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Quackery, Fraud and Denturists

By Robert B. Stevenson, DDS, MS, MA

For discussion here, denturists are defined as unlicensed people who supply, fit or deliver complete dentures to patients directly, without supervision by a licensed dentist. This paper will examine characteristics of illegal denturists and compare them with common signs of questionable care, fraud and quackery.

Webster's Medical Desk Dictionary defines the quack as "an ignorant or dishonest practitioner." All

unlicensed dental technicians who practice dentistry illegally are "dishonest" by definition, and many are ignorant of how much necessary dental knowledge they lack. Most patients also lack the dental knowledge to make informed decisions about their prosthodontics care, and they need the advice of an honest, competent dentist.

Illegal denturists' practice has a long, sad history, which led in part to the Federal Denture Act of 1948. One visible result is the common label on dental products, "Caution: U.S. Federal Law Restricts This Device To Sale By Or On The Order Of A Dentist." The specific law is Section 1821 of Title 19, U.S.C., enforced by the Department of Justice. It is based on the Federal Denture Act, which puts federal teeth into state laws which prohibit;

(1) the taking of impressions or casts of the human mouth or teeth by a person not licensed under such laws to practice dentistry.

(2) the construction or supply of dentures by a person other than, or without the authorization or prescription of, a person licensed under such laws to practice dentistry

(3) the construction or supply of dentures from impressions or casts made by a person not licensed under such laws to practice dentistry.

Violators shall be fined not more than \$1,000 or imprisoned not more than one year, or both. Reports of violations of the Federal Denture Act should be referred to the Center for Devices and Radiological Health, Office of Compliance, for review.

Most U.S. states currently have laws against the supply or delivery of dentures by non-dentists. Although legal in some states and countries, many licensed denturists illegally provide removable partial dentures (1). There have been repeated challenges to state laws regulating denturists in the past fifty years, and the central question to unsupervised prosthodontics practice always boils down to competence.

Laboratory fabrication of a denture prosthesis is only a part of prosthodontic treatment. The practitioner must be able to detect oral diseases as well as detect oral manifestations of systemic disease. The practitioner must be alert to possible hazards to the patient if dentures are placed on unhealthy tissues and the hazards if appropriate precautions are not taken in response to certain observed medical conditions.

Patients are not likely to be able to evaluate the adequacy of an oral exam or the competence of the person providing their dentures to perform such an exam. That is why accredited training, strict competency exams, and a bona fide license are necessary.

Aside from the fit of the denture, there are psychological aspects of prosthodontic treatment. A certain amount of patient cooperation is required, and expectations must be reasonable. Follow-up aftercare, such as denture adjustments for sore spots, must be provided in a professional manner at or above the standard level of care. Office cleanliness and infection control procedures grow more complicated every year.

Where can a young, potential denturist go to learn all of the above? Currently, there are no accredited denturist programs offered in the United States.

The 1987 JADA article titled, "Questionable Care: What can be done about dental quackery?" (2), notes one way to spot a quack; "Displays credentials not recognized by responsible scientists or educators, including 'degrees' from unaccredited schools." A perfect example is Mills Grae University, an unaccredited school that offers the nation's only DDM degree -- Doctor of Denturity Medicine.

According to an article by Steven J. Diogo in the March 2002 AGD IMPACT, (3) Mills Grae University supposedly was based in Kalispell, Montana, but there is no brick-and-mortar school there. Montana is one of the few states where denturists are permitted to practice. Cort C. Jensen, an attorney for the Montana Office of Consumer Affairs, said the operation is one of dozens of Internet-based "diploma mills" operating in Montana and other states that have slim resources for hunting them down.

The Mills Grae President, Ronald Gerety, DDS, PHD, was reached in Pensacola, Florida, and told AGD Impact that the website was being "reconstructed" and is still accepting students. The school charges many

thousands of dollars for the denturity program, administered via correspondence or online via the Internet, with on-site workshops offered twice a year, according to the article.

Mr. Jensen said he has no opinion on denturity, "I don't care if they're offering degrees in denturity, physics or janitorial services. The fact is you can't use college words like 'bachelor, master or doctorate degree' without the Permission of the Board of Regents." The Florida Commission on Independent Education is also investigating Mills Grae's presence, according to the AGD article.

Since there is no accredited denturist training program in the United States, illegal denturists might resort to displaying certificates or diplomas from recognized dental laboratory technology programs. However, patients may not be aware that these programs do not include any clinical training in how to actually make impressions or jaw relation records, or adjusting dentures at chairside. These laboratory certificates may be genuine, but are clearly not intended for clinical competence.

