicitation, or other promotional activities which is worded differently from the above standard shall be deemed to be in conflict with the ADA Principles of Ethics and Code of Professional Conduct.

Author Guidelines

Journal of the California Dental Association

INTRODUCTION

The *Journal of the California Dental Association* is a publication of the California Dental Association. Monthly distribution includes the member dentists of CDA, students and libraries of all California dental schools, and subscribers worldwide. Circulation exceeds 18,000. In addition, manuscripts appearing in the *Journal* are published on CDA's website, CDA Online. The *Journal* features scientific research, reviews of the literature, treatment techniques, practice management, legislation, professional guidelines and news.

EDITORIAL POLICY

The *Journal* is published under the supervision of the CDA Communications Department. Neither the staff, the editor nor the association is responsible for any expression of opinion or statement of fact contained in published manuscripts, all of which are published solely on the authority of the author whose name is indicated. The editorial staff reserves the right to edit all manuscripts to fit within the space available and for conciseness, clarity and stylistic consistency.

Articles will be considered for publication on condition that they are submitted exclusively to the Journal. The principal author will be notified of final status as soon as possible following submission, general within 90 days. Unused manuscripts and illustrations will be returned.

All manuscripts will be reviewed anonymously. The reviewers will be chosen from the consultants list of CDA's Council on Dental Research and Developments. Decisions to accept, reject or request a rewrite will be based upon the reviewers' recommendations.

MANUSCRIPT/ILLUSTRATION PREPARATION

All manuscripts must be typed or printed, double-space, on one side of 8½ x 11 inch white paper, with at least one-inch margins on all four sides. An abstract should be included. If one is not supplied, CDA staff will prepare one.

Manuscripts should not be less than 1,000 words (approximately four pages) nor more than 5,000 words (approximately 20 pages).

Authors who have prepared their manuscripts on computer should also submit a disk with the hard copy. The manuscript should be saved in Word for Windows 1998 or earlier, and the disk should be labeled with the file name and format used.

Moderate use of illustrations and photographs is encouraged. They should be submitted as prints, 35 mm slides, JPEGs or TIFFs. Two sets of hard copies must be submitted, regardless of original format. JPEGs or TIFFs should be individual files (one per image) that are not embedded in any other program. They should be at least 300 dpi at 2 inches wide. Illustrations and photographs should be numbered in the appropriate sequence in which they relate to the written text, and the top (and front on slides) should be clearly marked. The author's name should not appear on the illustrations.

A cover sheet with the manuscript title, author's name, address, fax, phone and e-mail must accompany the manuscript. The title should be kept short; a lengthier subtitle may be used if necessary. CDA reserves the right to shorten titles.

References should be selective. They must be keyed to the text and numbered consecutively with their appearance within the text. They should include, in order, name of author, title of article, name of periodical, volume, number, page numbers and date of publication. For books, the name of the publisher and its location should be included. Up to three authors may be listed. For four or more authors, the first two authors should be listed, followed by et al.

Example: White SN, MacEntee MI et al, Restorative treatment for geriatric root caries. *J Cal Dent Assoc* 22(3):55-60, 1994.

AUTHORSHIP REQUIREMENTS

When a manuscript is submitted, included should be a signed statement on authorship responsibility, a statement on financial disclosure, and one of the two following statements on copyright or federal employment. Each of these three statements must be signed by all authors.

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Assessing 'Real Science': Poor Studies, Industry Ties Taking Toll

By Janyce Hamilton

Far too often, scientific studies — subsequently printed in dental journals — are poor[1,2] or influenced by product manufacturers.[3-6] This misconduct is not limited to industry-funded researchers. Some individual and academic researchers also play loosely with the facts.[7,8] Government research is subject to mechanisms of supervision[9] or oversight.[9,10] But in the case of oversight, who is watching the watchdog? Worse, dentists are making clinical decisions and product recommendations based on these studies because they either don't know how to evaluate a study's scientific merit, or are not privy to the industry ties or other motivations influencing its authors. Regardless of the funding source, if a manuscript is well-written, it is virtually impossible to detect fraudulent data within its pages. Whistleblowers[11] and confessions then become the only hope.

This report looks at what constitutes "real science" and at some of the conflicts of interest in dental research and publishing. It seeks answers to the following questions:

- How are dentists doing at evaluating the scientific merit of studies they read?
- Can they trust the information about the products recommended in articles?
- Do pharmaceutical as well as materials, devices, and equipment companies have too much control over how their studies are designed and whether unfavorable findings are published at all?

Searches via MEDLINE, Google, and the ADA Library were combined with interviews to identify the issues around good vs. poor research and the conflicts of interest affecting dentistry and medicine. One interviewee preferred to remain anonymous.

Included are tips for health care professionals to better dissect data, weed out weak studies, and assess whether a research-industry relationship exists in a published study.

Plaguing the health of real science are problems that show no signs of de-

Author / Janyce Hamilton is a freelance writer in Naperville, Ill. Her article "Dental Implications of the Human Genome Project" appeared in the January 2001 issue of the *Journal of the California Dental Association*. For that article, she received the American College of Dentists/American Association of Dental Editors 2002 Prize for Dental Journalism.

creasing. As suggestions for safeguards have emerged in medicine, organized dentistry is finding its footing as sentry of research-industry ethics.

What Is and Is Not Real Science?

It's hard enough for a doctor of dental surgery or medicine to decipher if real science is behind a study, let alone to know the competence and integrity of its lead author. Imagine what the public goes through when they hear the latest dental scare on the news.

With the Internet and nonpeer-reviewed magazines disseminating what appears to be "solid evidence" on the dangers of amalgam restorations, for example, the pubic starts getting more than a little anxious. Policymakers, even congressional representatives[12] — "scientific illiterates"[13] untrained in evaluating real science from junk studies — pass a law, such as California's Proposition 65. Before you know it, dental offices are passing out Dental Materials Fact Sheets to all patients like they are invitations to a party.[14]

Before you know it, dental offices are passing out Dental Materials Fact Sheets to all patients like they are invitations to a party.

Meanwhile, in several other countries, the U.S. science exonerating amalgam risks is deemed an insufficient contribution to the body of evidence. Health Canada — the equivalent of the U.S. Food and Drug Administration — for example, recommends that amalgam not be placed or removed during pregnancy and that parents consider amalgam alternatives in children.[15] In fact, the contraindications to using amalgam are listed by some manufacturers abroad on amalgam package inserts.

And that's just amalgam.

Meanwhile, periodicals such as the journal *Fluoride* look and read every bit as professionally as the big peer-reviewed dental journals. "A publication that has the tone and trappings of science, but is so fundamentally and demonstrably flawed as to lack any serious claim to credibility"[13] is the definition of junk science, according to Marjorie K. Jeffcoat, DMD, editor of the *Journal of the American Dental Association*. Unfamiliar dental terms such as "fluoroporosis" and "toxic fluorification" may tip off savvy readers of a publication's anti-fluoridation agenda. Groups that oppose fluoride, such as the Fluoride Action Network[16] of Burlington, Vt., put articles on the front page of their web sites from well-known newspapers or magazines that seemingly indict fluoride. Take, for example, the headline "Weak Link on Fluoride and Cancer Is Backed" in the *New York Times* in April of 1990.[16,17] It's a good example of don't believe everything you read. The article seized upon unauthorized data released from a Public Health Service National Toxicology Program investigation and reported *inconclusive findings* of a weak association between high fluoride consumption and osteosarcomas in male rats.[18] Fluoride Action Network displays the *Times* article on its web site as if it were the final verdict in the trial of fluoride's carcinogenicity. This tactic of overgeneralization is another hallmark of junk science, according to *JADA's* Jeffcoat, who defines overgeneralization as "when association is confused with causation."[19] The Fluoride Action Network's web site fails to mention — even at this writing in the year 2004 — that the National Toxicology Program subsequently found that the supposed link between high amounts of fluoride and cancer in male rats was deemed inconclusive.[20] Nowhere in the "scientific references" lists of these organizations are the 1991 Public Health Service report,[21] the 1993 National Research Council literature review,[22] the 1999 Centers for Disease Control and Prevention article,[23] or the 2000 National Cancer Institute cancer fact sheet on fluoridated water.[24] Any of those references lay to rest the debate that "credible evidence" has proven fluoridated water causes cancer in humans.

So much for fluoride and "real science."

Caries research confusion is divided much as the country is split between two political parties. In 2003, why did the American Academy of Pediatric Dentists accept a $1 million grant from Coca-Cola to its foundation? Dentists have long pointed to the equation of "sugar + acid = bad news" in dentistry. It is not uncommon for soft drink companies to get cash-strapped schools to sign exclusive pouring-rights contracts. For every bottle of product sold, the schools get money back, which allegedly motivates schools to provide easy student access to pop machines. In 2000, ADA passed a resolution stating its position as being opposed to such contracts. An ADA spokesperson commented that the science suggests excessive consumption of sugar, such as through soda pop, can harm teeth. A National Institutes of Health systematic review[25] supports the philosophy of limiting sugar. But what if the consumption isn't excessive, and it is the consumer who is at fault for overindulging?

"There's no science to bash soft drinks; that's just old-school simplistic thinking. Why has permanent dentition caries declined as sugar consumption and school-age chil-

Table 1

Seven Elements Required in Any Good Clinical Trial.*

1. A clear statement of the objective based on sound scientific rationale, and a description of how the methods of analysis were selected.
2. A design that permits a valid comparison with a control to provide a quantitative assessment of the therapeutic effect. The study design should be described in detail (e.g., duration of treatment periods; whether the treatments were parallel, sequential, or crossover; how the sample size was determined).
3. A method of selection of subjects that provides adequate ensurance that they have the disease or condition being studied.
4. A method of assigning subjects to treatment and control groups that minimizes bias and is intended to ensure comparability of the groups with respect to pertinent variables such as age, sex, severity of disease, duration of disease, and use of drugs or therapy other than the one being tested. The study should describe how subjects were assigned to groups. This is normally accomplished through randomization.
5. Adequate measures must be taken to minimize bias on the part of the subjects, observers, and data analysts. This is normally accomplished through blinding.
6. The methods of assessment of subjects' response should be well-defined and reliable.
7. The analysis of the results of the study are adequate to assess the effects of the drug.

*Source: Adapted from various Food and Drug Administration publications.[27-30]

dren's access to vending machines has increased consistently since 1968?" asks AAPD's past president, professor of pediatric dentistry at Ohio State University, and interim editor-in-chief of the *Journal of Dentistry for Children*, Paul S. Casamassimo, DDS, MS.[26] Casamassimo counters that the peanut butter sandwich on wheat bread in a child's lunch bag may be more cariogenic than the can of pop from the school vending machine that will be washed away by saliva. He let his own offspring eat candy during their childhood, and today as adults their permanent dentition remains cavity-free.

"I see the AAPD as Robin Hood, taking from the rich (Coca-Cola) to fund the poor (AAPD research) to learn about complex caries-carbohydrate comorbidities to help kids," he said."Science is changing, but dentists are holding onto old beliefs."

He urges skeptical dentists to read about the conflicting data on sugar and tooth decay in the 2003 World Health Organization review "Diet, Nutrition, and the Prevention of Oral Diseases."

Web sites such as www.dentalwatch.org and www.junkscience.com point out some of the more typical methodologies that organizations and individuals use to give their research findings the stamp of credibility. Visiting web

Table 2

NIDCR's Division of Population and Health Promotion Sciences Good Quality Research Attributes.*

1. It is ethical and incorporates principles of respect for people (obtains appropriate informed consent), beneficence (does no harm, maximizes benefits, minimizes possible harm); and justice (fairness in distribution of benefits and burdens of research).
2. It adheres to all applicable federal and local regulations and guidelines for clinical research.
3. It is appropriately designed to answer questions that are of clinical importance to patients, consumers, and practitioners.
4. It has a sound biologic rationale.
5. It has appropriate statistical power to detect clinically meaningful results.
6. If it is a clinical trial, it is randomized with patients and clinicians appropriately masked to treatment procedures and outcomes.
7. If it is a clinical trial, it is of appropriate length to demonstrate a clinically meaningful result.
8. The population being studied is representative of those who are affected by the disease or condition being investigated.
9. The results can be generalized to the population at risk for the disease and not just to a very select sample of people.
10. The statistical methods are appropriate for the design of the study.
11. The investigator appropriately discloses any financial support for the study and any financial interests that he or she may have in any products or drugs that are involved in the research.
12. It is published in a highly respected peer-reviewed scientific journal.

*Source: Bruce L. Pihlstrom, DDS, MS, Division of Population and Health Promotion Sciences NIDCR.

sites such as these can be useful in developing and maintaining a critical eye for discerning credible scientific studies.

