May 2008
Volume 38, Issue 5

ASDA News

American Student Dental Association News

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Calendar

August
Annual Session
August 27–31, 2008
Scottsdale, AZ
Contact Meghan Keelean at
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September
Fall Leadership Conference
September 26–27, 2008
Chicago, IL
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October
ADA Annual Session
October 16–21, 2008
San Antonio, TX
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January
Leadership Conference
January 23–25, 2009
Chicago, IL
Contact Meghan Keelean at
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February
National Dental Student Lobby Day
February 10–12, 2009
Washington, DC

Pros and Cons of Mid-Level Dental Practitioners

Advanced Dental Hygiene Practitioner model subject of debate

by **Anish Gupta**, Detroit Mercy '10

State governments nationwide are discussing new legislation granting dental hygienists more responsibilities with less dentist supervision. At the forefront is Minnesota. Legislation for an Advanced Dental Hygiene Practitioner (ADHP) has been approved in both House and Senate subcommittees, although final details are still being discussed. The ADHP could set up a practice to provide cleanings as well as minimally-invasive restorative services without the supervision of a licensed dentist. These services include fillings, primary teeth pulpotomies, prescribing and dispensing medications, and nonsurgical extractions. Proponents argue that ADHPs will mitigate the access-to-care problem. Opponents, including the ADA, argue that ADHPs will be sacrificing the quality of care while not fixing access-to-care issues. One thing is certain: more discussion on this topic is necessary.

Pros

With the tragic, preventable death of Deamonte Driver, who died when bacteria from an abscessed tooth spread to his brain, the nation woke up to the access-to-care issue in dentistry. But relocating dentists and making health care affordable is no easy task. That's where a mid-level dental practitioner could help. When money is an issue, going to a dental hygienist is much more palatable than going to a dentist. Some argue that there is no clause in the legislation mandating that ADHPs practice in the underserved areas. That, however, is a moot point. The ADHPs, in order to have a successful practice, would sensibly go to the places where their services are needed the most — the underserved areas. The privileged patient who has always been to the dentist will remain with the dentist. It follows that those who couldn't afford or couldn't conveniently access dental health care previously would be the most likely patients in an ADHP practice. And don't dismiss these arguments as purely theoretical – programs allowing mid-level dental professionals to practice independently are available in Canada, New Zealand, and Great Britain. Empirically, this model has been proven to work.

Others argue that ADHPs will sacrifice the quality of care patients deserve. It's true that dentists receive much more training than an ADHP and can perform many more procedures than an ADHP. But primarily the ADHP would be a preventative practice — something that today's dentists don't believe can be profitable by itself. Secondly, anything out of the scope of an ADHP's capabilities would be referred to a dentist. ADHPs would have two years of training to decide what they are and are not capable of handling. Similarly, should we argue that a general practitioner should not place implants? Many of them never had training in dental school and many more supplemented their study with a quick CE course. Are all those dentists compromising the quality of care for their patients by not referring those implant cases to an oral surgeon who's had years of training? If a general practitioner can perform implants after a short CE course, then an ADHP can perform a pulpotomy after two years of post-hygiene training.

The ADHP is not going to take away our business and cheapen the care patients receive. For years, the ADA has urged that new legislation needs to be enacted to address the access-to-care problem. Now that Minnesota is doing just that we should applaud their efforts instead of being so

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Oral Brush Biopsy Detects Cancer

by **Melina Adamian**, Southern California '08

Each year in the United States about 29,000 people learn they have cancer of the oral cavity. Oral cancer accounts for about 3 percent of cancers in men and 2 percent of cancers in women. The primary risk factors for oral cancer include tobacco (including smokeless tobacco) and alcohol use. Infection with human papillomavirus 16 has been associated with an excess risk of developing squamous cell carcinoma of the oropharynx.

The Oral CDx BrushTest is a quick and painless method used to test the small white and red oral spots that most people have in their mouth at one time or another. The use of the brush biopsy as a highly accurate method of detecting precancers and cancers was incorporated into the 2006 National Cancer Institute's Physician Data Query, better known as PDQ. Screening examination can be made more efficient by inspecting the high-risk sites where 90 percent of all oral squamous cell cancers arise: the floor of the mouth, the ventrolateral aspect of the tongue, and the soft palate complex.[1] An oral examination often includes looking for leukoplakia and

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Chew on This

Help Patients Prevent Sports-Related Dental Injuries

What do Alan Thicke, Wilbur Wright and Ken Daneyko all have in common? They all experienced serious sporting injuries that resulted in lost teeth. Specifically, these accidents occurred while playing hockey. I admit, my knowledge of this sport consists mainly of what I learned from the Mighty Ducks movies. But if I had to picture a hockey player in my head, there would be skates, a stick, and a smile that is missing a few teeth. Today's hockey players are well aware of what services dentists can provide, such as mouth guards and dental implants. As of 2004, 60 percent of professional hockey players used mouth guards and many replace teeth with implants or removable prosthesis before granting interviews. The old stereotype of the toothless hockey player may still exist, but actually finding a player who has not had some sort of restorative dentistry is difficult.

by **Anna Fedak**, Nova Southeastern '09, Contributing Editor

This past August, the *Journal of the American Dental Association* conducted a study on the incidence and severity of sports-related dental injuries. This study demonstrated the need for people to take precaution while engaging in sports. For example, when the National Collegiate Athletic Association mandated the use of mouth guards in 1962 for football, the incidence of injury to the face and mouth region fell from 50 to 1.4 percent. In this study, the sport with the most incidence of injury was basketball and it was recommended that teams consider a mandatory mouth guard policy.