The 1987 JADA article mentions another way to spot quacks; "Supports claims with articles published in obscure, pseudoscientific journals or the public media." Denturist advocates often point to the 1980 document, "The Sale of Complete Dentures: Effects of Present and Alternative Regulations." (4)

Released by the San Francisco regional office of the Federal Trade Commission, it was submitted by an attorney and a "Consumer Protection Specialist." The 400-plus page report contained statistics related to edentulous populations and prosthodontic fees in the United States and in Canada. Around 100 pages of the report, which reflect pre-decisional opinions, recommendations and conclusions of the staff, are deleted and protected from mandatory disclosure by FOIA (Freedom Of Information Act) exemption.

The Federal Trade Commission never acted on the report.

According to Matthew Daynard at the Washington D.C. Office of the FTC, the "commissioners decided long ago that 'scope of practice' is outside the expertise of the trade commission, and it is loathe to try to second-guess individual state dental boards or the U.S. Department of health and Human Services." (5).

Likewise, the National Council Against Health Fraud, Inc. also tries to stay out of "turf battles," like optometrists verses opthamologists, according to spokesman Dr. William Jarvis. However, Jarvis agreed that unlicensed, untrained denturists are 'impostors,' a definite form of quackery. (6)

The American Dental Association has always held the position that only licensed dentists are competent to make final impressions and insert or fit dental prostheses. There was a flurry of legal activity in the 1970's that led to decriminalization of dental practice by non-dentists in a few small states. Organized dentistry worked with many state dental associations to combat illegal dentistry.

From a 1976 article published in the Journal of Prosthetic Dentistry (7), one of the keys is to promote better relations with dental laboratories. "New members in the local society must attend an orientation meeting where, among other things, they are instructed how to deal with a dental laboratory:

1. Get to know the laboratory of your choice
2. Send the same high-quality casts and records you would expect in return
3. Send adequate written instructions
4. Do not send the patient to the laboratory for any reason
5. Pay your laboratory bill promptly

In 1980 the ADA released a Public Information Manual on Illegal Dentistry (8). The denturist's themes and strategies were outlined, along with the dental profession's overriding objectives to counter the denturists. In Canada and the U.S. states where denturists prevailed, there was wide discussion in the public media leading up to political referendums, and denturists often seemed to be favoured in the press.

"Comfort the afflicted and afflict the comfortable" is an old newspaper axiom. To the uninformed readers & editors, dental laws appear to merely protect dentists and force many poor elderly patients to pay unfair fees for dentures. The dentist's message about health hazards and biologic training and professional standards was lost in the rush to find cheaper dentures.

Initially, fees charged by legal denturists were significantly lower than dentists. (9) A study in 1985 suggested that denture fees charged by dentists were being held down by competition from cheaper denturists, but concluded, "Unfortunately, there are as yet no reports on the oral health of patients treated by denturists." (10)

In 1984 the ADA released a Status Report (11) on care provided by dentists and non-dentists in the U.S. and Canada. The various state's denturist laws enacted all included training programs, and by the 1984 report *all* of the denturist training programs had failed. The future demand for denturist schools was apparently deemed too small for any state governments to invest in them.

Not surprisingly, the ADA studies also found that the average fees charged by denturists rose every year once they became legalized, and in many places the denturist fees were close or equal to those charges by dentists. Furthermore, denturists tended to practice in the same cities and large towns where dentists already practiced, which was no help to the denture needs in remote, under-served populations.

One explanation for the steady fee increases is that when denturists were practicing underground, they avoided many typical overhead costs such as license fees, costs of license examinations, liability insurance premiums, (for the same reason unlicensed drivers cannot buy auto insurance). Perhaps some avoided declaring the ill-gotten income from their illegal practice on tax returns. These new expenses may force denturists to raise their fees in order to maintain previous levels of take-home pay.

Nevertheless, the underground denturist movement continued to work toward legalization around the country. In 1987, a denturist in a large Midwestern state tried to rally dental lab technicians. Names have been withheld in the following description of what happened.

Dental labs across the state were solicited for contributions to mount a legislative campaign similar to those in Canada and Oregon. The particular denturist advocate was a dental technician recently retired from the military, who had opened a dental lab in a city of around 50,000.

When he contacted the local newspaper about the denturist's movement, it ran a story about the new denturist and the campaign, generating some feedback and letters to the editor. Next, the denturist took the clippings to the state's capital, and again met with the newspaper editors, who decided to pursue the story.

At approximately five minutes before five p.m. on Friday, October --, 1987, an investigative reporter from the daily metropolitan telephoned a local prosthodontist in private practice and requested an interview regarding the subject of denturists. The questions asked were straightforward, very similar to the sample questions contained the ADA materials for dealing with the media. The prosthodontist had a copy of the ADA guide handy, and replied with recommended answers.

For example, when the reporter asked about the Canadian provinces where denturism was legalized, the reply was read directly from page 20 of the ADA Public Information Manual on Illegal Dentistry (8);

"Between 1966 and 1972, five different studies of denturism were conducted by Canadian governmental units. Each concluded, just as an earlier study by the World Health Organization, that denture care for health reasons should be under the supervision of a fully qualified dentist. However, the Canadian provincial governments ignored the studies and acted to lower oral health care standards, making the public the loser."