Studies published in peer-reviewed journals have a better chance of being well-designed, with the results being valid, said Kenneth Burrell, DDS, senior director of ADA's Council on Scientific Affairs. "However," Burrell, cautioned, "readers should always look at any article with a critical eye, since even well-respected, peer-reviewed journals occasionally can publish questionable studies." Burrell provided a "checklist" of what he looks for when assessing a clinical trial in **Table 1**.[27-30]

A clinical trial is one type of research. Bruce L. Pihlstrom, DDS, MS, acting director, Division of Population and Health Promotion Sciences of the National Institute of Dental and Craniofacial Research, had his own list of attributes of good quality clinical research, shown in **Table 2**.

To be safe, dentists should never change what they prescribe or how they treat patients based on a single study.

How Well Are Dentists Assimilating Dental Data?

"Dentists aren't doing very well in general at evaluating studies and assimilating all the data published yearly in the journals on each clinical dental topic," Michael G. Newman, DDS, admitted. Editor of the *Journal of Evidence-Based Dental Practice*, adjunct professor at the University of California at Los Angeles School of Dentistry, and past president of American Academy of Periodontology, Newman said poor dentists are twisting in the wind trying to get the information they need from the thousands of research reports published each year.

"The classic scenario illustrating the problem is when the patient comes to the dentist with a clinical question," Newman said. "For example, 'What do you think about bleaching safety, doctor?' 'I don't know, I'll have to get back to you.' He goes to the Internet with the question and up comes 17,000 articles."

All dentists base their decisions on evidence, but the evidence they use isn't always valid and can't always be generalized. What Newman's journal does is publish reviews on clinical dental questions. An evidence-based assessment involves evaluating whether a study is scientifically sound and if the results can be generalized. See **Box**, this page, for examples of evidence-based dental web sites.

ADA supports the evidence-based dentistry concept,[31,32] as does NIDCR.[33]

"But from the practitioner's perspective," Burrell said, "evidence-based dentistry isn't there yet." Supporting his opinion, Burrell cited that, at this writing, only 72 clinical questions have been answered using evidence-based criteria out of thousands that need to be answered.

World Wide Web Examples of Evidence-Based Dentistry Information*

1. Journal of Evidence-Based Dental Practice

http://www.us.elsevierhealth.com/product.jsp?isbn=15323382

2. University of Michigan Dental Library

http://www.lib.umich.edu/hw/dent/clinical/eb.html

3. Centre for Evidence-Based Dentistry

http://216.239.41.104/search?q=cache:q7BGFbdNB7sJ:www.ihs.ox.ac.uklcebd/+8hl=en&ie=UTF-8

4. The Cochrane Library

http://www.update-software.com/cochrane/

5. The National Library for Health

http://www.nelh.nhs.uk/

*Nos. 4 and 5 are evidence-based medicine sites with dental articles.

Because they help to cull out what might be fraudulent, systematic reviews are desirable for good research. Burrell said ADA can play a role in evaluating the quality of systematic reviews, and summarizing and publishing condensed versions of such reviews along with its findings on the review. "Some reviews are known to be better than others."

ADA members are being surveyed in 2004 to learn which clinical questions clinicians want answered. For all groups conducting systematic reviews, ADA is holding a symposium in August to determine what clinical questions they want answered, and to gauge interest in conducting reviews to answer these questions and determine funding sources for such a cooperative project.

In the meantime, high schools and universities should teach critical thinking as part of the fabric of education in science. "By the time a student begins his or her dental education, it's almost too late," Burrell said. But applying evidence-based dentistry principles through the dental training process is a good way to foster critical thinking.

"Real science" tables and checklists are fine for some. But when Harold Slavkin, DDS, dean of University of Southern California's School of Dentistry, sits down with his dental journals (9,000 dental articles are published worldwide each year), he is able to recognize the real stuff. He looks for the gold standard — results derived from peer-reviewed multicenter, randomized, prospective clinical trials supported by funding that is without real or perceived conflict of interest. According to Slavkin, former director of NIDCR and current member of the Institute of Medicine's Clinical Research Roundtable, "Although the importance of research in dental and medical education has long been recognized, education

of the practicing clinical community about the clinical research process has not received sufficient attention. We must do a better job in education and training to best advance an understanding of the ethical, regulatory, and legal issues of clinical research."

Reading and interpreting real science also requires professional education and training. "Molecular dentistry, the human genome project, and proteomics have opened vast opportunities for translation of basic science discoveries to the chairside and bedside through clinical research. Training at the National Institutes of Health as well as several major research-intensive universities now offer MS and PhD education and training in the principles and applications of clinical research," Slavkin said. "The bar has been raised."

Besides evidence-based decision-making and roundtables, helping to raise the bar of quality research is Consolidated Standards of Reporting Trials. CONSORT (http://www.consort-statement.org/) consists of a checklist and flow diagram for investigators and editors to use to assess quality criteria and standardize reporting when they write and edit trials so that results can be "interpreted both readily and accurately."[34] The failure to use a process such as CONSORT in the past has resulted in some reports omitting information critical for evaluating a study's conclusion, according to Burrell. A study of published trials in journals before and after use of CONSORT tools found that the clarity of reporting improved by 22 percent.[35,36] This "help" has been embraced abroad[1] and by U.S. medical and health journals. In dentistry, the *British Dental Journal* and the *Journal of the Canadian Dental Association* have signed on to these tenets.

"Readers should always look at any article with a critical eye, since even well-respected, peer-reviewed journals occasionally can publish questionable studies."

KENNETH BURRELL, DDS

Always a sentry of research quality, ADA is pushing itself further. Coming from ADA are new guidelines for clinical trial reporting called Standardized Clinical Trial Protocol. A draft of the protocol indicates it will be used to help ADA evaluate clinical studies, including whether there may be financial conflicts of interest.

Industry-Funded Research: A Conflict of Interest?

Are industry ties nourishing or poisoning medicodental research? The popular media and health professions literature are sounding the alarm bells that they are.[37-40] Yet, many argue that industry — from a small dental lab supply company to a giant pharmaceutical maker — have more to lose if they are caught altering records or eliminating data. Their researchers must be just as vigilant as academic, government, and independent researchers in using credible methodology and keeping clean records. Reputation and goodwill take years to build, and companies don't take risking them lightly. Should fraudulent practices such as bribes or falsification of documents be uncovered, the wrath of boards of directors and shareholders and big fines are likely. Jail time is also a possibility — and a strong deterrent.

Dentistry has been flying under the radar when it comes to unethical conflicts of interest for researchers, authors, and lecturers in contrast to the attention paid these topics in medicine. But what's happening in medicine may foretell dentistry's pending predicament.

Following are the good, the bad, and the ugly in medicine's uneasy alliances with industry.

The good. Fantastic drugs, devices, and machinery that have clearly improved clinical practice were borne by industry-funded research fueled by the for-profit motive[41]: gene chips; new technologies to design and more quickly produce vaccines and antibodies against cancer and even viruses or bacteria released for hostile purposes; and more recently, synthetic high-density lipoprotein to flush clogged arteries.[42] In fact, this is how nearly all drugs are "discovered" today.

"Without industry funding, we would have no new products," Newman said. They have so much money at stake that he believes their regulatory departments comply very carefully and try harder than "the little guy" who doesn't have the funding for well-conducted studies.

In fact, the FDA approves only 1 of 5,000 screened compounds.[43] The growing complexity and increased length of trials required by the FDA means that researching, developing and introducing a new drug costs on average $802 million in 2000 dollars.[44]

According to the 2003 industry profile provided by the Pharmaceutical Research Manufacturers of America, U.S. pharmaceutical companies spend more each year on pharmaceutical research and development ($32 billion in 2002) than the total NIH operating budget — an amount that has more than tripled from 1990.[45] NIDCR's slice of the NIH pie is thin, only 1.58 percent of the total budget, according to Slavkin. This may not sound great, but NIDCR offers more

Real Science

funding now than five years ago, he said.

Government and academic researchers are increasingly being lured away from their traditional funding sources and toward industry financiers. Maryka H. Bhattacharyya, PhD, is a senior biochemist at Argonne National Laboratory, Argonne, Ill. Her life's research has been the effects of cadmium on bone loss. While she hasn't looked at bone density loss in the jaws, data analyzed from NHANES III show that postmenopausal women with osteoporosis have double the risk for tooth loss compared with those who don't have the disease.[46] Since 1980, Bhattacharyya has received $12 million in federal funding. Today at age 60, however, Bhattacharyya is in a predicament. Her last five grant proposals to NIH have been turned down. She is discovering that while federal health sciences funding has increased in recent years, in this postgenomic era, the funding trends have moved toward large-center grants that fund multidisciplinary research teams. A researcher just out of school makes perhaps 20 percent to 40 percent more in a biotech industry than one hired by a national laboratory, Bhattacharyya estimated. "As an older researcher, I would not benefit so much (salary wise) from switching to industrial research. Plus, I would have a hard time finding such a position." Her husband, also a scientist, left a national laboratory and formed his own business to continue researching on contract. Bhattacharyya has two patents but never made money from them. So today, she must keep her funding options open, or be jobless. Industry, once viewed as guys in black hats, are today being viewed more as "partners in research" with academia and government, Bhattacharyya reported. As such, for the first time in her career, she applied for funding for a three-year study from Research Management Group, through a program 100 percent funded by Philip Morris Co. The company is interested in the effects of cadmium on calcium loss in human bone because it is present in tobacco leaves.

Industry, once viewed as guys in black hats, are today being viewed more as "partners in research" with academia and government.

She wondered just how her colleagues would react to her pursuit of Philip Morris research. "I mentioned it to several of my colleagues, and they were either being funded by (Philip Morris), or were also applying for it."

Bhattacharyya's first choice is doing federally funded research on a basic science question that interests her. But at this point, she welcomes the opportunity to research questions tied to the health effects of a marketable product — namely, cigarettes. After all, there is that chance that her research would lead to reduced cadmium in cigarettes to lessen potential osteoporosis risks, should such related risks be discovered.

"I feel no pressure to 'get certain results' that will be favorable to Philip Morris' interests regarding hazards associated with smoking cigarettes. I would not change the design of my experiments to get certain results," Bhattacharyya said. Part of her comfort level comes from the safeguard Philip Morris put up of having a separate management group run their external research program, she said.

But are they really separate?

The bad. Drug and material safety trials used to be done at academic medical centers but are increasingly done at private "separate" research centers. "Their only income comes from drug companies that contract with them to do these clinical drug trials, so they really have no independence from the drug companies," said Thomas Bodenheimer, MD, MPH. He practices part-time at a low-income California clinic on Valencia Street in San Francisco. Besides being known as a clinical professor at the University of California at San Francisco School of Medicine, Bodenheimer has gained a reputation as a national correspondent for the *New England Journal of Medicine.* He lectures on the extent of pharmaceutical industry influence on the design of clinical trials, and how often studies with negative outcomes are suppressed.

How widespread are industry ties in research and publishing? The February 2002 *Journal of the American Medical Association*, reported that "90 percent of authors of clinical practice guidelines received research funding from, or acted as consultants to, a drug company." Are these authors at fault for such uneasy alliances? They may not be. More than half reported that there was no formal procedure for reporting these relationships to the publication or their affiliated institution. The thinking goes like this: "If there are no rules on it, it must be OK."

A 2002 editorial in the *Lancet* bemoaned that independent U.S. medical journals are publishing biased articles: "Industry may have delivered a fatal blow to a laudable enterprise: The bias that industry has injected effectively demolished the foundation upon which public and professional trust had been built."[47]

Bodenheimer is not alone. There's a courageous cadre of

health care and allied professionals, including the former editor of the *New England Journal of Medicine,* who oppose practices that bring medicine into disrepute. They are concerned that the situation is out of hand, and speak out in lectures and articles.

The response seems to be more of a ripple than a roar.

Research on research integrity sparse. An exhaustive review in 2000, "Assessing the Integrity of Publicly Funded Research," sponsored by the NIH Office on Research Integrity and other organizations, confirms that research on research integrity is relatively sparse in medicine. In dentistry, it's almost nonexistent.

A 2003 systematic review looked at eight articles that studied industry-sponsored research results in a total of 1,140 studies. The finding was that the association between study outcomes that favored industry and studies that are industry-sponsored is statistically significant (Mantel-Haenszel odds ratio, 3.60; 95 percent Confidence Interval, 2.63-4.91).[40] There was no statistically significant difference between studies that were randomized controlled trials and those that were not. This is not conclusive proof that negative findings on products are squelched by researchers, however. Other factors, such as publication bias, can favor studies that have positive results, regardless of funding source.[48]

"The bias that industry has injected effectively demolished the foundation upon which public and professional trust had been built."