Since the average patient does not read JADA, patient education is crucial for preventing sports injuries. As dentists we must provide an affordable way to protect the teeth of our patients. Explaining the risks involved when a mouth guard is not used is important. These risks are not limited to those who play in team sports but to those that engage in other potentially dangerous activities such as biking or roller blading. Parents should be reminded of how important it is for their children to develop healthy oral hygiene and safety habits to protect their teeth. Also, children who have protruding maxillary incisors, insufficient lip closure, and an overjet of 7 mm have a higher incident of dental trauma. For these children, orthodontics could be an important preventive step to protect their teeth. Finally, though a mouth guard might seem like an unnecessary expense for a patient, it will be at a significantly lower cost than the cost of treatment to restore fractured or lost teeth.

Alan Thicke, the star of the sitcom *Growing Pains*, wasn't wearing a mouth guard when he was injured. His treatment consisted of three root canals and two teeth that had to be extracted. He received implants to replace those teeth. Wilbur Wright lost his two front teeth from an injury during a hockey game. He was not able to replace his teeth and suffered psychological and physical complications. Instead of attending Yale he stayed at home to care for his sick mother and spent much of his time reading scientific papers. He developed an interest in flight. He later collaborated with is brother Orville Wright to create the first airplane. Ken Daneyko played hockey for the New Jersey Devils for 20 seasons. He lost 12 anterior teeth during his career and underwent full mouth reconstruction. He is now a spokesman for cosmetic dentistry.

Amateur and professional sport leagues have made great strides in injury prevention. Most require or endorse some sort of protection, such as padding for football or shin guards for soccer, and it's important that these preventative measures expand to include protection from mouth injuries. As dental professionals, it's our responsibility to stay current with advances in injury prevention and to share this knowledge with our patients. With our help, athletics can remain a positive and healthy part of our patient's lives.

Opinion

A Primer on Dental Insurance

So you're out of school (finally!) and making your way into the world of practicing dentistry. You are really doing all the procedures you learned in school, you're treating patients, you're doing pretty well. But what about all the other little things that go into practicing dentistry that they *don't* teach you enough about in school? Actually running a practice, managing employees, collecting money...insurance?

For many of us, dental insurance can seem like an afterthought. It's easy to get absorbed in the dentistry — doing the initial exam, formulating a diagnosis, presenting your treatment options from which the patient can choose — but you have to keep in mind the patient's ability to pay for everything you want to do for them and how you will ultimately be paid for your services. You will need to decide how you are going to collect their fees and what types of insurance plans you will or will not participate in. These are not small decisions. The types of payment options plans you offer can affect a patient's decision to continue with the care you provide them, to go somewhere else, or to not even walk through your door at all.

by **Amanda Hochstein**, Columbia '10, Member-at-Large

There are many options of payment that you can offer to a patient: self-payment, insurance, HMO's. But ultimately it's you who decides how they will pay by the types of payment plans you offer. Because there are so many choices, it's easy to get lost and confused in the shuffle. In light of this, here is a not-so-nutshell list of payment options you can offer your patients.

There are a couple of alternatives that avoid involvement with insurance companies:

Fee-for-service: the patient presents with no insurance. In this case, you formulate the treatment plan, minding how much you will charge for services rendered. The patient determines what they are willing and able to pay for, the terms of their payment are agreed upon for the plan at hand, along with a payment plan. The patient decides if they want to pay ahead of time, at the time of service, over thirty days, by cash, credit card, and so on.

Dental credit card: the dentist pays a percentage to belong to a company that is responsible for collections from the patient.

And then there are many options that involve insurance companies on a variety of levels. Insurance companies are for-profit corporations that collect fixed payments from groups of people and pay for specified services. Essentially, they work with a group of dentists ("in plan") who promise a volume of production in exchange for a reduction in fees for the "insured" patients. The insurance company then markets a discount card to employers/patients, where a fee is paid to the insurance company to receive the lower prices from a dentist. (Think of this like any other coupon book or discount card kids sell from local businesses.) The dentist collects money from the patient at the reduced rate agreed to in the discount plan, so that the patient pays a discounted price for their treatment procedures, with the remainder subsidized by the insurance company.

Dental insurance does provide opportunities for some people to receive dental care and allows others to have higher cost procedures done. A dentist may increase his profitability by an increase in patients and procedures. But you have to remember that all reductions in fees come out of profits and

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ASK ASDA

editor@asdanet.org

Dear ASDA,
I am a second-year student and am beginning to study for my Part 1 Boards. With so many options in study materials, which do you suggest for an in-depth knowledge of the covered subjects, and where do I start?

Thanks,
Marija

Hello Marija,
Thanks for the inquiry. This time of year can be stressful for D2's as they dedicate long hours to studying for the boards, all while trying to prepare to enter the clinic. With all that is on your table right now, it is imperative that you use the right materials in your studies in order to better utilize your time.

In general, there are three types of study aids: guides that give you a good general knowledge, those that are subject specific and in depth, and old/practice tests. The suggestion would be to become very familiar with the general materials and then step up to the more in-depth reviews if you deem it necessary in order to increase your score. Here's a list of some very effective study aids:

General Knowledge
Dental Decks – these handy study cards comprehensively cover national board material and are small enough that you can take with you anywhere. Since they are based on old test questions, they are a great addition to your studying.
First Aid for the NBDE1 – this review has only been in print for two years, but is a great way to cover all material on the boards in a short amount of time. There are also many helpful mnemonics and trigger questions it contained within.
Kaplan Book – this behemoth of a book borders on the general knowledge and in-depth knowledge category, and provides a thorough review of all subjects covered on the boards. This would be one book that would be worth reading from cover to cover.

Subject Specific In-Depth Knowledge
Board Review Series (BRS) Books – The BRS series was developed for medical students preparing to take Step 1, but also is a phenomenal resource for dental students seeking a high score. Each subject is reviewed in a separate book, thus allowing you to select which subjects you feel you need more help in. Word on the streets says the physiology, pathology and biochemistry books are second to none.
Microbiology Made Ridiculously Simple – the ridiculously simple series provides so many humorous memory triggers, it's hard to forget the subject matter. Though this series produces books on all subjects, their review of microbiology is one of their finest.
High Yield Histology – the high yield series was also produced for medical students preparing for their boards, though it applies to us as well. The histology book is a great resource for understanding the nitty-gritty details of histo.