The reporter immediately asked for specific dates and sources of these studies, but when he was referred to the ADA for details, the reporter replied that there was no time to check further because the story was going to be published very soon. The unexpected phone call had many earmarks of the "Ambush Interview" technique made famous by Dan Rather on the 60 Minutes television show.

The story appeared the following Monday morning on the front page of the local section, with a photo of the denturist holding an articulator and mounted dentures. The usual selling points for denturists movement were made. The story quoted the dollar amount (\$165) charged by this denturist for "a complete set of well-fitting, high-quality, long-lasting dentures." The prosthodontist was quoted saying denturists "can't provide an oral examination (and) lack the training to make quality impressions."

The denturist claimed, "I could teach you to make an impression in 10 minutes and take a bite in 15

minutes."

By remarkable coincidence, a scheduled meeting of the local dental society was held that same evening, with some 200 dentists attending. Nobody at the meeting mentioned the newspaper story from the podium, and nothing about denturists was said publicly. The newspaper reporter and/or the denturist, who might have planned for the newspaper story to coincide with the dental meeting, were probably lurking in the hotel and eavesdropping. Any dentist's remark whatsoever could easily be twisted by overzealous news reporters.

There were no subsequent letters to the editor, and no further denturist stories were published. The particular denturist activist later moved to another state. Evidently, once word got around that he was practicing dentistry illegally, ethical dentists stopped sending their denture cases to his lab. The particular state has seen no other similar denturist efforts since then.

The moral of the story is that individual dentists should be extremely careful when talking to the media about denturists. Just refer those questions directly to the American Dental Association (or state association), where spokesmen are trained to deal with reporters about those hot button topics. Practicing dentists have little to gain and much to lose by grappling with the media. The American College of Prosthodontists also works actively with the ADA in the fight against denturists. (13)

With no denturism training programs currently available, it is now impossible for any new denturist to become licensed in any U.S. state. The denturist's legal movement could wither on the vine if the present handful of licensed denturists eventually retire and are not replaced by younger licensed denturists. But don't be complacent.

The dental profession must remain vigilant, because there will always be illegal denturists who prey on denture wearers. Denturists are just as dangerous as any other fraudulent practitioner or quack. Uninformed patients will continue to seek their denture service, and that's why laws are necessary -- to protect those patients.

Pseudo-Science Terminology The Five "Laws" of Quack Science

by Roy Auerbach

Executive Committee of The Association for Rational Thought in Cincinnati, Ohio

<http://www.reall.org/newsletter/v01/n11/index.html>

1. **Think Big** Quack sciences are also likely to take on the giants of sound science, rarely attacking the lowly assistant professor, preferring instead to claim that Einstein (or Newton, Pauling, or Feynman) was wrong.
2. **Think Difficult** laws of a quack science are usually claimed to be very difficult to verify.
3. **Rule of Paranoia** I'm a genius and they're out to get me.. view themselves as victims of persecution.. big organisations repress my work
4. **No Criticism Allowed** public announcements or publications unimpeded by peer review. This allows the public to absorb the new alleged findings in the absence of immediate critical response.

5. **Lonely Hero of the Laboratory** advances normally are produced through a social process that involves communities of scientists over time--new findings are often not unexpected and are usually compatible with earlier work. The quack scientific discovery, however, is likely to arrive out of the blue, unsupported by previous research.

British Select Committee on Health

adding clinical skills to the work of **dental** technicians (the auxiliary workers who make dentures and other appliances) will not help because most people would still need to see a dentist as well, for care of their natural teeth. Few **dental** practices now have technicians working on site because of the sophistication of technical processes and equipment used by the **dental** laboratory industry. It does not make operational sense to add clinical/biological skills to the work of **dental** technicians now mainly working in a non-clinical environment away from dentists.

To summarise—while treatment needs are polarising, and while more patients can be expected to have minor needs in future, delegation away from a multi-skilled dentist to an auxiliary with more limited duties will not necessarily produce efficiency or service gains. Also, and as we already discussed, some patients have needs which are **dentally** simple but complex in other respects, because of medical or social problems. This will also make auxiliary delegation an inappropriate answer to dentist shortage.

French intellectuals attack 'war on intelligence'

Jon Henley in Paris

Wednesday February 18, 2004

[The Guardian](#)

More than 20,000 French artists, thinkers, film-makers, scientists, lawyers, doctors and academics have signed a petition accusing the centre-right government of "waging war on intelligence" and instituting "a new state anti-intellectualism".

the signatories denounced a "coherent policy" to "pauperise and fragment every field"

The collected professions "of knowledge, thought and research" are under systematic attack from a state-sponsored philistinism intent on reducing the complexities of Gallic public debate to a series of "simplistic and terrifying" alternatives, the protesters say

<http://www.ag.state.mi.us/opinion/datafiles/1990s/op06770.htm>

The learned professions have not been permitted to practice as corporate entities by virtue of "learned profession doctrine."