LANCET EDITORIAL

While it is unfair to pick on industry as the poster child of research misconduct, researchers and authors with industry ties do their share. To be fair, it is important to remember that some university faculty members who want to get tenure may be tempted to fudge data. Some federal or Indian Health Service employees who want to be promoted to a supervisory position could be thinking about plagiarizing. If problems such as these are not acknowledged and better managed by health care leaders — especially when it involves drugs — how can we expect people to continue to volunteer for clinical studies?[49]

The ugly. A survey of more than a thousand postdoctoral fellows about ethical matters related to biomedical research and publishing showed revealing findings on misconduct. Twenty-seven percent said they were willing to select or omit data to increase the chances of getting a grant funded; 15 percent would select or omit data to make publication of their work more likely or benefit their career.[50] Surprisingly, having taken a course on research ethics had no bearing on stated willingness to fabricate data.

"An error of omission is viewed less harshly than the error of commission," said a Midwest cardiac interventional radiologist who preferred to remain unnamed.

Fortunately, documented science, medical, and dental researcher misconduct is rare.[51] But still, preventive strategies and good supervision of researchers is advised by Jane Steinberg, a research integrity officer at the National Institute of Mental Health. Steinberg advises organizations doing research to "inoculate staff against the temptation to find a 'better' way to run the study midstream."[51]

"Human nature cannot be legislated," the radiology physician commented. This same physician explained that he is approached frequently with offers of free trips to destinations such as Las Vegas and other substantial perks. Although he refuses most of them, he said it would be easy to get a company to pay the tab for a fantasy vacation. "I can turn in my airfare and other receipts with no questions asked."

Meanwhile, if this radiology physician wants to invest in stock in the company that makes a product upon which he is doing academic medical research, his teaching university allows this. Harvard Medical School does too.[52,53] If that same company continues to fund grants for the radiology physician to do studies of their product, as well as lavish dinners and golf, this is allowable too. He continues to reinvest his earnings in the company, and around it goes.

Why do we assume a medical researcher is more immune to financial influence than any other person? Why are there not certain conflicts that are not allowed in health research?

One reason for the status quo is that universities don't want to lose prestigious physicians to other institutions with less stringent conflict-of-interest policies, so they don't crack down. In one study of the top 100 institutions receiving the most funding from the NIH, most of these institutions' policies on conflict of interest lacked specificity about which kinds of relationships with industry are permitted and which kind are prohibited.[54] The NIH Office of Extramural Research also reports finding "diffuse policy on and vague statements in conflict of interest policies" in its study of more than 100 policies representing a mix of public and private academic institutions, public and private research institutions, hospitals, and large and small for-profit organizations.[55] But public scrutiny of these ties is increasing[54] If nothing is done by institutions, organizations, or govern-

ment, research standards in the United States could erode further. "Doing something" would include more than having a clear, specific conflict of interest policy — it would mean having an additional policy on management strategies to mitigate or eliminate each type of conflict of interest.[56,57] For example, when does stock need to be sold? When does a new principal investigator need to be named for the study? Does a researcher need to resign from a post before the study will be published? Granted, none of these rules would undo fraud already committed at the research stage. Yet, having policies and procedures at, say, the publishing stage, culls out unethical activities. The potential for author embarrassment could serve to discourage those prone to sleazy practices from submitting their manuscripts, and encourage researchers with twinges of ordinary human greed to ignore temptations to shortcut and "keep it clean."

Publication Problems and Their Prevention in Medicodental Journals

Accuracy alone is a challenge. By the time research makes it into a journal, the resulting article may be the one in four published articles whose abstract does not necessarily accurately reflect what's in the article.[58] One investigator claims providing authors with instructions for abstracts doesn't adequately eliminate abstract deficiencies, but having journal editors assume this responsibility does.[59] Meanwhile, there are some who call for industry ties to a study's author to appear in the "methods" section of the published reports to increase the chances that these conflicts of interest will make it to the MEDLINE abstracts.

Burrell thinks it is unnecessary for industry sponsorship to be in the abstract as long as it is obvious in another area of the paper. "Somewhere in the article it should be revealed," he said. Bhattacharyya says that's a great idea. (The *Journal of the California Dental Association* requires authors to disclose any affiliations with a company that has direct financial interest in subject matter discussed within the article. These are printed in a "disclosures" or "acknowledgments" section.)

Bodenheimer, in a recent *New England Journal of Medicine* article, explained that the pharmaceutical industry's partnerships with commercial research companies to create clinical drug trials is a slick business enterprise on more than one front. Staff writers and independent ghostwriters for these companies are purported to create articles the marketing people tell them to write. The company then convinces academic scientists and physicians to willingly sign on as the "authors" of studies. Why would they do so? Little or no work on their part, and all the recognition in a publish-or-perish environment.

How to tell if a study is funded by industry. If you are reading a journal that has conflict of interest sunshine policies, there are tip-offs that a study is linked with a manufacturer. For instance, a statement in the article says the study is funded by the company or that the researchers received a grant from the company. Or perhaps at least one of the co-authors of the study is affiliated with "a middleman" — a medical education or research firm. This information may be found in the acknowledgements or author biography section of an article.

A journal that fails to reveal industry-funding information should not be relied upon as a sole source of educational information since all the facts are not revealed. It is ill-advised for a practitioner to make any clinical decision without all the facts.

In a study linked with manufacturers, it may be harder for the researchers to be 100 percent financially independent from that product's makers and marketers. This does not mean one should devalue the insights provided by the study. "Companies can support studies to find out if their products work or not. What is important are that safeguards are in place to prevent misconduct," Burrell said.

Organized dentistry and medicine must continue pursuing these issues through talking about them in workshops, publishing articles on conflict-of-interest issues, and updat-

There is Nothing 'Potential' About a Conflict of Interest

*By Marcia Angell, MD**
Editor-in-Chief, New England Journal of Medicine

A financial conflict of interest, I believe, is any financial association that would cause an investigator to prefer one outcome of his research to another. Let me give you an example. If an investigator is comparing drug A with drug B and owns a large amount of stock in the company that makes drug A, he will prefer to find that drug A is better than drug B. That is a conflict of interest.

Note that it's a function of the situation, not the investigator's response to it. If the investigator then finds that drug B is better, he may swallow his disappointment and report the facts objectively — or he may not. Thus, there is nothing "potential" about a conflict of interest. Either it exists or it doesn't. What is potential is whether a conflict leads to bad research.

*Excerpt from a speech delivered at the HHS Conference on Financial Conflicts of Interest, Aug. 16, 2000.

ing their policies to self-police, or government watchdogs may further intervene with legislation.

Currently, it is not possible to assess the degree to which a researcher-industry relationship is problematic, so scrutiny of study design is advised. Research has found that some companies have been known to design studies in a way that favors their products.[41] To brush up on the methods some companies may use to produce desired results, worthwhile reading is an article by Bero and Rennie that catalogues some of these methods.[60]

Even industry-sponsored placebo-controlled trials for a new drug for persistent asthma (a life-threatening and debilitating disease) has suffered from numerous and serious ethical flaws.[61] If that's how industry treats asthma, what's to say they won't be more bold on claims, and lax on research and reporting standards, when it comes to periodontal disease?

The suggestions provided in the first half of this article provide several suggestions for how to prevent being duped by poor research.

Industry-supported and -sponsored research in dental journals. "Industry-supported research can be superb in every way," Slavkin said. "Major pharmaceutical companies very often sponsor outstanding clinical studies. The devil is in the details."

The details hidden from view may or may not reflect ethical abuses. If dentistry continues to shine more light on such details, it will spare its reputation from going through the meat grinder of public opinion.

If dentistry continues to shine more light on such details, it will spare its reputation from going through the meat grinder of public opinion.

According to John Kanca, III, DMD, editor-in-chief of the *Journal of Esthetic Dentistry*, "Abuse invites regulation."[62] Kanca is one dentist who is unhappy that air abrasion is used to diagnose caries in stained pits and fissures without "definable data to establish an epidemiological basis." Yet, where are the systematic reviews proving either effectiveness and safety or just the opposite? They haven't been done yet, and that's the challenge.

As a result, dentists' individual skills and experience on this and other clinical issues will continue to be valued as much as any study. Most of the time, dentists conservatively implement trial and error in treating their patients with newer products and ideas to make incremental improvements by themselves. By the time the research-publication lag has caught up with them, they already know what works for their patients.

As a guardian of the profession, ADA's Principles of Ethics and Code of Professional Conduct calls on dentists to disclose to readers (of articles) and participants (in seminars) any "monetary or special interest the dentists may have with a company whose products are promoted or endorsed in the presentation."[63] Of course, a lawyer could advise a researcher how to work around not "promoting" or "endorsing" the product they are researching. Regardless, this is a noble effort by the profession's leading organization to light a pathway for those in the dark on this issue.

JADA reveals conflict of interests — such as sources of research support and industry affiliations — with a disclaimer in a "prominent and accented position" in the article.[63]

Research of health care literature may clear up whether problems result if these affiliations are not specifically included in journal articles' "methods" sections. In theory, placement in the "methods" section would increase the odds that this information makes it to MEDLINE, which usually only includes article abstracts. Yet we live in a world where some researchers are not scrupulous enough to access the full text and instead cite research results by reading abstracts only. This makes it clear that the responsibility for ethical values rests with the individual as much as it does within the policies of organizations, academia, government, and publications.

What about when a dental education company hired by the dental equipment manufacturer (much like pharmaceutical companies hire research companies) uses ghostwriters to say what the equipment company wants? Medical education company affiliations are often perceived to be "separate," even though their funding depends on keeping their equipment manufacturer client happy. More research is needed into whether any influence actually results when these subcontractors — independent entities on paper — are hired by industry to do research, writing, and education.

Slavkin, Burrell and Jeffcoat contend that the threat of harsh penalties that could result from fraudulent research and authorship practices is a big deterrent. So while attorneys are helping their clients parse what they can get away with, dental researchers need to be reminded that fraud can qualify as a criminal act, and that medical researchers have landed in jail for this.

Lisbeth Maxwell, editorial director of JADA, had this comment: "I truly hope none of our authors has succumbed to this

temptation — but if any have, they are in the minority. I have found dentists to be scrupulous." JADA's policy to instruct its authors to adhere to the 2001 Uniform Requirements for Manuscripts Submitted to Biomedical Journals helps it to zero in on affiliations that require a closer look.[64]

Summary

Preliminary research is still done by academic researchers. The expense of designing and conducting a good clinical trial by today's standards (i.e., a multicenter randomized controlled trial) has resulted in academic institutions not being able to afford to conduct such studies. Therefore, research on dental products and drugs is often funded by the companies that have the potential to profit off their success. This is a trend, and there is good that comes from this. With plentiful funding, for instance, a study's sample size may be larger and the equipment used may be cutting edge compared with what could be mustered by a lone university researcher assisted part-time by two dental student interns.

Stories of industry hijinks such as controlling study design, storing the data and refusing to release it to the study's researchers, writing the manuscript and then only allowing portions of the results to be reported, continue to make the news. Whether factual or fictional, these stories are fueling the conspiracy theories of compromised research integrity.

Research shows financial backing from a company introduces a conflict of interest in a study because the arrangement may reduce the independence of the investigators. Subconsciously, a researcher may feel an allegiance to the funding source. Meanwhile, a contracted research or education company doesn't want to upset its clients, or it would go out of business in a competitive market. Thus, they may be consciously designing the study as directed by the companies, for the purpose of finding the findings desired. These biases on the part of the researchers cannot be used to vilify industry funders. To be fair, they are researcher issues.

Companies are not alone in doing pretesting in internal pilot investigations before a full-blown study to avoid wasting money on trials that are unsuccessful at producing desired results. Because of this, there is evidence that negative findings on drugs, devices, products, and machinery are less frequently published. Are disclosure laws on study results needed to protect the public? If a telemarketer can be fined $10,000 for interrupting someone on the do-not-call list who is watching TV, shouldn't a research team be fined something for halting studies "not going well," and for subsequently failing to mention the dangerous side effects found with the product if used under certain circumstances?

To quiet the controversy, perhaps leaders in industry, academia, government, and publications need to create clearly written researcher and author policies with defined do's and don'ts. Additional articles on managing research and publication conflicts of interest are welcome in the dental literature. Combined with the recent move in organized dentistry to request that researchers follow certain clinical protocol, this would bode well for the profession. They would serve as evidence that dentistry is a health profession that has a working compass that continues to point toward justice. It will take discipline to use self-determination to follow the ethical road becoming less traveled.

Ideally, studies of all funding source types will try to utilize researchers employed by dental schools to control the design, implementation, data analysis and publication. Whether industry scientists, commercial research companies, academic, government, or individual researchers are at the helm, publication editors should hold their manuscripts to strict methods CONSORT standards.

Dentists should seek to learn more about evidence-based dentistry, and heed the advice from ADA Council on Science reports on what is clinically trustworthy.

Conclusion

Is real science endangered?

While industry ties and weak studies are perceived by some to be taking a toll on dental research, Burrell does not seem worried. He said that he uses skepticism to protect against poor science. "A healthy attitude might be that all research is guilty until proven innocent. It doesn't matter if it's from industry, academia, government, or an individual."