Old / Practice Tests
Released Exams – these are essential in not only becoming prepared for the format of the test, but also in reviewing material you've already studied. A bonus in studying these is that some questions will re-surface on your actual exam.
2004 Pilot Exam – with the change in 2007 to a more case-based exam, this resource is a must in order to be familiar with the new format.
Q-Bank – this resource is for those of you who want to go above and beyond on test day. Q-Bank questions tend to be much more difficult than what most people see on test day, so if you know these, you're most likely well prepared for the exam.

The aforementioned items are great for preparing to ace your exam, but there are also many other guides out there. A suggestion would be to also speak to upperclassmen at your school who excelled on the exam, and find out what they used and how they studied. Best of luck, Marija!

Insurance from page 2

there are increased administrative costs associated with insurance claims in the office. Thus you must weigh the good with the bad when deciding whether to participate in an insurance plan.

Under the "insurance" umbrella, there are even more options for you and your patient to take into account:

Direct Reimbursement: a patient pays the dentist for their treatment and then takes their bill and applies to their employer (in some cases) or directly to their insurance company for reimbursement. The insurance company may have a maximum cost they will pay for a procedure that is less than the price charged by the dentist, in which case the extra is taken on by the patient. In this case, the patient can select his/her dentist, and the employer/company only pays for those who seek dental care.

Dental insurance: a contract between the patient and the administrator of the plan, which is normally limited to specified procedures called benefits (*benefit*: the amount payable by the third party put toward the cost of various covered dental services; basically, what is covered by the particular insurance plan, which is generally determined at the 90th percentile) with co-payments (*co-payment*: a provision of a program by which the insured patient shares in the cost of covered services on a percentage basis) and deductibles (*deductible*: a stipulated sum the insured patient must pay toward the cost of dental treatment before the benefits of the insurance plan go into effect). The patient can select his/her dentist. In this situation, you receive payment for your services from two sources: the insurance company, who pays the bulk of the fee, plus the co-payment provided by the patient. The patient pays the insurance company a premium per month to belong to the plan.

Dental HMO (Health Maintenance Organization): pays a dentist a capitation (*capitation*: fee that a dentist is paid by the HMO for each patient that is enrolled) per time period, no matter what procedures are performed. The plan may include a co-payment when services are rendered, but the dentist receives the payment up front. Thus the increase in income comes from "maintaining health" rather than treating disease. This is the most restrictive plan, as the patient has no choice in who will care for their needs, and can only select dentists who have joined the HMO.

Dental PPO (the most popular insurance plan today): a dentist must sign a contract with agreed maximum allowable cost in order to be "in the network" (a reduction in fees). A patient may still choose to see an "out of network" dentist, but the patient will be responsible for some penalty ranging from higher co-pays to full payment for services rendered. The dentist increases volume in exchange for the lower fees.

Clearly, there are many different ways you can have your patients pay for their care. You will have to gauge your patient population, the distribution of their payment ability, and their compliance with payment to determine what collection method will best serve you and the needs of your patients and practice.

However, if you do decide to enroll in an insurance plan, here are a few rules to keep in mind when signing a contract with an insurance company:

1. Make sure you obtain and *carefully* review all attachments, exhibits, appendices and undisclosed documents before signing the contract.
2. *Never* sign a contract without first consulting your personal attorney and your malpractice insurance carrier to avoid problems that may arise down the road due to fine print you may have missed.
3. Confirm exactly what your obligations are so you will know if you need to purchase additional insurance or change carriers.
4. *Golden Rule of Contracting*: Your primary and steadfast obligation is to your patients—to make sure that their treatment is not compromised in any way. In other words, contract obligations should not alter the standard of care that the dentist owes to patients. Giving sub-standard care is not acceptable, no matter the circumstances of your contract.

Be sure to be informed when the time comes for you to incorporate insurance plans into your practice. Because when patients have the ability to pay, you can set that worry aside and focus on the things that you *were* taught in dental school – the dentistry!

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ASDA Member Spotlight

Growing Up Surrounded by Wars, Student Was Inspired to Be a Dentist

by **Katie McNutt**, Arizona '10, Contributing Editor

Meena Tappouni, a dental student at the Arizona School of Dentistry and Oral Health, was born in Baghdad, Iraq in 1981 during the Gulf War with Iran. Her mother was pregnant with her when her dad fled the country on a student visa to the United States to avoid being drafted for the war. Because her mother was a physician, she was not allowed to follow Meena's father to the United States. So Meena and her mom were forced to stay in Iraq, separated from her father for more than 12 years.

Even though Meena was born into a time of war, her memories of growing up in Baghdad are very pleasant. As a child, Meena was chosen to dance for Saddam Hussein on his birthday. His birthday was always a big event when he invited children from all over the country join in the celebration. As a gift to him, children performed choreographed dances. The palaces where the parties took place were unbelievable, but what stood out to Meena as a child was the size of the cake—a sheet cake stretching the length of eight large tables covered by a large canopy and adorned with gold-dipped candles and pearls. To further add to the surrealism of the situation, group pictures were hand delivered to each one of the kids by secret service the next day.

In 1992, after a second war—this time Desert Storm—Meena and her mother took a 17-hour bus ride through the desert in order to escape to Jordan. After six months there they were able to get their visas to join her father in the United States. Meena started school as a fifth grader without knowing a word of English. But with tutoring she was able to become fluent in English after six months.