A four-point rationale is the basis for this doctrine:

- 1) Laymen should not be permitted, directly or indirectly by virtue of the corporate form, to practice medicine;
- 2) Necessary confidential and professional relationships existing between a physician and his patient could be destroyed by lay shareholders interested only in a profit;

- 3) The limited liability of the corporate form is not appropriate where the client must place such a high degree of trust and confidence in the physician; and
- 4) It is impossible for a corporation to fulfil the licensing and ethical requirements medical practice demands.

Quackery: How Should It Be Defined?

Stephen Barrett, M.D.

"Quackery" derives from the word *quacksalver* (someone who boasts about his salves). Dictionaries define *quack* as "a pretender to medical skill; a charlatan" and "one who talks pretentiously without sound knowledge of the subject discussed." These definitions suggest that the promotion of quackery involves deliberate deception, but many promoters sincerely believe in what they are doing. The FDA defines health fraud as "the promotion, for profit, of a medical remedy known to be false or unproven." This also can cause confusion because in ordinary usage -- and in the courts -- the word "fraud" connotes deliberate deception. Quackery's paramount characteristic is promotion ("Quacks quack!") rather than fraud, greed, or misinformation.

Medical Education

The poor quality of medical training offered in the United States was one reason for the slow development of the medical profession and the rapid growth of quackery in the 19th century. Medical schools were proprietary, had few entrance requirements, and provided no clinical training. Most doctors learned their trade through apprenticeships with practicing physicians, which provided the doctors with needed extra income and cheap labour. Hence the profession was unwilling to replace the proprietary schools and apprenticeship system with more appropriate education. Medical training and medicine suffered as a result. Fierce competition for students resulted in lowering standards. When a school tightened its admissions standards and toughened its curriculum, enrolment dropped as students left for easier schools. Because the schools emphasized profit, medical education was separate from the university system and those schools affiliated with universities were affiliated in name only. In an effort to improve standards, state medical societies fought colleges for the right to license physicians through examinations. In 1847, the newly formed American Medical Association established a committee to study medical training. The committee recommended tightening requirements, lengthening the academic year, and establishing a minimum of seven faculty members with different specialties to open a medical college. Medical education improved slightly in the second half of the century, as the exploding knowledge base of the profession finally forced colleges to improve. Harvard president Charles Eliot seized the opportunity in 1869 to extend the medical

college's school year from four months to nine, require both written and oral examinations, and establish a three-year curriculum. But it was not until Johns Hopkins University opened in 1876 that medical education improved significantly because Civil War hospital experiences and the new theories of bacteriology slowly produced fundamental changes in medical practice. Medical training adapted to the growing **knowledge base of the profession**, and by the end of the century, America was well on its way to having the best medical care in the world. The founder Daniel Coit Gilman required clinical practice as an integral part of training. The apprenticeship system was ending

Dental Council of NZ

Brent Stanley

From the Chair of the Dentists Disciplinary Tribunal

The practice of dentistry is based on trust.

Patients trust their dentist to provide appropriate advice and treatment.

They trust their dentist to provide reasonable quality treatment at a fair price.

Importantly they trust their dentist to keep them informed about options and possible consequences. It is the responsibility of the practitioner to ensure that the patient has a clear understanding of the procedure involved and the expected cost. The more complex and expensive the treatment the more important informed consent becomes.

Implant dentistry is extremely complex to design, expensive to provide with serious biological, emotional and financial setbacks should the superstructure of the foundation suffer failure or be threatened by shoddy adjacent structures.

Dentists push the boundaries of their knowledge in assessing x-rays of potential sites so to provide full information - *informed consent*.

A provider must morally & legally provide options and cost benefit details, complication and disadvantages.

This requirement is valid so to allow a patient to choose implant vs. denture vs. no treatment.

No treatment is sometimes the best choice. Dentists have been trained to **not recommend** partial dentures when against the patient's interest nor do they have a need to 'push' partial dentures which are a time consuming less profitable centre compared to the other modalities in the repertoire of a biologically trained gatekeeper provider.

A single modality Prosthetist with just one limited income source may be less hesitant in placing a partial denture especially in unhygienic mouths. The dentist is the gatekeeper to prevent "over-servicing" by an industry that may consider itself under-utilised.

Gatekeepers keep national health costs down by removing the provider from street level in shopping centres, hidden from accessing the market with expensive services that may not be necessary.

Gatekeepers choose quality providers whereas an open market often encourages financial avarice from profit motivated entrepreneurs such as NSW deregistered ex surgeon Dr Eggleston.