"The ADA knows that fraud exists in research and publications," Burrell said. "We are on it, and we're doing something about it to protect you." CDA

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Debra S. Finney, MS, DDS

Uniting Our Community

Following is the text of Dr. Finney's incoming president's speech to the 2003 House of Delegates, given Nov. 9.

Today, I applaud you, the delegates and trustees of the California Dental Association. I applaud you for making a significant change in the leadership of this association.

Never before has a woman held the office of president of CDA. Never before has a dental hygienist been president of CDA. I have not been a component president, a delegate or a trustee. I did not come into this office by the traditional route.

I represent not only a change in leadership but also a change in the pathway to leadership in our organization. The trail has been blazed for any of you or any member of CDA with the desire and commitment, to serve as a leader in CDA – leadership is not an exclusive club.

You had the courage to make a change. Change requires courage because change involves risk. But, if you don't risk anything, you risk even more.

Change is what our association must do to stay current, to lead the way for our profession and those we serve. As we pass the baton from leader to leader, we often do so without a lot of thought. We simply do what has been done. We model those before us just as we have modeled our parents and teachers.

We turned out all right didn't we? CDA is functioning all right isn't it? Dr. Bowen White in his book titled, *Why Normal Isn't Healthy* suggests that while "all right may be normal, it is not the same as healthy."

How do we move from normal to healthy? With advances in technology constantly modifying our environment, immigration continuously altering our demographics and elections transforming the political atmosphere, how do we assure that our association will continue to be relevant to our members in the face of such significant change?

Most importantly, by "Uniting our Community." (slide) This is the theme or the focus that I have chosen for the next year. Our community, the dental community, is increasingly diverse. Yet we are more similar than we are different.

If we unite our concerns and our resources, I believe that CDA can become the pre-eminent dental community in the world. We can go from *Good to Great* as Jim Collins writes in his book with the same title.

We already have some of the attributes of a great company. The first, according to Collins, is what he calls Level Five Leadership. Surprisingly, leaders of the top companies are not high-profile celebrities but unassuming individuals with a strong sense of professionalism. That is the type of leader we have in our executive director, Peter DuBois.

One of the most rewarding roles I have had with CDA was to participate on the committee to select a new executive director last year. The committee members, Dr. Dennis Kalebjian who served as chair and Drs. Marv Scott, Steve Chan, Gerry Gelfand, Brian Scott, Dave Gaynor and I were well aware of the magnitude of our task.

We knew that we didn't need to find an executive director for CDA; we needed to find the right executive director for CDA. We agreed at the outset that we would settle for nothing less even if that meant not selecting someone at that time. We were indeed fortunate to secure the right person

We can go from *Good to Great* as Jim Collins writes in his book with the same title.

and that decision is confirmed everyday.

Peter DuBois has been demonstrating another characteristic of companies that have gone from good to great. That is by first determining who and then what. Jim Collin's research showed that great companies first got the right people in right seats on the bus and then determined where to drive it. Great vision without great people is irrelevant.

When Peter joined CDA last March, he recognized that we had great people already on board at CDA even though some of them may not have been in the right seats. One of the great people Peter brought on board is our very capable CFO, Mark Soeth.

Another quality that great companies exhibit is identifying not what they are good at but what they can be the best at, and just as important, what they cannot be the best at. It requires discipline to stop doing things but a "stop doing" list is just as important as a "to do" list.

This House is considering resolutions to discontinue the Direct Reimbursement Committee and the Communications Committee. Next year you will consider additional proposals for governance changes. Remember, "normal isn't healthy."

United, we can identify not only where change needs to take place, but implement it and embrace it. While we may change our goals and objectives, our culture and structure, we must preserve our core values and our mission. They represent our common bond.

The stakeholders in our community are numerous. We have dentists, dental specialists, dental educators, allied dental health personnel, gender-based associations, generational groups, multicultural societies and different practice modalities.

We have recently made significant strides in connecting these groups. Let me identify some of the ways we have already begun to unite our community.

Starting in our own CDA family, during the past year we formed a task force to study our subsidiary companies and determine if there was an alternative structure that would enhance the efforts of TDIC and 1201. The recommendation of the Task Force: unite the companies.

In August, for the first time ever, at our invitation, Russ Webb and I met with the president and president-elect of the California Dental Hygienists' Association at CDA. We discussed how we could enhance communication between our associations and collaborate our efforts for endeavors such as the California First Five Initiative.

While we may change our goals and objectives, our culture and structure, we must preserve our core values and our mission. They represent our common bond.

In 2000 we formed the Inter-organizational Affairs Committee, recently renamed the Dental Forum. It consists of representatives of the Arab American Dental Society, the Armenian Dental Society, the Association of Filipino Dentists, the Association of Black Women Dentists, the California Association of American-Vietnamese Dentists, the Chinese-American Dental Society, the Coalition of Foreign Dental Graduates of California, the Hispanic Dental Association, the Indian Dental Society, the Iranian Dental Association of California, the Korean Dental Association, the Latin American Dental Association, the Lebanese American Dental Association, the National Dental Association, the American Association of Women Dentists and more.

The Dental Forum has been meeting three times a year. It is an enthusiastic group and continues to attract new members.

In an effort to connect with dental education, the executive committee meets biannually with the deans of the five California dental schools. Together, we are currently working on licensure reform and reducing student debt. We are considering a proposal by Dr. Slavkin, dean of the USC School of Dentistry, to form a California alliance for oral health research.

Now let me tell you about what we have planned to advance our efforts to unite our community.

In past years, we have started the year off with an executive committee retreat to plan for the coming year. In January 2004, the executive committee will meet with CDA senior staff to identify our strategic objectives for the next two years. Consequently, the plan will already be set for 2005 when we enter into the budgeting process.

The executive committee retreat has been renamed the "CDA Family Retreat" as representatives from TDIC, 1201 and the CDA Foundation will join us. We want to share our goals with the rest of the family and identify ways we can work together and support each other in the execution of our strategic plan.

In February, we will hold the annual leadership conference titled "Limitless Leadership: The Strength of the Dental Community" for interested CDA members and especially for those in component leadership positions.

In April, at the Anaheim Sessions meeting, we will try something new: A general session for all attendees, a tribute to the dental team. Erin Gruwell will be speaking about how she united

a classroom of teenagers with no hope for their future into a group of published authors.

Their journey and their book *The Freedom Writers Diary* is the basis for a motion picture that will be released next summer. Please join us in Anaheim, if for no other reason to hear this incredible story of how lives can be transformed.

In addition, we are planning a pre-session day for oral cancer screenings. We will work together with allied dental health personnel, dental students and dental educators to screen and educate for oral cancer.

At the Fall Sessions in San Francisco, we are planning a pre-session event called "Uniting our Community: A Celebration of the Dental Profession." We will have a keynote speaker from the Multicultural Healthcare Group and will include tracks for classes related to gender, generational, cultural and practice diversity as well as leadership.

We need to pay attention to diversity, but we must focus on how we are all alike and what we have in common. That is what brings us together.

United, we have greater resources, greater influence and perhaps most importantly, greater vision. Vision is our future and our vision is gleamed by environmental scanning.

We do this through staff and leadership who constantly explore the horizon to identify trends and their possible implications to our profession. With the technology available today, the resources are limitless. We look to other associations, network with other leaders, read publications on management and leadership.

Through environmental scanning, we know that we are on the threshold of a crisis in dental education due to escalating costs and lack of faculty. We also know that we have opportunities to provide assistance such as the national endowment for dental education. Dr. Dugoni has been advocating for the endowment for years and now is spearheading that effort.

We know that our licensure process has serious problems, which must be addressed. We know that there are alternative licensure models being utilized such as the PGY-1 in New York state that grants a dental license to those completing a post-graduate residency.

We need to pay attention to diversity, but we must focus on how we are all alike and what we have in common. That is what brings us together.

We know that we have a healthcare crisis, especially in California where 6 million children have no dental insurance. We know that the recent cuts to the adult Denti-Cal program have exacerbated the problem.

We know that there are programs all over our state like the Su Salud Clinic in Stockton, La Clinica in Oakland and many others, that are making a difference. We know that together we can make a greater difference.

Environmental scanning tells us that we must streamline our governance to be the most effective we can be. We must create opportunities for our younger members. We must engage the Gen-Xers who are skeptical and value freedom as well as the millennials who are realistic and value meaning. We know that what they value least in organized dentistry is structure, yet they want to be included.

We must be proficient at environmental scanning to stay current and relevant. Environmental scanning helps us identify our challenges so we can strategize for success. It helps us create the future while managing the present.

Our members often tend to focus on the present. They are concerned about how CDA is advocating for them on legislative and regulatory issues. They look to CDA as an informational resource.

Advocacy and information are two of the services an association should provide according to Dr. Jim Bramson, the executive director of the ADA. The third thing associations should provide, he says, is community. There is that word again, "community."

Why do we need community? In the book "*The Community of the Future,*" a collection of authors has written about the value of community.

Communities often form around standards and traditions and require conformity. But many of the authors agree that the thriving community of the future must value both freedom and connectedness and not fixate on form and structure.

We can accomplish this by focusing on the heart of the community – what matters, what brings us together and what we can do together. Shared vision is the single most important factor in building bridges to the future. When we have clarity of purpose boundaries disappear and diversity flourishes. Together we can reach new levels of possibility.

Each of you is a volunteer in this organization and every one of you has some stewardship or personal responsibility to improve our community.

I encourage each of you to be a spokesperson for CDA. Each of you needs to participate in environmental scanning by scanning your horizon and bringing the information back to this

meeting. We need to create the opportunity for you to do that – and we will.

If each of us, each delegate, each trustee and each officer called just one member a week over the next year we could connect with over 13,000 of our members. Think of the impact it would have and the sense of community we could create.

I intend to make those calls and I ask each of you to do the same. Let's find out what is important to our members, what they think CDA does and doesn't do for them. Let's ask them what we can do better.

Communities of the future will have intense competition for members and face greater challenges in retaining members. They will be communities of choice. Let's help our members continue to choose CDA. We need community as we move toward the future, into the unknown

However we operate and however we're structured, we must always maintain relevance to our members. We will have to be flexible and responsive to our members' needs.

The traditional standards of leadership that may have been acceptable in the past will not lead to success in the future. So let's stop perfecting the past and start preparing for the future. You are the leaders of the future.

The journey begins just beyond where we can see and is limited only by our imagination. The gap between what can be imagined and what can be accomplished has never been smaller.

As Mahatma Gandhi said, "The difference between what we are doing and what we're capable of doing would solve most of the world's problems. Let us become the change we seek in the world."

Is change necessary? Without a doubt. Is it risky? Absolutely. It requires courage (slide) but "courage is the most important of all virtues. Because if you haven't courage, you may not have an opportunity to use any of the others."

Leaders challenge the process. I am ready for the challenge and I hope you will join with me.

I am here to serve you this year and I thank you for this opportunity and the gift you have given me. You have given me the gift of your confidence. You have placed your trust in my ability to lead our association for the next year.

I treasure this gift and pledge to work with you to lead us not only forward but also upward. Together (slide) we can go from normal to healthy, from good to great. Together, we can improve oral health care. CDA

Dennis M. Kalebjian, DDS

Moving to a New Rhythm

Following is the text of Dr. Kalebjian's outgoing president's speech to the 2003 House of Delegates, given Nov. 8.

When I last stood before you, I spoke of composing a plan, of creating organizational rhythm, of producing a balanced "sound" for CDA. I spoke of how the music of our profession would play. *Since then, there has been the sound of music!* I am happy to report that our members and a significant number of non-members have begun to hear the clear melody of the California Dental Association. Today, it is especially relevant to remember the classic Rodgers and Hammerstein musical entitled "*The Sound of Music*" for within the story is a scene when the VonTrapp family members conclude their final performance. One by one, they step from the performance stage, and in the dark of night prepare to leave the homeland. Today the CDA family begins the final performance of the CDA year. While none of us has any plans to leave the homeland, it will be time for me to step from the CDA stage on which I have had the privilege to be. I am grateful for the opportunity, and ready to repeat the lyrics and song of the VonTrapp family. *However,* before I do, let us reflect for a moment on where we were, and where we went during 2003 ...

The year began with more questions than there were answers, and among some individuals, there was more doubt than confidence. There was uncertainty and a list of unresolved issues. However, to CDA's credit, there was an ingrained organizational optimism.

The first three months of the new CDA year brought closure for two important areas of activity within the association. Settlement was finally reached on the Proposition 65 consumer notice after two years of protracted legal involvement. Secondly, the seven-member Executive Director Search Team concluded its seven-month effort on a foggy Sacramento day in January. The board hired Mr. Peter DuBois as the new CDA Executive Director. It was very soon thereafter that volunteer leadership began to spend quality time on the priority issues that define the profession and not on matters of management. Suddenly, CDA began to function with an organizational rhythm! The Board of Trustees quickly acclimated to the new focus—discussing issues such as the statewide peer review process; a global approach and strategy regarding amalgam and wastewater; and, professional ethics.