During Desert Storm, Meena's family was forced into hiding, where basics such as clean water became a luxury. So oral hygiene became secondary and she went from having a healthy mouth to one full of decay. This inspired much of her interest in dentistry. She wanted to combine her love of science and her desire to help people in the way that she would have liked to be helped. Today, her goal is to participate in one dental mission trip a year. The Arizona School of Dentistry and Oral Health has enabled her to do just that, providing her with the opportunity to participate in a trip to Costa Rica and Panama last year, and she will be going to Peru in June.

ADHPs from page 1

defensive.

Cons

The major argument against an ADHP program is that no evidence suggests that ADHPs will solve the access-to-care issue. There are no guarantees that these practitioners would be educated enough or located in the proper areas to solve the crisis. From a student's perspective, I believe we are being trained not just for the ideal class I lesions, but for the "thinking" cases. We spend four years learning intricate thought processes and complex diagnosis, prognosis and treatment planning. This is not to say that a mid-level dental practitioner can't think; but could a person with any less training than a D.D.S. or D.M.D. handle these cases? When even the dentists need to refer cases to oral surgeons, prosthodontists, orthodontists and endodontists, can someone with less training properly treat patients? When dental students often feel unprepared to take on GPRs, AEGDs, and associate positions after four years of dental school, can anyone be prepared to independently practice in less than four years?

Furthermore, the access to care problems occur in areas that have the most compromised patients and difficult cases. A patient who sees a dentist once a decade is bound to have more complicated treatment needs than a patient whose insurance covers semi-annual visits. The restrictive nature of the ADHP's work is important, but the concern arises when we think ahead. Most agree that access to care will not be solved ten years from now, even with the institution of a mid-level practitioner. So, what will happen then? Will the restrictions of an ADHP be lifted in attempt to increase care? At what point are we compromising quality for quantity? The slippery slope of mid-level dental practitioners leads to a scary ending, and one that should concern the dental students of today.

Do you have an opinion? Start a discussion topic at

Brush Biopsy from page 1

erythroplastic lesions, which can progress to cancer.

The BrushTest consists of two components. First, a dentist uses a specially designed brush to painlessly obtain a sample of an oral spot. The BrushTest requires no anesthesia, causes no pain and minimal or no bleeding. Second, a laboratory where pathologists detect abnormal cells analyzes the sample.

The OralCDx BrushTest has been used by more than 30,000 U.S. dentists and has resulted in the detection of more than 10,000 precancerous spots, years before they can cause any harm. The accuracy of OralCDx was demonstrated in one of the largest dental studies ever conducted and performed at 35 academic universities in the United States, involving nearly 1,000 patients. Based on this study, which was published in the October 1999 issue of the *Journal of the American Dental Association*, OralCDx received the ADA's prestigious Seal of Acceptance.

Dr. J. Venturin, assistant professor of the University of Southern California School of Dentistry special patients clinic and a USC oral facial pain/oral medicine graduate, says, "Based on our experience in the oral medicine clinic we opt to use incisional biopsy as our gold standard for cancer detection. But the brush biopsy can be used as an initial screening followed by incisional biopsy if indicated."

An article entitled, "OralCDx brush biopsy—A tool for early diagnosis of oral squamous cell carcinoma" states, "*The aim of a present study was an evaluation of the OralCDx brush biopsy as a screening method for apparently benign lesions of the oral mucosa, which due to their harmless clinical appearance previously wouldn't have been subjected to incisional biopsy. One hundred and eighteen brush biopsies from 100 patients were analyzed. Ninety-three brush biopsies from 79 patients revealed a negative result. All OralCDx "atypical," "positive" and "inadequate" results were referred for conventional scalpel biopsy and examined by conventional histology. In six patients (seven OralCDx tests) with the result "positive" and in 14 patients with the result "atypical" by histological examination, carcinoma (4), severe dysplasia (4), moderate dysplasia (1) and mild dysplasia (4) were detected. The OralCDx brush biopsy proved to be a valuable new minimally invasive method for early detection and surveillance of oral dysplasia and of oral squamous cell carcinoma of innocuous appearance.*"[2]

Based on clinical studies, the recognition of oral cancer with the use of the Oral CDx brush biopsy has proven to be a beneficial and accurate method in detecting precancerous cells.

1. Joseph BK. Oral cancer: prevention and detection.Med Princ Pract. 2002;11 Suppl 1:32-5.
2. Kosicki DM, Riva C, Pajarola GF, Burkhardt A, Gratz K. OralCDx brush biopsy- A tool for early diagnosis of oral squamous cell carcinoma. Schweiz Monatsschr Zahnmed 2007;117: 222-7.

Position	Student	Chapter	Year
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Chair, Council on Licensure	Tessa Modiri	Maryland	2010
Chair of the Legislative Grassroots Network	Sonia Karamchandani	South Carolina	2009
Vice Chair of the Legislative Grassroots Network	Gail Garrett	San Francisco	2010
Chair, Council on Membership	Dustin Janssen	Baylor	2009
Chair, Council on Professional Issues	Tyler Scott	Ohio State	2009
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Contributing Editor	Katie McNutt	Arizona	2010
Contributing Editor	Ryan Lee	New York	2010
Contributing Editor	Jim Heidenreich	Connecticut	2010
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Chicago Administrative Extern (2)	Sara Twardy	Alabama	2011
Scientific Affairs Research Extern	Wesley Shute	Buffalo	2010
State Government Affairs Extern	Ankit Patel	Alabama	2011
Washington National Health Policy Extern (1)	Tim Anderson	Minnesota	2011
Washington National Health Policy Extern (2)	Piyali Roy	New York	2010
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Central Regional Legislative Coordinator	Jack O'Neill	Georgia	2011
Western Regional Legislative Coordinator	Allison Tar	Arizona	2009
Rhode Island Delegate	Ibrahim Shihadeh	Connecticut	2010

Congratulations to ASDA's 2008–09 Appointed Leaders!