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 SUBMISSION TO THE
 ACT LEGISLATIVE ASSEMBLY
 STANDING COMMITTEE
 PLANNING & ENVIRONMENT
 ENQUIRY INTO THE
 ROAD TRANSPORT
 (PUBLIC PASSENGER SERVICES)
 AMENDMENT BILL 2003

The concept of public interest and provision of a .. service are inextricably linked to any sustainable ..policy. This Amendment Bill attempts to regulate the introduction of deregulation. It sets down the steps to add taxi licences ..each year without cause, thereby reducing taxi plate values. It does so in defiance of empirical evidence and international research that demonstrates the uniqueness of the taxi industry model. It is the sustainability of the market that is an inherent building block for a sustainable transport policy..be a disaster for consumers. ...(a new) regulator, or any bureaucracy that is remote .. will never be able to fill. And (the old regulator) performs this role without any cost to the Government. But short sighted, economically rationalist, and financially opportunistic philosophy within some elements of the Government and their senior policy advisers is destructive to the industry.

problems of attrition of denturists Oregon

<http://www.hlo.state.or.us/minutes/dt031601.htm> problems of attrition of denturists Oregon

"Servants of Nature, A History of Scientific Institutions, Enterprises and Sensibilities"

by Lewis Pyenson and Susan Sheets-Pyenson, HarperCollins Publishers, London, 1999, ISBN 0 00 223842 X

Post Modernism (Page 21):

"Recent debates about whether science expresses truths about the world call to mind an observation by a sixteenth-century patron of natural knowledge, Thomas Gresham (1518/19-1579). Councillor of State, founder of the British stock exchange, and endower of a college that served as the nucleus of the Royal Society and persisted into the twentieth century, Gresham proposed a principle of economics that had been epitomized as:

'Bad money drives out good money.'

That is, silver currency will inevitably force gold currency out of circulation. The principle applies more generally to governments, trades, and professions. In a parliamentary system of government, the actions of one corrupt delegate can provoke a vote of 'no confidence' that will produce new elections.

Gresham's Law suggests why professional.. are concerned about enforcing standards.

If isolated unscrupulous practices shake confidence in, for example stock brokerage, physical therapy, or dental surgery, **people will cease patronising the enterprise.**

In the world of scholarship, outrageous or demonstrably false assertions can bring an entire specialty into disrepute.

What sacrifices do dentist make “in the public interest”

Double tax payments: taxed as sole traders

No kickbacks or commissions. General dentist cannot be partner or practice with specialist

Practice only sold to dentists: no share market buy-outs or fortunes made

Contributions to ADA & FDI public education campaigns: 70 Perth dentists at Royal Show stand for ADA

We invented prevention -we preach low sugar, low liability - bad for us!

For 110 years, 99% of dentists don't stimulate *usage* by capitalism's most powerful persuasion - advertising

We self-fund our own further education through degrees, subscriptions, Societies and Conferences

Taxpayers don't fund regulation of Dentists! We fund the Board and its litigation via Registration Fees

We provide information for informed consent from our knowledge and training

Dentists compete fiercely by quality, "being better"

What do Dentists want from Parliament?

Only Validation for our priority for "quality" over "price".

We need a clear market signal that our high standard will not be diluted especially by "grandfather" lawbreakers who have not controlled illegal dentures, nee, that *they* are *the problem* and they are not a solution merely 'more of the same'

What are the consequences of diluting professional standards of care?

Parliament will be seen as sanctioning a sectional group intent on their own money grab at the unsuspecting market

Good dentists will be discouraged, bad dentists will flourish in cahoots with money focused quack prosthetists

Dentists will not want to work in a country town with a Prosthetist in the same town

Dentistry will be split into 2 factions

Other ancillary workers in other sectors will be encouraged to break from the team

Prosthetists are too small a group to self-fund Clinicians

Principles of Fairness: An Examination Guide for Credentialing Boards

Credentialing examinations are "high stakes" tests, designed to protect the public by assuring that individuals have adequate knowledge and/or skill. Therefore, the primary responsibility of credentialing boards is to ensure the validity, reliability, security, and integrity of examinations.

College of Dental Technologists of Ontario

Fee or Income Splitting

Dental technologists may not fee or income split with anyone other than

- a dental technologist who engages in the practice of dental technology as an employee of yours;
- another dental technologist who, while not employed, comes to your office to provide services as an independent contractor for your laboratory;
- a dental technologist who engages in the practice of dental technology as your partner.

THE DOMANI GROUP

Looking at Tomorrow Today™

MOVING HR FROM CERTIFICATION TO LICENSURE: IMPLICATIONS FOR SHRM

Prepared for
Society for Human Resource Management

<http://www.shrm.org/about/shrmstrategy/occupationallicensing.pdf>

requests for licensing almost always come from professional or trade associations acting on behalf of their members, not from aggrieved consumers.

This fact is seen by critics of licensure as convincing proof that **the primary goal of licensure is to gain an economic benefit for members of the profession, not to protect the public.**

Further, newly-licensed professions routinely demand that existing practitioners be "grand-fathered"

i.e., made exempt from the now-higher entry requirements for newcomers to the profession -- and

licensed without proof of fitness.