The subsequent organizational direction has been outstanding:

- Dr. Dave Famili has led development of a stronger statewide peer review process,
- Mr. DuBois has promoted an amalgam strategy collaborative with the ADA, and
- Finally, 10 demographically diverse CDA members will fashion an Ethics Code that is not only relevant to the 21st centu-

The year began with more questions than there were answers.

ry, but also worthy of full enforcement by **this** association. CDA **is** the trusted source. Never forget that the U.S. Supreme Court gave us the victory and the ability to remain the trusted profession. *Now it is up to us to carry out that charge.*

As the year progressed and the external legislative agenda unfolded, the association was reminded that in today's world—nothing is ever easy. The Restorative Techniques (RT) examination as a separate gateway for licensure was sunset in good faith (and hopefully for the final time). On another front, an effort to place dental assisting scope of practice into legislation was pre-empted with regulatory action by the Dental Board of California. Next year, CDA will commit further time and effort to establish the appropriate dental assisting duties into statute. At the same time, we will continue to protect on-the-job experience as a training alternative for dental assistants, preserving an important avenue of entry into the dental workplace.

In 2003, we also learned that the added twist of the recall of a governor, coupled with a $38 billion state budget shortfall creates added challenges. Substantial volunteer and staff resources were consumed in the effort to save the adult Denti-Cal program. A special CDA workgroup analyzed every proposal, and we even came up with a few on our own. In the end, adult Denti-Cal was preserved, but with mixed results accompanied by DHS regulations, which jeopardize provider participation. **Access to care again becomes the issue**.

The same mixed result was true with CDA-sponsored legislation to allow debt-burdened dental students an opportunity to acquire an interim license to practice hygiene. There was unanimous support from the Legislature, but in the end, it was derailed by recall politics. Next year we will watch a new governor and we will watch the 2004 World Olympic games. In matters of good legislation (such as AB539), we are hopeful that the Olympic games will be the *only* games observed by Californians.

In matters of good legislation (such as AB539), we are hopeful that the Olympic games will be the *only* games observed by Californians.

As the year progressed, CDA was also introspective. A special project was undertaken under the auspices of CDA Holding Company. A committee of 10, in consultation with PriceWaterhouseCoopers, considered alternative scenarios to enhance efficiencies of the 1201/TDIC relationship. The 1201/TDIC Organizational Strategy has been advanced and offers strategic and operational benefits for your serious consideration.

Last but not least, your association has considered licensure alternatives, which have potential to refocus energy and resources that will improve our profession. The team created to respond to last year's House resolution 26RC was broadly chosen. It was placed under the guidance of Dr. Stan Surabian and the Council on Education and Professional Relations. If we are truly **here to seize the moments that define us and the profession**, then we must say "**No**" to an out-of-control licensing process which finds patients, and auxiliaries leveraging their services to the highest bidder; we must rethink the arbitrary benchmarks of current testing practices; we must reject our parallel with cosmetology as the only professions to use live patients for licensure testing; and finally, we must question how exactly it is that the current process "protects the public."

We would do well to cast aside the status quo of 70 years, and incorporate validity, not chance; respect, not burden, into the process, which introduces hard-working, bright, young professionals into dentistry. **I urge you to seize this moment**.

Ladies and gentlemen, add to my list conferences and sessions, ADA programs, for-profit subsidiaries, the CDA Foundation, Cal-DPAC, and there you have the essence of the 2003 CDA year. For many in the cast, the year felt like a performance without an intermission—but the "show must go on"—and it did. It went on because of the spirit of volunteer leadership, the administrative know-how of our talented executive team, the committed and dedicated staff we enjoy at all levels.

How was our performance in 2003? Perhaps, performance is judged by a net change in membership, or measured by the stabilization of membership dues. Maybe it is judged by advocacy, which improves the practice environment, or just measured by the public perception that CDA is the "trusted source." Whatever the case, whatever the final judgment, we are poised for the final act, known as the 2003 House of Delegates.

As we play out that final act this weekend, we begin with a curtain call of the 2003 cast. Importantly, it is *not* the lead actors or actresses who are front and center, who always deserve the curtain call crescendo of applause, *but all of you* who work hard at your components and represent all members of this fine association. You hold their proxy on the future of this profession. I invite you now, as part of the cast, to listen to the music, and draw your own conclusions about "The Performance of 2003" and the future of dentistry. CDA

Debra S. Finney, MS, DDS
President

After a year as president-elect, Finney advances to the position of president of the association. She had served one year as vice president and two years as treasurer. Prior to becoming treasurer, she was on the Council on Education and Professional Relations. She was chair of that council from 1994 to 1998.

She has a long history of service to professional associations. She is a delegate to the ADA House and has served on the Executive Committee of the American Association of Dental Schools and as president of the Alaska Dental Hygienist's Association.

Finney received a bachelor of science in dental hygiene from Idaho State University and a master's in oral biology from the University of Washington. She acquired her DDS from the University of Pacific Dental School in 1986 and received a certificate in periodontics from the University of Texas at San Antonio. She is a diplomate of the American Board of Periodontology, a fellow of the Pierre Fauchard Academy, the Academy of Dentistry International, and the American and International Colleges of Dentists.

Finney maintains a private periodontics practice in Folsom. She and her husband, Koos Prins, PhD, have four children.

Russell I. Webb, DDS
President-Elect

Webb becomes president-elect after one year as vice president, two years as secretary and five years on the Board of Trustees.

His volunteer positions with organized dentistry have included being a member and chairman of CDA's Strategic Planning Committee, chairman of the ad hoc Committee on Diversity, and chairman of the CDA Council on Membership Services. As a result of his Executive Committee position, he has been a member of the TDIC Board of Directors for three years. He is also a delegate to the ADA House and has been a member of the ADA Council on Membership.

His memberships include the Pierre Fauchard Academy, the American and International Colleges of Dentists, Omicron Kappa Upsilon, the International Congress of Oral Implantologists, and the California and American Associations of Oral and Maxillofacial Surgery.

Webb received his bachelor's degree and DDS from the University of California at Los Angeles. He also received a certificate in oral and maxillofacial surgery from UCLA Hospitals and Clinics.

Prior to his dental career, Webb competed internationally in water polo, winning a bronze medal as a member of the U.S. Olympic team in 1972. He recently was inducted into the UCLA Athletic Hall of Fame.

Webb maintains a private practice in Upland, Calif. He and his wife, Kathleen Lynn, have two daughters, Tiana and Leahe.

Dennis W. Hobby, DDS
Vice President

Hobby becomes vice president after two years as treasurer and enters his eighth year on the Board of Trustees. He has also held positions on the Council on Legislation, Issues Work Group and Screening Committee and Corporate Operations Task Force.

Hobby has held several positions with the Stanislaus Dental Society including president. He has also been active with The Dentists Insurance Company, recently serving on its Board of Directors as well as the Board of Directors of 1201 Financial & Insurance Services. He also chaired the Finance Committee for 2002-2003.

His memberships include the American College of Dentists and the Pierre Fauchard Academy.

He received a bachelor of science degree at the College of Notre Dame and his DDS degree from the University of the Pacific.

Hobby is married to Caroline Low-Hobby, PharmD, and has two children, Alyssa Marie and Alexander Michael.

Donald M. Schinnerer, DDS
Treasurer

Schinnerer joins the Executive Committee as treasurer. He has held numerous professional offices with groups that include the American College of Dentists, Northern California Section; TDC/TDCIS board member and chairman; CDA Holding Company, Inc.; and the Dentists Insurance Company of which he recently was chairman of the Board of Directors.

He maintains his practice in San Ramon.

Schinnerer will not enter the succession ranks leading to CDA president. The 2002 House of Delegates removed the treasurer position from the sequence of officer ascension to the presidency.

He received his DDS from Northwestern University in Chicago. He served in the U.S. Coast Guard as chief dental officer, Port of New York City, was assistant western regional consultant for the U.S. Public Health Service, and a staff member at the Dental Health Center in San Francisco.

He and his wife Diane have been married for 43 years. They have two children, Amy Creed, 37, and John Schinnerer, 36, PhD, both of Alamo, as well as six grandchildren ranging in age from 3 to 12.

Ronald B. Mead, DDS
Secretary

Mead is continuing as secretary after numerous years on the Board of Trustees. Mead's service with CDA has included being chair of the Screening Committee, a delegate to the ADA House, and a member of the 1201 Financial & Insurance Services Board of Directors. He has also held several positions with the Central Coast Dental Society, serving as president for 1989-90.

His memberships also include the American Association of Oral and Maxillofacial Surgeons, the American Dental Society of Anesthesiology, Omicron Kappa Upsilon Honor Dental Society, the Pierre Fauchard Academy and the American College of Dentists.

He has been in private practice as an oral and maxillofacial surgeon for more than 20 years.

Mead received his DDS from Loma Linda University School of Dentistry. He did his general practice residency at the Naval Regional Medical Center in Oakland, Calif., and his residency in oral and maxillofacial surgery at Highland General Hospital, also in Oakland.

His son Chris is a journalism major at Colorado University in Boulder, and his daughter Alison lives in the Bay Area.

Dennis M. Kalebjian, DDS
Immediate Past President

After a year as president, Kalebjian moves into the immediate past presidency. He has served CDA in many capacities, including many years on the Board of Trustees, the Finance Committee, and the Executive Director Search Committee. He currently serves on the Council on Legislation, and is on the CalDPAC Executive Board.

Kalebjian has served as a delegate to the ADA House for 14 years. He began his involvement with CDA on the Council on Hospital, Geriatric, and Prosthetic Dentistry, where he served as council chairman for 1986-'89.

A 1978 graduate of the University of the Pacific School of Dentistry, Kalebjian completed a general practice residency program at University (formerly Valley) Medical Center in Fresno. He has been a member of the Fresno-Madera Dental Society since 1979 and served as president for 1988-89.

Kalebjian served as a director for The Dentists Insurance Company for 1999-2000 and is currently a director for the CDA Holding Company Inc. He is a fellow of the Pierre Fauchard Academy and the American College of Dentists.

He and his wife, Paulette, have three children. He maintains a general practice and serves as part-time faculty for the general practice residency program in Fresno.

Matthew J. Campbell, Jr., DDS
Speaker of the House

Campbell continues as Speaker of the House after three years as a trustee. He has also been a delegate for CDA and ADA.

He has a long history of volunteer leadership. He has been active with the Sacramento District Dental Society for 30 years, serving as president in 1998. He has also held positions with The Dentists Company (including chairman for 1997 and '98), The Dentists Company Insurance Services, and The Dentists Insurance Company.

His memberships include the American Institute of Parliamentarians, the American and International Colleges of Dentists, and the Pierre Fauchard Academy.

Campbell received his DDS degree from Loyola University in Chicago and did his general practice residency at Hines Veterans Administration

Hospital in Illinois.

He is active in local sports dentistry, is a founding member of the International Academy for Sports Dentistry, and is the team dentist for the NBA's Sacramento Kings. He also is a multi-year board member and a past chairman of the Sacramento Sports Commission.

Campbell and his wife, Irene, live in Sacramento and have two grown children, Jennifer and Matthew III.

Roddy N. Feldman, DDS

13th District Trustee

Feldman began a four-year term as 13th District trustee beginning in October 2002.

He has served as a delegate to ADA House and chairman of the ADA Council of Ethics, Bylaws, and Judicial Affairs, and Committee on Constitution and Bylaws.

For CDA, he served as a trustee from Napa-Solano Dental Society, chair of the Judicial Council, and as a member of the Holding Company Board of Directors.

Feldman practiced dentistry in Fairfield, Calif., for more than 30 years and is currently active as a forensic expert for Napa and Solano counties. He also has been a lecturer on risk management issues.

He received his DDS from the University of California at San Francisco and his memberships include the American and International Colleges of Dentists, the Pierre Fauchard Academy, the American Academy of Forensic Sciences and the American Society of Forensic Odontology.

Feldman and his wife, Linda Seifert, reside in Green Valley.

Jack F. Conley, DDS

Editor

This April marks the 21st year Conley has served as editor for the *Journal of the California Dental Association*. During this time, he has guided the publication into a position of national prestige and respect.

His service with CDA began with the Council on Dental Education in 1972, both as member and chair. He next served two terms as a CDA trustee, prior to his appointment as *Journal* editor in 1983. He has been a delegate to the ADA House since 1978, has served on the Reference Committee on Communications, and chaired the Reference Committee on Dental Education and Related Matters.

Conley is an active member of the Los Angeles Dental Society and served as president for 1976-'77. He received his DDS from the University of Southern California in 1964, an MEd in 1970, and has been a full-time faculty member since 1966. He maintains a part-time dental practice in Los Angeles.