At the Board of Trustees' April meeting in Chicago, ASDA's 2008–09 national leaders were appointed. Congratulations to all the leaders, and thank you for your dedication to ASDA. These leaders will serve ASDA and the ADA in the coming year in the areas of legislation, licensure, access to care, health policy, membership, education, administration and publications.

(Note: the Trustees, Speaker of the House of Delegates and Executive Committee leaders are elected at Annual Session.)

Interested in Participating in a Research Project?

Data suggests that dental students at both public and private institutions are graduating with increasing amounts of debt (Weaver et al, 2002). This trend may be attributed to a confluence of factors, chief among them tuition increases (Hardigan, 2004), and the increasing instance of students graduating from their undergraduate institutions already in debt (2002 National Student Loan Survey).

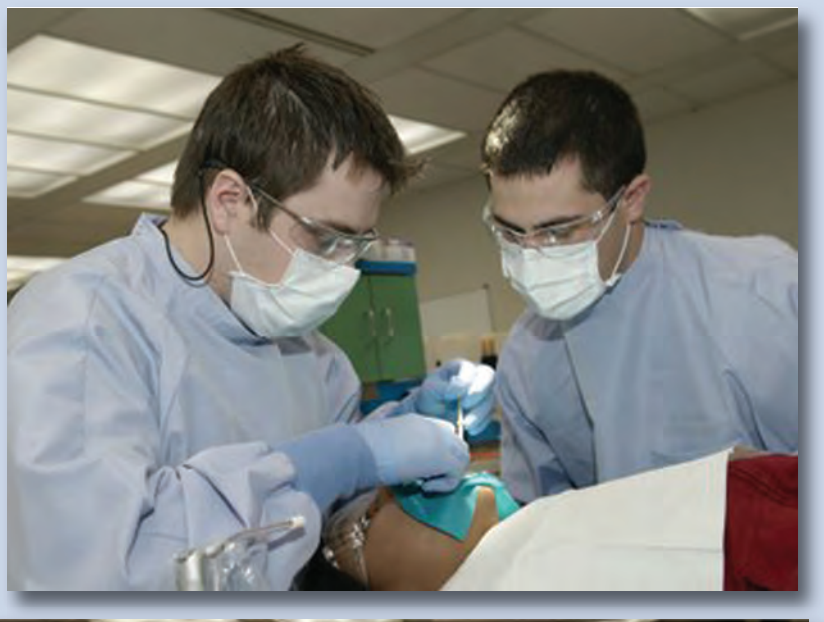
Thus far, previous studies have dealt mostly with the purely quantitative aspects of dental education and debt. As a part of her undergraduate studies at Georgetown, pre-dental student Maria Lapointe is conducting a survey in an effort to find out what relationships may exist between debt ownership, perceptions of the dental school experience, and debt's impact on future professional plans. The results of this survey will be combined with qualitative information gathered through a series of previously-held focus groups.

If you are a current dental student and would like to participate in this survey, please click on the following link: http://www.surveymonkey.com/s.aspx?sm=3Pef5aDRkFBIRGUsLBEifw_3d_3d. The survey takes approximately 15 minutes to complete, and survey respondents will be eligible to win a $100 gift card from Amazon.com. You do not have to enter the drawing to participate.

All data collected through this survey will be anonymous. Contact information will be used solely for the purposes of the drawing and will not be connected to other data collected through this survey. All results will be presented in aggregate.

Thank you for participating!

GKAS Smiles in Minnesota



by **Amy Truong**, Minnesota '09, District 8 Trustee

The fourth annual Give Kids a Smile day at the University of Minnesota took place on February 2, 2008. With the support of the U of MN Dean Patrick Lloyd, the coordinators Ellen Dufresne, Kelsey Vibeto, Camille Jensen, Nicole Amundson, Sheena Eken, and more than 180 student volunteers and 50 faculty and staff, we were able to provide free care to 110 children. This student-coordinated event allowed patients to be seen for 90 minutes, giving time to provide more treatment to those who had more extensive needs.

First- and second-year dental students helped with registration, dental assisting, oral hygiene instruction and served as patient escorts throughout all the stops in the process. Third- and fourth-year dental students and pediatric residents treated patients. This was another great year of giving kids a smile in Minnesota and we look forward to being able to provide care at our next GKAS event next year!

Maryland, Howard Dental Students Provide Lunches, Oral Health Tips

Dental students from the University of Maryland, Baltimore College of Dental Surgery and Howard University College of Dentistry came to Jessup Elementary School to support the "Lessons In A Lunch Box: Healthy Teeth Essentials & Facts About Snacks" program. Students from both dental schools showed up in double digits to offer their help to The Maryland Children's Oral Health Institute. The student doctors working in groups of two were motivated and ready to help some 187 very excited kindergarten through second grade children learn about their newly acquired oral health care lunch boxes.

The Lessons In A Lunch Box program launched on Jan. 18 at Franklin Square Elementary School in conjunction with the kick off of "Give Kids A Smile®" in Maryland.

Despite the snowy weather, 183 children attended classes and went home delighted with lunch boxes in hand. In February, students also assisted with the oral health presentations and lunch box distribution at Waverly Elementary School. The future dentists cheerfully demonstrated flossing and brushing. Triumphant pandemonium erupted when lunch boxes were given to the 432 jubilant children.

On March 1, students from the Baltimore College of Dental Surgery descended on The Maryland Children's Oral Health Institute and placed oral hygiene products in lunch containers and applied the "See Yourself Becoming A Dentist" sticker at the opening. By the end of their two-hour volunteer work shift, the youth had completed a grand total of 2,040 lunch boxes.

Arizona Students Help Kids Brush Up on Oral Health

by **Lauren Companioni**, Arizona '10

Crest Healthy Smiles, a community outreach event organized by Arizona School of Dentistry and Oral Health students, offers free screenings, fluoride varnish application, and oral health instructions for kids. This year's event took place March 28 at the I.G. Homes branch of the Boys and Girls Club in Phoenix. Approximately 70 children, ages 5-17, attended.