Grandfathering, critics say, is inconsistent with true concern for the public welfare since it relies on the implausible conclusion that all existing practitioners are competent and honest. In truth, critics claim, grandfathering is common because it is an effective means of **suppressing opposition to licensure among existing practitioners**. The benefits of licensure to the licensed profession can take many forms. The licensure requirements can be used to restrict the number of qualified entrants, and thus the number of competitors, thereby providing a sort of "career insurance"

A modified quote by editors of the top two American medical journals:

There is no alternative medicine or dentistry. There is only scientifically proven, evidence-based medicine supported by solid data or, unproven medicine for which scientific evidence is lacking.

..it is irrelevant except for historical purposes and cultural interest. . . . As believers in science and evidence, we must focus on fundamental issues-namely, the patient, the target disease or condition, the proposed or practiced treatment and the need for **convincing data on safety and therapeutic efficacy.**"

Fontanarosa PB, Lundberg GD. Alternative medicine meets science. *Journal of the American Medical Association* 280: 1618-1619, 1998

"There cannot be two kinds of medicine -- conventional and alternative. There is only medicine that has been adequately tested and medicine that has not, medicine that works and medicine that may or may not work.assertions, speculation, and testimonials do not substitute for evidence."

Angell M, Kassirer J. Alternative Medicine -- The risks of untested and unregulated remedies. New England Journal of Medicine 339:839-841, 1998.

UK Health Minister response:

the inquiry carried out by the Office of Fair Trading...

It seems **unlikely** that denturists providing facilities to see patients could provide them much more cheaply.

Against any savings would need to be **set the cost of additional training for denturists if this was provided at public expense.**

I see little justification for the introduction of **denturism** on economic grounds.

We did not assess the arguments about health care and quality of service

but found little to suggest they would strengthen the case for **denturism** in the United Kingdom



Baroness Finlay of Llandaff:

The UNITED KINGDOM PARLIAMENT

Dental stomatitis and gingivitis needs good oral hygiene and **denture**-cleaning, not anti-fungals or antibiotics. **Dental** abscess, which is normally due to prevotella, which is an organism found in the mouth, develops penicillin resistance very readily by Beta Lactamase production. I would remind your Lordships that some **dental** abscesses have been fatal.

Serious infections, such as cellulitis, need a serious diagnostic medical workup, for they are potentially fatal. The amount of antibiotic in every community must be decreased to avoid that individual community developing more and more antibiotic resistant strains of organisms.

That is why I would like to see antibiotic prescribing more restricted and not extended to the initiation of antibiotics by more people...

The UK Minister for Health (Mrs. Virginia Bottomley) :

..Age Concern..is particularly interested in problems of the elderly, was unequivocal that the responsibility for fitting **dentures** should remain with dentists and should not be passed to dental technicians

However, the Dentists Act 1984 specifically prohibits dental auxiliaries of any class from fitting, inserting or fixing dentures or artificial teeth for a good reason. It protects the public by restricting dental practice to those who are properly trained and qualified. The provision of dentures cannot be considered in isolation from the total oral and general health care of patients. The insertion of a denture significantly changes the oral environment and this may have harmful effects on any remaining teeth, the gums and oral mucous membranes or the whole of the masticatory apparatus. In the Department of Health, we are convinced that a patient's oral health will be better served if, when dentures are required, that function is carried out by a person who is trained to prescribe and fit dentures ; can recognise pathological conditions which may be caused or exacerbated by dentures ; and can at the same time advise the patient--particularly where partial dentures are being fitted--of any other dental treatment which should be carried out.

.. that about 2,000 new cases of oral cancer are reported each year, most in the 50 to 70 age group. It is vital that early diagnosis is made and any precancerous conditions recognised, and dental surgeons are uniquely placed and qualified to undertake that work. There are many other conditions in the mouth that are markers of systemic disease, such as diabetes, anaemias and malabsorption syndrome, as well as numerous mucosal conditions which require treatment before dentures are constructed--indeed it is estimated that approximately half of all persons with dentures show evidence of some form of oral pathological condition.

My hon. Friend will appreciate that while we welcome the contributions made by dental technicians, we believe that they should work with dental practitioners as part of a team to ensure that patients receive a quality service that protects their oral health and general well-being

Based on the book [The Demon Haunted World](#) by Carl Sagan

The following are suggested as tools for testing arguments and detecting fallacious or fraudulent arguments:

Wherever possible there must be independent confirmation of the facts

Dental philosophers and Scientists are aghast at Legislators' naivety.

Encourage substantive debate on the evidence by knowledgeable proponents of all points of view.

There has been no opportunity for airing these matters: TV Debate or Select Committee or consultation with MP's on "the horns of the dilemma". Dumb silence. Parliamentary democracy at its best? Let's see.

Arguments from authority carry little weight (in science there are no authorities").