He has received special recognition from the Southern California Section of the Pierre Fauchard Academy, the Los Angeles Dental Society, the USC Dental Alumni Association, and the Southern California Section of the American College of Dentists. The 2000 CDA Scientific Session in San Francisco was dedicated to him in recognition of his long-term service to the profession.

Conley and his wife, Jo Ann, live in Glendale.

Peter A. DuBois

Executive Director

DuBois became CDA executive director March 1, 2003. Prior to joining the association, he led management teams for large faculty practices affiliated with the University of Southern California and the University of California at San Francisco medical schools.

In addition to serving as executive director, he is chair of the board of CDA's holding company and vice chair of the boards of its subsidiaries and charitable foundation.

DuBois has extensive experience in state and national public policy research and advocacy, high technology manufacturing, government service and academic medical practice administration. He has served as CEO of University Children's Medical Group at USC Children's Hospital, Los Angeles, executive director of the UCSF Medical Group and executive director of the Physician Foundation at California Pacific Medical Center, a Sutter Health affiliate.

He continues several affiliations in health care, particularly the Children's Specialty Care Coalition, for which he is a member of the Executive Committee.

His wife is Leslie Zimmerman, a faculty member of the UCSF medical school and director of the Intensive Care Unit at the UCSF/VA Hospital.

Council on Community Health

Lindsey A. Robinson, DDS
Chairman

The Council on Community Health acts as a liaison to state and local agencies, local component dental societies, and the public for the purpose of enhancing access to dental care, enhancing dental health education, and monitoring developments of dental health issues in other states and at the national level. The council also provides guidelines for activities that promote National Children's Dental Health Month in February of each year. In addition, the council is represented on an array of dental health task forces, committees, and steering groups.

The council is organized into three areas of focus: regulatory, advocacy/access, and communication. Council members are given responsibility for policy-related projects within the focal areas.

The council focuses efforts on the development of materials to complement its policy-related activities. The council continues to be involved in educating the public on access and utilization of special dental services, such as programs for children, the disadvantaged, elderly and/or other special care populations.

Through the liaison to the Department of Health Services, the council works closely with the public sector. Consequently, the council provides policy input to statewide organizations and programs such as the Child Health and Disability Prevention Program, Healthy Mothers/Healthy Babies, the Dental Disease Prevention Program, Office of Oral Health, Medi-Cal Dental Services (Denti-Cal), and Healthy Families Program.

Council members
Luis R. Dominicis, DDS
Irene V. Hilton, DDS
Jennifer H. Holtzman, DDS
Phyllis M. Ishida, DDS
Mireya S. Ortega, DDS
Arnold C. Paulos, DDS

Council on Dental Research and Developments

Richard T. Kao, DDS, PhD
Chairman

The mission of the Council on Dental Research and Developments is to evaluate and monitor scientific, technical, and regulatory matters for the purpose of recommending association policy and apprising membership of the significance of these issues to the practice of dentistry. Critical matters the council has worked on during the past year include dental office wastewater, amalgam safety, hazardous waste, infection control, the Dental Materials Fact Sheet, and Proposition 65.

Environmental agencies across the country are seeking to reduce levels of mercury and amalgam in dental office wastewater. CDA has promoted for several years the implementation of best management practices for waste. A recent scientific assessment conducted for the American Dental Association supports the effectiveness of these practices in reducing the amount of amalgam impacting the environment. Certain best management practices became mandatory statewide in March 2003. The council continues to communicate with the respective regulatory agencies to monitor these developments and to advise members and components of regulatory activity.

By the end of 2003, the council anticipated the announcement of updated infection control recommendations from the Centers for Disease Control and Prevention and their impact on the Dental Board of California infection control regulations. Additionally, the council has been actively involved in advocating that the Dental Board's newly proposed consumer-friendly Dental Materials Fact Sheet be reflective and consistent with consensus science. The council will also continue to monitor Cal/OSHA's recent activities related to glutaraldehyde use in healthcare establishments. Information and tools for complying with Cal/OSHA, infection control, and waste management regulations are provided by the council in the CDA Regulatory Compliance Manual.

The council will continue to monitor and evaluate scientific developments in dental treatment technologies, methods, materials, asepsis, and infectious diseases. The council seeks improved methods of communicating significant issues to the membership. To assist the association with gaining cutting-edge information, the council developed and maintains a consultants' list. Consultants are CDA members with particular expertise in various areas of dentistry and are used to assist the council and staff in researching issues and answering inquiries from members, the media, and public. The list also is used by the Publications Department, which refers submissions to the *Journal of the California Dental Association* to the consultants for peer review.

Council members
Ronald Brown, DDS
John C. Chao, DDS
John P. Ducar, DDS
Emilio E. Garcia, DDS
Robert G. Keim, DDS

Council on Dental Care

Raymond S. Pedersen, DDS
Chairman

The Council on Dental Care advises and informs the association on policy matters involving the dental profession and third-party payment issues, including government programs and health care reform.

In addition, the council assists member dentists in resolving problems they encounter with their patients' dental benefit plans and provides input to third parties concerning benefits and acceptable claims practices. In conjunction with the ADA, the council assists members in gaining a greater understanding of the legal implications of contracting with third-party payers through the contract analysis service.

To serve as a source of information for the association and its membership, the Council on Dental Care monitors government health care programs, the status of national health care reform, and regulatory developments affecting provider/plan relations within the California Department of Managed Health Care. The council monitors the activities of entities that influence and affect health care plans and services.

Council members
Devang Gandhi, DDS
Vickie Greenberg, DDS
Thomas Jacobs, DDS
Yolanda Mangrum, DDS
Michael McRae, DDS
Michael W. Perry, DDS
George Stratigopoulos, DDS
Kenneth G. Wallis, DDS

Council on Education and Professional Relations

Stanley R. Surabian, DDS, JD
Chairman

The mission of the Council on Education and Professional Relations is to support and advance the association's strategic plan in the areas of education, licensure, allied dental health personnel, and enhanced professional relations. It does this by providing direction to and oversight for specific programs, projects, and task forces.

Increasing the number of allied dental health personnel in California continues to be a priority for the association and the council. A recruitment campaign, including radio and bus stop media ads, was launched in 2003. A concentrated recruitment effort is planned in 2004 in areas identified with allied dental health personnel shortages. Following up on a feasibility report, the council also plans to oversee the development of a business plan for a proprietary dental hygiene school.

The council will work with a second task force on licensure that is being formed to research licensure-by-graduation models and to determine the most appropriate one for California. The task force will also review accredited postdoctoral general dentistry/specialty program and enhanced licensure by credentials options in California, with an understanding that a legislative plan may be introduced to implement licensure reform.

A significant portion of the council's time is devoted to monitoring the activities of the Dental Board of California and its many committees, including the Committee on Dental Auxiliaries. Expansion of dental assisting duties and efforts to place the scope of practice in statute, instead of regulation, is ongoing. Licensure by credential, foreign-trained graduates, and enforcement continue to be matters of significant interest.

The council also reviews all CDA-sponsored courses that may qualify for continuing education credit. The council continues to monitor the issues of continued competency and student debt/faculty recruitment, while enhancing relations with specialty and allied dental health organizations and with the dental education community.

Council members
Robert H. Christoffersen, DDS
Terry L. Eggleston, DDS
Judith E. Grunstein, DDS
Gary Herman, DDS
Cindy Lyon, DDS

Council on Insurance

Dennis DeTomasi, DDS
Chairman

The Council on Insurance develops, monitors, and evaluates CDA-sponsored insurance programs. The council's primary goal is to provide a meaningful membership benefit for CDA members through its selection of outstanding insurance products and a superior level of service through 1201 Financial & Insurance Services, Inc.

Throughout the year, the council and its consultants closely monitor each of the sponsored plans in terms of benefits, pricing, and service. Based on comparative analysis of plan features and costs, the council evaluates the future direction of the markets in which the sponsored programs compete and selects programs that merit CDA sponsorship.

A significant portion of the council's

time and effort during the past year has been devoted to overseeing the challenging renewal for CDA's workers' compensation coverage, which will again be a major focus and priority in 2004. The past year also saw the council add several new long-term care carrier endorsements to ensure adequate diversity in plan options available to members. The council has been and will continue to monitor the increasing healthcare costs and utilization that have resulted in nationwide increases in medical plan premiums and will work closely with its consultants to search the marketplace for the best health plan alternatives.

The council, its consultants, and 1201 will continue to exercise due diligence in exploring all options to ensure that insurance products offered to CDA members are as cost-effective as possible given the state of the overall market. The council is looking forward to continuing to represent CDA members and overseeing the CDA-sponsored insurance programs in 2004.

Council members
Richard A. Cuevas, DDS
William Marble, DDS
David F. Levine, DDS
Sanjay Patel, DDS
Marvin S. Waldman, DDS
Howard J. Winer, DDS

Council on Peer Review

Raymond Sheridan, DDS
Chairman

The Council on Peer Review is responsible for overseeing the association's peer review system. This system is an alternative to litigation that provides the member dentist with an objective, professional review when disagreements concerning the quality and/or appropriateness of dental care occur between dentists and patients. In addition to patient-initiated complaints, the peer review system also provides utilization review to assist members with problems related to obtaining benefits from third-party payers.

The council's purpose is to ensure that procedures are followed in a consistent manner by components and specialty committees statewide, and that they comply with the CDA *Peer Review Manual*. The council has three subcommittees: two advisory panels that hold monthly conference calls to review select cases and the appeals panel, which meets once a month via conference call to review cases that have been appealed.

The council reviews approximately 600 cases each year involving quality and appropriateness of treatment, and its primary objective is to timely and credibly assess and resolve such cases.

This year, the council will focus on promoting the peer review system as a service to the general membership and alter the perception that the system is punitive in nature. Members of the council are prepared to provide CE courses to educate the general membership on how to use the system to benefit their practices and their patients. The council will continue to implement the regional/calibration training workshops for all component and specialty peer review committees to ensure consistency and credibility throughout the state in order to serve members and their patients more efficiently.

Council members
Norman C. Bitter, DDS
Adrian J. Carrington, DDS
Edward Casper, DDS
David S. Humerickhouse, DDS
Randy J. Jelmini, DMD
Alan O. Robb, DDS
James H. Thompson, DMD
Philip Wolkstein, DMD

Council on Scientific Sessions Board of Managers

Carol Gomez Summerhays, DDS
Chairman

It is the goal of the Scientific Sessions Board of Managers to present two outstanding dental meetings per year and to assist the entire association in achieving its goals through appropriate programs and speakers. This goal is accomplished by working with other councils, committees, and the subsidiary companies, and by scouting the other major dental meetings throughout the United States and Canada to identify speakers and pertinent topic information.

The planning of the Spring 2004 Scientific Session has been finalized and advance registration materials were sent to all member dentists in California and selected ADA members throughout the United States in December of 2003. There will be up to 100 programs presented and approximately 85 nationally well-known and up-and-coming speakers. The exhibit hall will consist of over 600 exhibiting companies. The entire dental team will be honored at the opening session and breakfast on Friday, April 15 with an uplifting message by Erin Gruwell. The Membership Celebration will feature the Bacon Brothers at the House of Blues Anaheim.

The Fall 2004 Scientific Sessions meeting will be moving to the brand-new Moscone West Convention Center and the board of mangers is working diligently to make the best use of the new space to benefit the attendees.

The board of managers is focusing on finalizing the Spring 2005 Scientific Session and planning the Fall 2005 program. Both sessions are filled with quality speakers and pro-

grams and promises to keep all CDA members and their dental team on the cutting edge of technology.

The Spring 2003 Scientific Session, one of the most successful meetings to date, attracted 27,695 attendees, of which 6,717 were dentists. Many lecture and workshop rooms were full to capacity. The three exhibit halls housed more than 1,200 booths with 600 exhibiting companies. The Membership Celebration featuring Megastars in Concert, who performed to a sold-out crowd, was an entertaining event for CDA members and guests.

In lieu of the Fall 2003 Scientific Session, staff concentrated on streamlining online registration and selecting a new CE automation process for future sessions. The Scientific Sessions Board of Mangers has also been assigned to work collectively on Distance Learning.

Board members
Gary R. Ackerman, DDS
Jeff J. Brucia, DDS
R. Bruce Coye, DDS
Frank T. Curry, DDS
Richard K. Rounsavelle, DDS
James C. Withers, DDS
Associate members
Stafford Duhn, DDS
Daniel Miyasaki, DDS
Anthony Perez, DDS
Craig Yarborough, DDS

Council on Membership

Virginia Hughson-Otte, DDS
Chairman

The Council on Membership has as its mission to assess the needs of all California dentists and to address those needs through the development, coordination, and implementation of programs designed to promote the success, health, welfare, and diversity of CDA membership. The council is largely responsible for membership services and membership development. Council members oversee activities designed to maximize the accessibility, usefulness, and relevance of CDA's services, programs, and membership benefits, which in turn will enhance recruitment and retention efforts. The council also oversees the activities of the Committee on the New Dentist, a group of new dentists who bring their perspectives into the consideration of membership programs and recruitment activities.