Every year the students try to make it fun for the children by including games and raffles. This year an iPod Shuffle was raffled, prizes of stickers and spin toothbrushes were awarded at game stations, and each child received goodie bags complete with age appropriate toothbrushes, toothpaste, and floss. "The kids seemed eager to use their new toothbrushes and had a great time learning how to brush their teeth on the puppets," Jamie Haas, a second year dental student who helped organized the event said. In light of how successful this year's event was, next year two CHS events are in the process of being planned.

Organized Dentistry Can Guide You After Graduation

Whether you're a graduating senior or a first-year student, as you plan for your transition from school to practice, also plan your transition from student member of ASDA/ADA to practicing member of ADA. Organized dentistry can really help you make a smoother transition!

When Dr. Jennifer Barrington, who practices general dentistry with her husband, was planning a move to a new city, the first place she went was that location's component, or local, dental society to get information about their regular meetings.

"We called ahead," notes Dr. Barrington, a 1996 graduate of the University of Texas Health Science Center Houston, "so it was almost like we had family waiting for us."

Other dentists cited the availability of leadership positions early in their careers. Dr. Chris Liang joined the Maryland State Dental Association shortly after completing his orthodontics residency in 2001. He was tapped to participate on meaningful committees almost from the beginning. Getting involved right away was a real confidence booster for Dr. Liang. "It's more seasoned dentists showing confidence in the younger people," Dr. Liang says of organized dentistry. "It validates me."

Dr. Barrington, currently chairperson of the ADA's Committee on the New Dentist, echoes that experience. "As soon as they see you are eager, opportunities begin to come forward," Dr. Barrington says. "At first I was concerned I had bitten off more than I wanted to chew so early in my career. But once I was in the swing it was exciting and fulfilling!"

Dr. Garrick Lo, a 2002 graduate of the University of Washington's School of Dentistry, agrees that organized dentistry is welcoming. "Some people may be concerned that they will feel like outsiders when they go to a meeting," Dr. Lo says. "But people have been more than welcoming. If you show conviction, they'll make you part of the team."

Another advantage of membership is the informal mentoring that happens when dentists gather together. Dr. Brandon Maddox, a 2001 graduate of Southern Illinois University's D.M.D. program, says, "The answers to all the questions a new dentist has, especially one who is starting a practice from scratch, are available from either the ADA or from other members." Local, state, and national meetings – such as the ADA New Dentist Conference every summer or the ADA Annual Session every fall – are a great place to make these dentist-to-dentist connections.

Dr. Ben Adams, a 1996 graduate of the Medical College of Georgia, appreciates the mix of ideas that comes from meeting dentists at the state and national level. "Talking with dentists who aren't from my neck of the woods, we're in a completely non-competitive environment. I can share without worrying about someone taking a patient or stealing an idea."

Dr. Matt Krische, who earned his D.D.S. degree in 2001 from the University of Minnesota, says, "I like to be really active in organized dentistry, and that level of involvement isn't for everybody. I understand that. But if you don't want to take an active role, then by becoming a member, you support the people like me who enjoy working on your behalf!"

Depending on your post-graduation plans, you may need to apply for membership directly with the ADA or with your state dental society. Contact the ADA Office of Student Affairs at 800-621-8099 ext. 7470 for guidance on where to apply or visit www.ada.org/goto/join.

Interested in specializing?

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Student Column

A Dental Student Living in Harlem

by **Ryan Lee**, New York '10

I still vividly remember one of my first real "lectures" as a starry-eyed first-year dental student. The guest lecturer, a highly successful GP from the affluent Long Island suburbs, proudly flashed a half-dozen photographs of his Maserati parked in front of his palace of a private practice. I was left breathless, simply bedazzled by the bounties of his success. "Forget about the BMW," I thought. "How many years would it take me to drive my own Maserati?"

Fast forward a year-and-a-half…and I'm still dazzled by visions of my own future, one that entails a fancy car, a palatial private practice in a pleasant suburban setting, and maybe a modest mansion to house my loving wife, 2.7 kids, and 1.3 dogs. Perhaps I, too, can return one day to my alma mater and inspire younger colleagues with promises of health, wealth and success. The only difference, though, is that I'd drive the Maserati straight to school and park it right outside the front lobby – all in good will, of course.

Lest you've detected my sarcastic tone, let me admit my slight discomfort with this notion of immense financial success as future dentists. Sure, good income potential as a respected healthcare professional influenced my initial decision to become a dentist. I did my due diligence as a pre-dent, eagerly computing the hourly wages of different health providers (i.e., dentists vs. physicians vs. pharmacists) on a Microsoft Excel file and sharing it giddily with friends. I – just like you – hope to make truckloads of money in the future, and there is nothing wrong with that, right? As long as we give back to society in the form of volunteer work, mission trips, church tithes (for the religiously inclined among us) or philanthropic donations, no?

For the past six months, I've called home an apartment building in Harlem, NY. What started last summer as a shameless attempt to find cheaper rent in New York has led me down a path of fascinating lessons and newfound passions I never would've encountered elsewhere.

Because there are no supermarkets here (only bodegas), I've discovered that I can no longer stockpile my fridge with organic soy milk and turkey burgers. Because there are no taxis here (only contraband 'limo' operators), I've discovered that I always have to leave my apartment a little bit earlier to get to school – or the airport – on time. Because there are no after-school programs or Kaplan SAT Centers here (only basketball courts…and there are tons of them), I've discovered that I can be a mentor to area teens by providing free weekend tutoring sessions. And because there are no young professionals involved in the political process here (only those who've lived here for decades seem to care about local issues), I've discovered that I can double as a local public servant of sorts, as an elected community board member. In fact at the next meeting I will be outlining the fundraising needs for those free weekend SAT classes I started. And I've been in contact with area politicians to arrange free volunteer dental care to the 2,000 residents of my apartment complex – the majority of whom are on Medicaid.