Not **one oral educator or medical practitioner supports the grab for greater biological and invasive clinical duties.**

Spin more than one hypothesis - don't simply run with the first idea that caught your fancy.

Try not to get overly attached to a hypothesis just because it's yours.

Quantify, wherever possible.

If there is a chain of argument *every link* in the chain must work.

"Occam's razor" - if there are two hypothesis that explain the data equally well choose the simpler.

Ask whether the hypothesis can, at least in principle, be falsified (shown to be false by some unambiguous test). In other words, it is testable? Can others duplicate the experiment and get the same result?

<http://www.wilder.org/goodage/Features/dentures403.html>

How do I get an anti-snoring device?

Your best choice for a professionally trained dental specialist is a denturist.

Implants

Factors such as your medical history, a clinical examination, X-rays, a prosthetic guide and a surgical guide are considered first.

Once decisions have been made as to the type of prosthesis, your denturist will evaluate and plan the number of implants, discuss the surgical procedure with the oral surgeon and plan every step in the process working as a team along with the surgeon.

Speak to a denturist to find out if implantology is right for you.

This is classic cart before the horse.

This denturist newsletter talks of one day courses, keep your certificate to prove you are qualified, refers to patients as prospects and "don't let them walk out the door".

Give them a full understanding of the benefits and downsides"

Heavens that's informed choice but they don't have training in the surgical downside... so its fake or incomplete choice to proceed OR NOT to proceed.

They also talk about "sell" to the "prospect" and prepare for "the lag in your income".

Is this a professional group with higher ideals of patient care and real qualifications?

President's Message

A message from WDA President Pat Carbone

I would like to thank everyone who attended and supported us in Olympia to try to get Senate Bill #6319 passed. Unfortunately, it was shot down in the House, but that's just the way some battles go. You win some and you lose some. We will be back and hopefully with stronger support to keep the insurance companies from discrimination.



We had a lot of great ideas of being Licensed Denturists. A few ideas were to have announcements on TV and radio. Another was to hold a free denture and/or partial clinic for educating the people that need our services.

Overdentures

continued from page 5

2. Contact your implant manufacturer reps to find out about courses they are offering, such as Straumann
3. Ask your dental suppliers about courses that they know of.
4. _____
5. As well, there are courses put on by various groups and organizations. For example, in Ontario there are three:
 - a. CanDEC. (4746) which offers one day courses for set up techniques, Ivoclar processing, Straumann Implants, Molloplast B softliners.
 - b. Denturist Academy for the Study of Implant Retained Prosthetics.

Keep in mind that while it is necessary to read about, study and be taught the techniques, it is essential that you get the hands-on training as well. Be sure that you receive and keep certificates for each program that you do so you can easily establish your qualifications to do dentures on implants.

Now educate the patient

More and more of our clients are offering dentures with implants to their patients and, as in any service, we have found that there are right ways and wrong ways to meet this new challenge.

If you have working relationships with dentists, oral surgeons or periodontists, referrals from these individuals may well have already been sold dentures on implants. No brainer.

In the case of your own patient, new or old, who are candidates for dentures on implants, offer them this option along with the usual denture type you sell. Give them a full understanding of the benefits and downsides. Sell them what you believe in. Don't let them walk out of the practice without having made a choice.

The biggest downside is that the patient will have to undergo surgery, though relatively minor. Not all patients will want to proceed with that.

Then there is the cost. Present the value and benefits to overcome this. One prime factor in getting patients

to go ahead with implants is that they often "hate" their existing denture.

In other words, there has to be a strong motivation on the part of the patient in order for them to proceed with implants. Your job is to educate the patient and create this motivation.

Business matters

Begin cautiously and selectively when first starting to offer implants on dentures. You need to build your team and gain experience and work out all the bugs before you get fully into them. Also, keep in mind that patients who decide to go ahead with implants will not be returning for some time for the denture, so there will be a lag on your income from delivering this service.

A separate ad or line of advertising can be set up which is designed specifically to attract patients who have some interest in dentures. This advertising should have a different phone number or something which clearly identifies the prospective patient as someone who is specifically interested in implants. One such ad which was run in the U.S. is: "Loose Dentures? Call 123-333-1234".

Another thing to watch out for is that prospects cool off over time. In other words, once they've decided to see the specialist for their implants, they must get in there and get serviced as quickly as possible. They won't wait three months to get a consultation with the specialists. Therefore, if necessary, work out special arrangements with your team members for fast service to your patients.

Note the themes of sell & promote yet a lack of "us running stringent training courses" or caution in overstepping scope or anything other than income, sell etc.

Source: <http://www.canlii.org/bc/cas/bcsc/1996/1996bcsc10241.html>

On Friday, 25 August 1995, the respondent's inspectors visited the offices of Mr. Gavrilko. (disgraced denturists) They found syringes and needles used for administering anaesthetics, forceps, cement used for cementing crowns, etc. They also found a cast of a partial denture.