The council oversees many benefits and programs including the Universal Membership Application and Procedures (UMAP) programs for students and new dentists, and the Well-Being Program.

The council's membership development responsibilities comprise membership records and dues billing, recruitment and retention, and membership categories.

Highlights of the past year include the CDA New Dentist Conference, a one-day conference held in conjunction with the San Francisco Scientific Sessions; "Tips from the Pros: Advice from the Dental Board Before you Graduate!", a seminar for junior and senior students on preparing for the state licensure examination; the Senior Transition Seminars, a program held at the five dental schools to assist senior students with the transition from a student to a practitioner; hosting an all-student representative conference; sponsoring and hosting a Well-Being Network Training Conference, and monitoring the UMAP for the 32 components in California.

Plans for the upcoming year include hosting a one-day conference in conjunction with the San Francisco Scientific Session, sponsoring the Senior Transition Seminar at the five dental schools, implementing the new application procedures, and hosting a Student Reception at the Anaheim Scientific Session.

The Committee on the New Dentist, a subcommittee of the council, is responsible for integrating new dentists into organized dentistry and assisting new dentists in the transition from dental school into practice. In the next year, the members of the committee will be working more aggressively on creating links with local dental societies' new dentist contacts and implementing its mission statement and strategic plan. Some of the goals on the committee strategic plan include: hosting a workshop for component new dentist committee chairmen, participating in the ADA New Dentist Conference in San Diego, and electing a student member to the committee.

Council members
John P. Cunningham, DDS
Gerald G. Gelle, DDS
John D. Williams, DDS
Joseph M. Nunez, DDS
Judee Tippett-Whyte, DDS

Judicial Council

J. Andrew Hunter, DDS
Chairman

The CDA Bylaws charge the Judicial Council to consider proposals for amending the Code of Ethics and Bylaws, among other things. The Bylaws also charge the council to provide advisory opinions regarding interpretation of the ADA Principles of Ethics and Code of Professional Conduct and this association's Code of Ethics. Additionally, the Judicial Council is charged with rendering decisions in disputes arising between component societies.

The council's mission continues to be the promotion and maintenance of high ethical standards within the dental profession; development and uniform enforcement of a viable and legally enforceable Code of Ethics; and interpretation and enforcement of the Code of Ethics on behalf of the association, components, individual members, and the public.

Through its subcommittees, the Judicial Council reviews membership applications (through the Membership Application Review Subcommittee); determines whether members should be charged with violation of the Code of Ethics (through the Investigating Panel); and determines whether charges of violation of the Code of Ethics are valid (through the Hearing Panel). Through its Subcommittee on Ethics in Dentistry, the council also sponsors an annual ethics conference to train component ethics committees and staff on the ethics counseling and investigation process.

Council staff provides confidential counseling on dental ethics issues and interpretation of the Code of Ethics for the components, individual members, and the public. The CDA Council on Peer Review and component dental societies' ethics and peer review committees also depend upon the council for advice, guidance, and assistance in enforcing their committee decisions and the Code of Ethics.

Revitalization of the Code of Ethics, as resolved by the Board of Trustees in the summer of 2003, will be the Judicial Council's primary concern in 2004. The Judicial Council will work closely with the appointed Ethics Task Force to incorporate aspirational values and refine the operational guidelines within the Code of Ethics. The Judicial Council and Ethics Task Force will ensure that the code is responsive to the membership and that it models unwavering professional integrity. Continued interpretation and enforcement of the Code of Ethics; increased component communication and training; and amplified member education are crucial to the success of this revitalization effort. These goals can be achieved by ensuring the Code of Ethics is a relevant and legally viable document for guiding association members; reviewing potential violations of the Code of Ethics; and communicating these actions to components and members.

Council members
Leif K. Bakland, DDS
Lisa J. Dobak, DDS
Kenneth J. Fischer, DDS
Mark D. Kaufman, DDS
Robert "Dodie" Lynds, DDS
Howard C. Richmond, DDS
Jeffrey C. Shepherd, DDS
Richard O. Spencer, DDS
Alan R. Stein, DDS
Douglas R. Wall, DDS

Council on Legislation

James D. Wood, DDS
Chairman

The Council on Legislation is responsible for guiding CDA activities in the legislative and regulatory arena. The council initiates and responds to legislative and administrative proposals with the goal of implementing and maintaining CDA policy objectives. The council also oversees grassroots political activities and political education programs for component societies and other dental groups. The council has a representative on the Executive Committee of CalDPAC, the political action arm of the California Dental Association.

In the 2003-2004 legislative session, the council will be moving forward in several areas. CDA is an active participant in the state's budget process every year; but this year, with another significant budget deficit, CDA will defend the importance of the optional adult Denti-Cal program and attempt to identify other areas for improvements. The Dental Board undergoes another joint legislative sunset review, and CDA will participate in those discussions. In 2002, legislators on the Sunset Review Committee recommended through SB 1950 that interested parties discuss the possibility of developing a separate board for hygiene, a structure that is used with other health care providers (e.g., nursing, physical therapists). Other legislative proposals include the scope of practice for dental assistants, the status of the restorative techniques exam, and oral surgery scope of practice. CDA will continue its involvement in the fight to protect the use of dental amalgam and fluoride. Access to dental health care continues to be a pressing issue, balanced with the need for dentists to work in a business-friendly environment with the goal of treating patients from all economic levels.

The council reviews all legislation introduced in the California Legislature and closely monitors all bills having an impact on dentistry, including licensure of dentists and allied dental health professionals; insurance issues; government programs; environmental and OSHA issues and hazardous waste disposal; small business and tort concerns; public health and access to oral health care; and other areas of professional concerns.

Council members
Nicholas Caplanis, DDS
Michael R. Clark, DDS
Debra S. Finney, DDS
Dennis M. Kalebjian, DDS
Irving S. Lebovics, DDS
Tim S. Shahbazian, DDS
Roger B. Simonian, DDS
James D. Wood, DDS

CDA Foundation

Steven D. Chan, DDS
Chairman of the Board

The California Dental Association's mission is to improve the health of all Californians, particularly the underserved, including children, their caregivers, and the elderly. As the philanthropic partner of the California Dental Association, the CDA Foundation serves to link the dental profession with community needs by promoting oral health's vital role in a person's total well-being. The Foundation accomplishes this mission through strategic partnerships with the dental profession, public health, academic institutions, and government. These partnerships develop and implement programs and services in several key areas, including:

- Promoting total health, disease prevention, and treatment of oral health-related diseases.
- Increasing access to dental care services for all Californians.
- Supporting and strengthening the academic achievement of students enrolled in California dental education programs.
- Delivering valuable information, research, and findings to dental professionals.
- Engaging in research to access oral health needs, epidemiology, service delivery, and outcomes.
- Assisting people in our professional community who, because of misfortune, are in need of assistance.

The CDA Foundation depends on oral health professionals, individuals, private foundations, corporate partners, and the general public to invest in its mission. It is this unique partnership between donors and the Foundation that fosters the seeds of philanthropy that grow into fruitful programs serving our communities.

Board of Directors
Lowell G. Daun, DDS
R. Kent Farnsworth, DDS
Ernest L. Garcia, Jr., DDS
Brian E. Scott, DDS
Harold Slavkin, DDS, PhD
David R. Springett, PhD
Robert L. Witt
Executive Director
Jon R. Roth, CAE

CDA Holding Company, Inc.

Peter A. DuBois
Chairman of the Board

The California Dental Association formed the CDA Holding Company, Inc. in 1995 in order to provide management support services and oversight to its operating subsidiaries while still maintaining its non-profit status as an association. Besides providing oversight for the association in reviewing the operations of the operating subsidiaries, the Holding Company also provides administrative services to CDA and its operating subsidiaries. These business services include finance, human resources, information technology, legal affairs and mailroom/print shop services.

Board of Directors
Charles R. Bocks, DDS
Wayne D. Del Carlo, DDS
Peter A. DuBois
Debra S. Finney, DDS
Jeffrey R. Hazarian
Bettina Hooper
Dennis M. Kalebjian, DDS
Dennis L. Roginson, DDS
Russell I. Webb, DDS
Donald M. Schinnerer, DDS
Operating Subsidiary Chairman
(*ex officio/non-voting*)
(To be determined)

1201 Financial & Insurance Services, Inc.

Thomas H. Stewart, DDS
Chairman of the Board

1201 Financial & Insurance Services, Inc., (1201) offers innovative insurance, financing and practice management solutions that specifically benefit CDA member dentists, their families, staff and practices. The keys to 1201's success are its strength, stability and service. Our strength lies with rigorous product research, evaluation and review followed by the approval of the 1201 Board of Directors, CDA Council on Insurance, and/or the CDA Holding Company Board of Directors and/or the CDA Board of Trustees. 1201's stability is reflected in our commitment to select highly rated, nationally recognized insurance carriers and endorsed vendors with a proven stability in the market place. 1201 is dedicated to provide excellent, consistent and knowledgeable customer service to CDA members, their families and staff. The Board of Directors and 1201 staff continue to explore ways to enrich the personal and professional lives of CDA members by maintaining high quality programs and services, and researching and providing new ones.

Insurance Plans

The following CDA-sponsored insurance plans are available to all qualified CDA members (family members and dental office employees of CDA-member dentists may apply for certain plans, too) through 1201:

- **Professional & Business Liability,** underwritten by The Dentists Insurance Company;
- **Building & Business Personal Property,** underwritten by The Dentists Insurance Company;
- **Workers' Compensation,** underwritten by The Zenith Insurance

Company;

■ **Business Overhead Expense,** underwritten by UNUMProvident Corporation;

■ **Group Disability Income,** underwritten by the United States Life Insurance Company in the City of New York;

■ **Individual, Non-Cancelable Disability Income,** underwritten by the Guardian Insurance Company of America;

■ **Health Plans,** underwritten by Blue Cross of California;

■ **Hospital Income,** underwritten by National Casualty Company;

■ **Long-Term Care,** underwritten by John Hancock Life Insurance Company, Lincoln Benefit Life, General Electric Capital Assurance Company (GE), or UnumProvident Corporation

■ **Individual Life Plans,** underwritten by Transamerica Occidental Life Company;

■ **Group Term Life,** underwritten by the United States Life Insurance Company in the City of New York; and

■ **Accidental Death & Dismemberment,** underwritten by the United States Life Insurance Company in the City of New York, Member American General Financial Group.

Endorsed Programs

The following update on 1201 endorsed programs is based on the past 12 months' activities as of late November 2003:

CareCredit/Dental Patient Financing: This program was implemented to give CDA members an additional payment option to offer their patients — one with no recourse to the dentist. The program continues to do very well. As of September 2003, 2,624 CDA members actively promote this program to their patients.

OSHA Review, Inc./Spore Check System: As CDA members are aware, weekly biological monitoring of their sterilizers is a requirement of the Dental Board of California. OSHA Review, Inc., offers CDA members a quality spore check system.

The Keller Group/Investment Management & Advisory Services: 1201 has endorsed The Keller Group's Investment Management & Advisory Services program since January 1995. As of June 2003, Keller manages $57 million in CDA members' assets. Its investment management presentations at CDA's two annual sessions are well attended.

Sky Financial Solutions, Inc./ Practice Acquisition and Equipment Financing: Sky Financial is the exclusive vendor for the 1201/CDA-endorsed practice acquisition and equipment financing, new office financing, and commercial real estate financing programs. In addition, other value-added programs offered through Sky Financial is its demographic site analysis, which provides valuable information to doctors to determine the best area in which to reside, open a practice and how to effectively market their practice; debt consolidation; and Sky's Market Resource Guide for Dentists.

MBNA America Bank/Credit Card and Financial Programs: In addition to the CDA *WorldPoints* Platinum Plus credit cards with travel miles, for both personal and business usage, through MBNA, CDA members; are offered special rates on consumer loans; money market and certificates of deposit accounts. CDA shares the revenue it receives on the credit card and travel miles programs with CDA's components. As of mid-2003, CDA has provided $1,262,010 in revenue to the components from this program.

WebMD/Envoy / Electronic Claims Processing: CDA members pay only a $35 registration fee compared to $75 for nonmembers. New CDA members receive two months of free claims processing. WebMD/Envoy is the leading electronic clearinghouse for dental insurance claims in the United States.

Safety-Kleen/Medical & Hazardous Waste Disposal: From waste dental amalgam to sharps disposal and more, Safety-Kleen's waste disposal services have been endorsed by 1201 since 1999. Safety-Kleen provides both scheduled and as-needed pickups. Additionally, Safety-Kleen's WE CARE Program, offers a cost-effective solution, structured to keep dental practices in compliance with city, state and federal environmental regulations.