Some of the greatest needs in my neighborhood—and perhaps in neighborhoods only a few miles away from yours—involve the lack of access to quality health, education, and even the most basic of public utilities like transportation and heat in the wintertime. And as dental students, we can provide so much in terms of meeting these needs – even before we graduate, even outside of the scope of dentistry. We all can be mentors and leaders in our locales, but too many of us don't even know the first names of our next-door neighbors.

I still want that Maserati as a trophy of my future success. But I've learned how being a professional student can make one believe he or she is entitled to future comforts. The humanitarian needs around us can be easy to miss. If a shameless search for cheaper rent opened my eyes in amazing ways, how much more breathtaking will your genuine attempts at community involvement turn out to be? So if your future vision includes a Maserati, make sure to park it in Harlem every once in a while…all in good will, of course.

Share Your Opinion!

ASDA has a
DISCUSSION FORUM
where ASDA members can ask questions and share opinions on topics related to dental education and the profession.

Log on today and start a conversation!

http://www.asdanet.org/forum.aspx

Celebrating Ethics

by **Brian Black**, Pacific '09

At ASDA Annual Session in Ft. Lauderdale last year, two points were made very clear:

(1) Ethics is an issue among dental students throughout the nation.
(2) We have the responsibility to be self-regulated throughout our education and careers.

After participating in these discussions, ASDA leadership from the University of the Pacific hosted an inaugural "ASDA Ethics Day." On Tuesday November 6, 2007 over 200 Pacific students attended a lunch time seminar featuring Dr. Arthur A. Dugoni, Dean Emeritus of the University of the Pacific Arthur A. Dugoni School of Dentistry. Dr. Dugoni shared experiences from his professional career as a dean, practitioner, and leader in organized dentistry. He encouraged students to live a high code of ethics and understand the responsibility that has been given to us as doctors. Dr. Dugoni described that a dental professional is defined by three special qualities:

Competence. "My observation- You will get along on charm for about 15 minutes; after that, you better know something."

Caring. "For your patients, your community, your family, friends, and yes, your country. It will be your responsibility, as you will be one of the best educated in your community and one of the most affluent."
Commitment. "Commitment to a higher standard, to the greater good."

Dr. Dugoni continued, "Today, you are called 'doctor' and you are filled with pride when you hear your name called as doctor, or when that patient says to you, "Thanks you, doctor, thank you for stopping my pain," or "thank you for my smile." What does the calling to be a doctor imply? Again, in my mind, it implies: fairness, integrity, honesty, service above self, respect for human dignity, a passion for quality, and a commitment to excellence."

He finished his seminar by saying, "In the final analysis, we all have the power to decide what we do and what we say, and we are morally responsible for the consequences of our choices…living a life that matters does not happen by chance. It is not a matter of circumstances but one of choice."

All students were given an Ethics Handbook for Dentists provided by The American College of Dentists.

To read Dr. Dugoni's full "ASDA Ethics" Day speech, or to join the "ASDA Ethics Day" forum, log on to ASDAnet.org.

Looking Back on my Dental School Years

by **Porchia S. Willis**, Meharry '08

During my first year of dental school, I was a very serious student. I realized that I was a little closer to my lifelong goal and it was necessary to perform to the best of my ability. The excitement of being in dental school drove me to study long hours in hopes of remaining competitive with my peers. Being in class from 8 a.m. to 5 p.m. every day was very challenging and stressful. During first year I had to stay in Nashville for Thanksgiving because I had major exams the following Monday.

Second year, while very different from first year, offered a new set of challenges. The goal was to balance laboratory work and academic bookwork. The "babying" that you may have had freshman year suddenly disappeared. Professors graded your work much harder to ensure that students were capable of adequately treating their patients. We were finally learning the true artistic craft of dentistry. Second year was also a humbling experience for many students who excelled academically in their first year's basic science courses—they were not as competent in their manual dexterity skills. A few students who had not excelled masterfully academically were able to improve their ranking through achieving an efficient level of manual dexterity.

When I entered my third year I was extremely excited. I had finally arrived at the level that I had been waiting for since entering dental school…the clinical years. I was finally applying and practicing everything I learned during my freshman and sophomore years. No more waiting to get tooth drawings reviewed by professors, no more carving teeth, no more classes in the basic science building. I realized how comprehensive dental care was. Being a dentist is more than "drilling and filling," it is about the overall care of your patient's oral health.

Graduation is finally here and I will soon have earned the title of "Doctor." Hopefully, I will no longer hear the term "Buzzard." At Meharry Medical College School of Dentistry, we use this term of endearment to mean an act or procedure that does not meet certain standards. We understand by tradition that every student is a Buzzard until he/she graduates.

On commencement day the seats will be filled with thousands of proud family members relatives and friends. I've always been told that your measure of success is not only in the lives you heal, but also in the influence you wield. Our responsibility is to ensure the oral health care of our communities, and I am ready to face this challenge!

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Walking for Oral Cancer Awareness

by **Steven Myles**

The Howard University chapter of the Student National Dental Association (SNDA) held its first annual Oral Cancer Walk April 12. The Walk seeks to bring together members of the SNDA from regional participating chapters, including University of Maryland Baltimore County, Virginia Commonwealth University, University of North Carolina Chapel Hill, and University Medical and Dental College of New Jersey, as well as Howard University's own Oral Cancer Society. This year's Walk was held in conjunction with our SNDA Regional Conference to allow for maximal collaboration and intra-organizational support among regional chapters.

The Oral Cancer Walk is an event the SNDA has adopted to raise awareness of oral cancer prevalence in minority communities overrepresented by the disease, communities for which SNDA is greatly responsible and places in its mission to serve. With the first SNDA Oral Cancer Walk held by the NYU chapter in the summer of 2005, the Walk has expanded to the University of Detroit Mercy in 2007 and summer of 2008, Howard University's this year, and a host of chapters beginning the planning to host their own Walks in the next school year.