Merchant Credit Card Processing/ NOVA Information Systems, Inc.: NOVA offers a broad range of payment processing solutions tailored to meet the daily requirements of the dental industry. CDA members pay only 1.92 percent plus 15-cent per item for qualified transactions. NOVA provides payment processing for all major credit cards as well as ATM/debit cards; check verification, Internet solutions, and wireless processing solutions. CDA shares the revenue it receives on this program with participating CDA components. To date, more than $302,718 has been shared with participating components. Additionally, NOVA has waived for CDA members most of its usual processing fees.

Pension Plan Advisory Services/ Benetech, Inc.: In 2003 1201 added an endorsed Qualified Retirement Plans program through Benetech, Inc. to its portfolio of endorsed membership programs. Benetech designs and administers retirement and profit sharing plans for small businesses and provides small business clients and their financial advisors with the most up-to-date, objective information on IRS-approved Qualified Retirement Plans.

1201's commitment is to provide dental professionals with the best possible products and services. CDA member dentists and their employees have come to count on 1201 for help with their insurance and professional services. With 1201's extended hours of service and a web site that gives policyholders access to personal account information 24-hours a day at www.1201services.com, members receive the comprehensive personal service they expect. In addition, 1201 has six full-time sales representatives located throughout the state and three home of-

fice sales coordinators ready to speak with members at their convenience. Additionally, 1201 is your personal liaison for CDA-endorsed programs. For more than 20 years, dentists have turned to1201 for help with their professional and insurance needs. Whether it's today or tomorrow, dentists can rely on 1201's strength, stability and service to help with their professional goals.

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The Dentists Insurance Company

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Chairman

In 2003, TDIC continued to hear reports about the hard dental professional liability market and learned of competitors withdrawing from this segment. Once again, TDIC persevered, growing and succeeding in these tumultuous times.

TDIC's enrollment grew by 6 percent from the previous year to 14,366 active policies. Premiums earned were $25 million for the calendar year 2002, compared to $23 million for 2001. TDIC continues to manage its financial position carefully and methodically. As of Dec. 31, 2002, TDIC's surplus was $101 million. TDIC's net income after policyholder dividends and federal income tax was $5 million. To ensure TDIC remains fully diversified, part of its portfolio includes real estate investments, which have a higher rate of return than common stocks and bonds. These investments continue to yield positive returns for TDIC.

This year, TDIC added two associations to its family. In March, the Alaska Dental Society officially endorsed TDIC as its professional liability insurance carrier. The Pennsylvania Dental Association endorsed TDIC as its professional liability and office property insurance carrier in December 2003. Additionally, TDIC began actively marketing its products with state association leadership approval but without endorsement in Arizona, Georgia, Nevada, New Mexico and North Dakota. TDIC is now endorsed in six states and licensed to offer coverage in 35 states.

In addition to gaining the endorsements of new states, emphasis is being given to increase penetration in our existing endorsed states through a mix of direct mail, print advertising, exhibit booths, and sponsorship of component events and activities. In January 2003, TDIC was a sponsor for CDA's Leadership Conference. In April, TDIC sponsored CDA's "Tips from the Pros" dental board exam program at the spring Scientific Session. In May, the TDIC Board of Directors voted to donate $250,000 to the CDA Foundation, bringing TDIC's total donation to more than $1.6 million. TDIC was also the major sponsor for the 1201 Executive Directors' Retreat in September 2003. In addition, TDIC is sponsoring and participating in CDA's Senior Transition programs at the five California dental schools. TDIC, along with CDA, continues to offer coverage at no charge to dental students for the clinical portion of the dental board examinations.

TDIC also supports the components in their recruitment and retention efforts. Components can apply for sponsorships of events that yield maximum exposure to prospective members.

TDIC is assisting CDA and the components in their efforts to recruit foreign-trained dentists. Sources in the insurance industry have revealed that at least one large carrier is non-renewing the policies of foreign-trained dentists. That is not the case with TDIC. In fact, TDIC has examined its claims data and found that there is no apparent difference in the loss experience of insured foreign-trained dentists compared with those trained in the United States. Along with CDA and 1201, TDIC, supports the multicultural dental societies through sponsorship fees, advertising dollars, and participation in their events.

TDIC looks for innovative ways to serve policyholders and the dental community. After three years of planning, The Dentists Mobile Center, a completely equipped mobile dental unit, is available to policyholders who have experienced severe property damage to their offices. TDIC acquired the unit to offer policyholders an alternative to closing their practices or renting temporary space while repairs are being made following property losses. When not in use at a TDIC claim site, The Dentists Mobile Center is available for use by components for their community outreach programs. Members toured The Dentists Mobile Center during the CDA House of Delegates' meeting in November. Already in use at a TDIC claim site, TDIC has received many requests for future use by components.

At its October 2003 meeting, the TDIC Board of Directors declared an 8 percent dividend equaling $1.8 million for California policyholders. Each policyholder who maintained an active professional liability policy during the 2002/2003 policy year will receive a check from TDIC averaging $151. By

law, no insurer can guarantee dividends; however, since 1989, TDIC has declared $44.4 million to policyholders.

TDIC holds to its mission of offering quality products at an actuarially sound premium. Following a thorough actuarial analysis, the TDIC Board also voted to increase professional liability and office property policy rates for the 2004/2005 policy year. Pending California Department of Insurance approval, professional liability rates will increase by 5 percent, and office property rates will increase by 9 percent, beginning July 1, 2004. TDIC rates each state independently considering the state's loss experience. The last time TDIC changed professional liability rates was in 1995, and that was a 14.5 percent decrease.

The board also declared a shareholder dividend to the CDA Holding Company, Inc. (CDAHCI). The dividend totaled $2.7 million and will be paid to CDAHCI after Jan. 15, 2004. This brings the amount TDIC has declared to its parent company since 1993 to approximately $14 million.

TDIC is the best choice for members because it remains strong, solid and true to the profession of dentistry. When associations partner with TDIC, they are choosing the operating philosophy of a dentist-run company and the company's commitment to their membership. TDIC has the experience, relationships, financial resources and service expertise to meet associations' needs. With the reorganization of the 1201 and TDIC Boards of Directors, 2004 promises to be an exciting year as the boards and staff work toward a more cohesive operating strategy in support of CDA and CDA members.

Robert E. Horseman, DDS

Dreams, the Deficits and Dry Gulch

A couple times a month, a large truck backs up to my building and disgorges upward of 82,000 cubic feet of dental literature in the form of subscription-free magazines. Some of them are of conventional size, others are large enough to qualify as room dividers, but they all have one thing in common—-fear. The U.S. Postal Service must have sent all these publications a thinly disguised threat that if they couldn't prove every few days that the dentists on their mailing lists had actually asked for their publication, the USPS was going to raise their mailing rates to an exorbitant 37 cents for the first ounce like everybody else pays.

That's why every couple of issues, we are requested to take a few minutes of our time to fill out a detachable card indicating that YES we want to continue to receive the magazine and YES, we are still in the same practice location, same type practice, see the same number of patients per week, still claim we graduated in the same year as the last 100 times we have complied with the requested information. Apparently, the magazines' computers crash regularly and these facts are lost in cyberspace. Then if we will take a moment to circle the little tiny numbers on the card representing advertisers, brochures with additional information will be sent to us in 8 to 10 weeks long after

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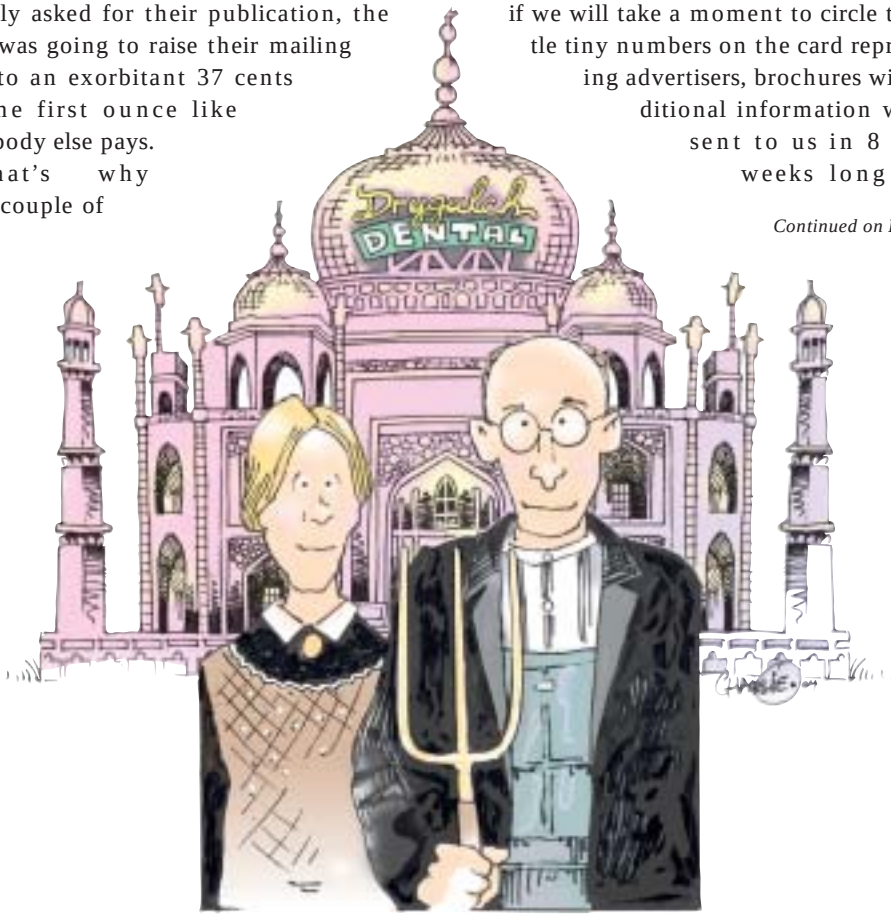
Within nine months they had created a dental office compounded of equal measures of the Taj Mahal and Rockefeller Center.



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we've forgotten what it was we wanted to know.

Otherwise, they say ruefully, they will have to hit the "delete" key and we will have lost the opportunity to ever again know what's going on in the profession. An exception seems to be that if we should forget to return the pre-paid card, we will be given another 40 or 50 chances to re-establish ourselves as the magazines continue to arrive regardless.

This must come as a relief to the advertisers whose contributions to the publication make it possible and therefore can claim upwards of 90 percent of the content. Fair enough! It's the theme of some of the articles hidden randomly among the ads that can tilt us precariously toward clinical depression.

Case in point: **Featured Office of the Month** — Dry Gulch, Texas, population 3,416, mean average per capita income $4,027 per annum, $63.15 per month after taxes. Number of dentists in town: 22. There are no blue-collar workers, they can't afford collars. However, they are a proud people and none more so than Dr. Billy "Doc" Deficit and his wife Ellie Mae "Marge" Deficit.

The Deficits came to Dry Gulch, reports the article, seeking a better life after Billy Doc graduated from dental school two years ago $125,000 in hock for student loans. They had only the clothes on their backs, plus a few strategically placed remnants on their fronts, but they had a dream. Yes! And a goal. A goal and ambition. And drive! These attributes were so evident to banker Roy Jack Fignewton of the Dry Gulch Debenture and Fiduciary Bank, that he immediately granted the pair a 30-year loan of $895,000 at 2.32 percent interest, taking their 1937 Gremlin as collateral.

Billy Doc and Marge set to work with a determination born of American grit and impending starvation. Within nine months they had created a dental office compounded of equal measures of the Taj Mahal and Rockefeller Center; 25,000-square feet of the very latest in dental equipment and amenities unequalled outside Beverly Hills.

In the last 12 months, Dr. Deficit grossed $1,325,538 on a three-day week. Interviewed by the dental magazine corps, Billy Doc was asked how he accomplished this remarkable feat.

They had only the clothes on their backs, plus a few strategically placed remnants on their fronts, but they had a dream.

Q. How did you accomplish this remarkable feat, Doctor?

A. We had this dream, me and Marge and …

Q. No, really, how did you do it?

A. Just because this is a small town and the people are poor and there are 21 other dentists to care for their needs, doesn't mean that they don't want and appreciate quality dentistry if it is offered to them at 18 percent interest compounded daily in an environment that is caring and unlike the galvanized iron lean-tos to which they are accustomed.

Q. And you do this?

A. No, I read that in a magazine. Marge's uncle died and left her $400 million. So I hired the other 21 dentists and signed them up for every HMO I could find. We'll check in after we return from St. Moritz later this month.

Next month you will read about Olaf Knudsen, DMD, of Swampwater, Minn., who last year paid $755,000 income tax working his little one-man practice in a hamlet of 819 souls whose only water supply comes from Knudsen's three-way syringes. Alternatively, you could forget to return one of those subscription cards and maybe you'll get lucky. CDA