Howard's SNDA chapter, in collaboration with our Oral Cancer Society, has been working diligently throughout the year to hold an Oral Cancer Walk to promote the awareness of oral cancer, help fund oral cancer research, and position Howard University in the center of oral healthcare advocacy in the Washington, D.C. area. Besides the SNDA students in attendance, the Walk brought together dental professionals in the Washington D.C. area, as well as faculty from HUCD, to better to serve the community in which we all live and from which we all gain support.

The Walk began in an historic section of Washington, D.C.—Dupont Circle—and continued through other historic D.C. neighborhoods (U Street Corridor, Columbia Heights, Shaw communities) populated by the different cultures and nationalities that SNDA seeks to serve. The Walk terminated at Howard University's College of Dentistry. At the university, students and faculty held oral cancer screenings and raised awareness for this and other forms of cancer prevalent in our community. Money raised will go towards oral cancer research and the establishment of other Oral Cancer Walks put on by other chapters to continue to help SNDA raise maximal awareness of the potentially life-limiting disease. We expect to have a turnout worth continuing this event for years to come.

STUDENT VIDEO CONTEST

DENTAL ETHICS - WHO?. . .WHAT?. . .WHY?

ASDA members - Find your *ADA Principles of Ethics and Code of Professional Conduct** and develop video enactments of situations demonstrating one of the ADA's Principles, Codes, or Advisory Opinions.

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TOP FIVE VIDEOS will be recognized at the 2008 ADA Annual Session San Antonio, Texas

SUBMISSION DEADLINE: June 1, 2008

General Information:

- Participation is limited to current ASDA members
- Videos may be in the form of drama, comedy, documentary, interview(s), PSA (Public Service Announcement), music video or any combination
- Videos should not be more that 4 minutes in length
- Applicants must include 2 copies of the video on disc in AVI format

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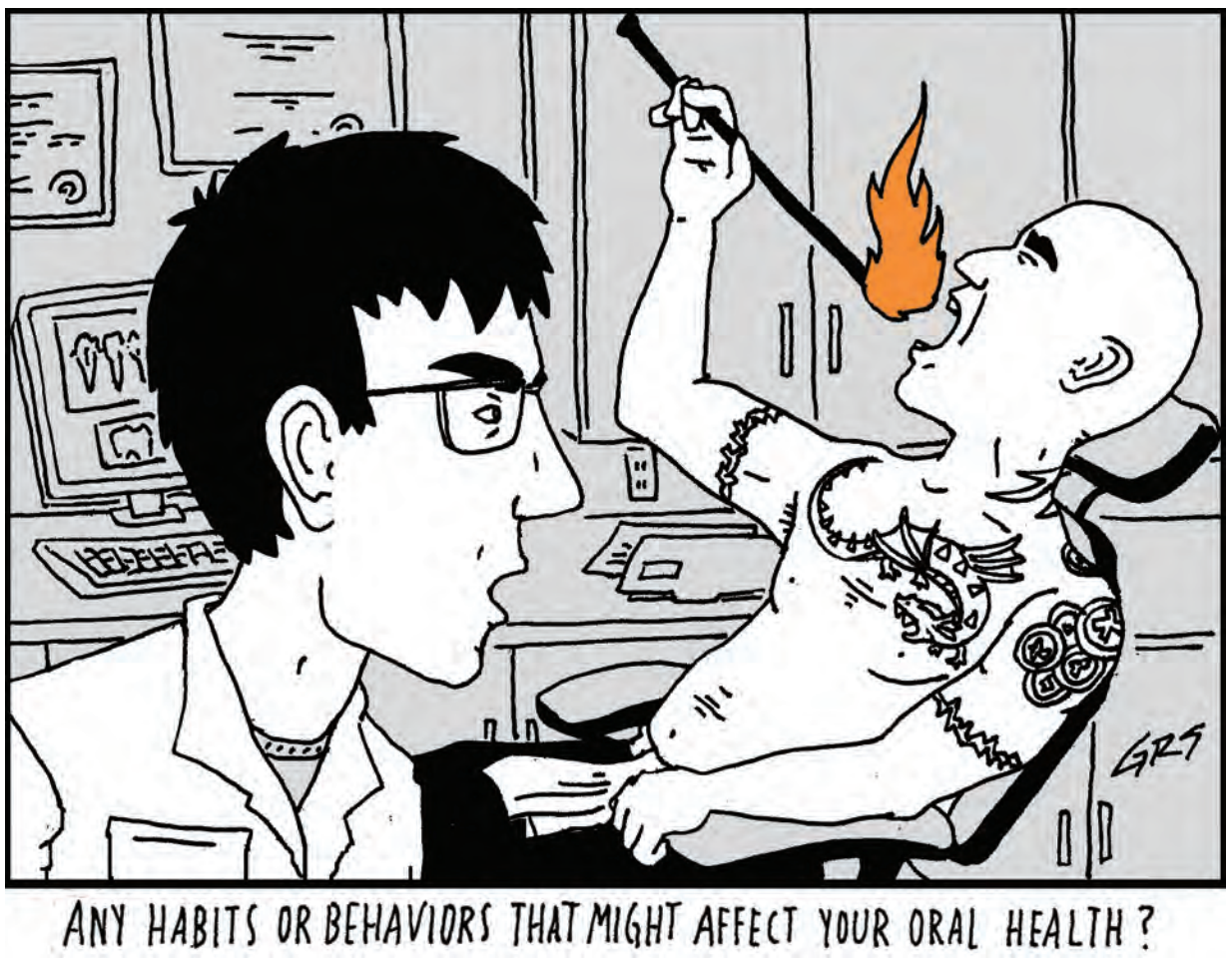

by Grant Snider, Missouri '11