Creating legislative complexities to solve a stupidity:

Denturism Act, 1991

Loi de 1991 sur les denturologistes

ONTARIO REGULATION 854/93

Amended to O. Reg. 602/98

PROFESSIONAL MISCONDUCT

This Regulation is made in English only.

1. The following are acts of professional misconduct for the purposes of clause 51 (1) (c) of the Health Professions Procedural Code:

The Practice of the Profession and the Care of, and Relationship with, Patients

1. Failing to abide by any term, condition or limitation imposed on the member's certificate of registration.
 2. Failing to maintain the standards of practice of the profession.
 3. Delegating a controlled act except to a student,
 - i. attending a course of study at an institution recognized by the Registration Committee leading to a diploma in denture therapy or denturism, and
 - ii. acting under the personal supervision of a member.
 4. Abusing a patient verbally or physically.
 5. Practising the profession while the member's ability to do so is impaired by alcohol, drugs or any other substance.
 6. Discontinuing **denturist** services to a patient without adequate reason unless,
 - i. the member has entered into an agreement to denturists services and the period specified in the agreement has expired, or the member has given the patient five working days' notice of the member's intention to discontinue the services agreed upon,
 - ii. the services are no longer required,
 - iii. the patient requests the discontinuation,
 - iv. the patient has had a reasonable opportunity to arrange for the services of another member, or
 - v. alternative services are arranged.
 7. Failing to fulfil the terms of an agreement with a patient, except in accordance with paragraph 6.
 8. Practising the profession while the member is in a conflict of interest.
 9. Giving confidential information about a patient to a person other than the patient or his or her authorized representative except with the consent of the patient or his or her authorized representative or as required by law.
 10. Making a misrepresentation to a patient including a misrepresentation respecting a remedy, treatment, device or procedure.
 11. Performing a controlled act that has been delegated to the member unless the delegation is authorized by the regulations.
 12. Using or having in the member's office premises dental instruments or equipment, other than instruments or equipment appropriate to the practice of denturism, unless,
 - i. a dental surgeon practises dentistry in the same office premises, or
 - ii. the member has obtained the consent of the Executive Committee.
 13. Using or having in the member's office a drug as defined in clause 113 (1) (d) of the *Drug and Pharmacies Regulation Act* other than,
 - i. drugs or anaesthetics prescribed for the personal use of the member, or
 - ii. drugs in the exclusive custody of a dental surgeon practising dentistry in the same office premises.
 14. Failing to refer to a dental surgeon or a physician a patient who has an apparent intra oral condition that the member recognizes or ought to recognize is outside the scope of practice of denturism.
 15. Permitting, assisting or counselling any person to perform a controlled act except in accordance with the *Regulated Health Professions Act, 1991*, an act listed in Schedule 1 to that Act and the regulations under those Acts.
 16. Practising denturism in a public place or in a vehicle or other movable contrivance without the approval of the Executive Committee.
 17. Recommending or providing services.
- Representations about Members and their Qualifications
18. Using a term, title or designation other than one authorized by the Act or the regulations, or as provided in section 2.

Record Keeping and Reports

19. Failing to maintain records as required by the regulations.
20. Falsifying a record of the examination or treatment of a patient or otherwise relating to the member's practice.
21. Failing, without reasonable cause, to provide a report or certificate relating to an examination or treatment performed by the member, within thirty days of a request from the patient or his or her authorized representative.
22. Signing or issuing, in the member's professional capacity, a document that the member knows or ought to know is false or misleading.
23. Failing to make arrangements with a patient for the transfer of the patient's records when,
 - i. the member ceases practice, or
 - ii. the patient requests the transfer.

Business Practices

24. Submitting an account or charge for services that the member knows or ought to know is false or misleading.
25. Failing to disclose all relevant fees before providing services when requested to do so by the patient.
26. Charging a fee that is excessive or unreasonable in relation to the services performed.
27. Failing to itemize an account for professional services, using terminology understandable to a patient,
 - i. if requested to do so by the patient or the person or agency who is to pay, in whole or in part, for the services, or
 - ii. if the account includes a commercial laboratory fee.
28. Failing to issue a receipt when requested to do so.
29. Selling or assigning any debt owed to the member for professional services, but a member may retain an agent to collect unpaid accounts and may accept payment for professional services by a credit card.
30. Failing, while services, to carry professional liability insurance in the minimum amount of \$1,000,000 for each occurrence or failing, when requested by the College, to provide proof of carrying such insurance.
31. Accepting an amount in full payment of a fee or account that is less than the amount submitted by or on behalf of the member to a third party payer unless the member has made reasonable efforts to collect the balance or has obtained the written consent of the third party payer.
32. Contacting or communicating, directly or indirectly, with a person, either in person or by telephone, in an attempt to solicit patients.

Miscellaneous

33. Contravening by act or omission the Act, the *Regulated Health Professions Act, 1991*, or the regulations under either of those Acts.
34. Contravening a federal, provincial or territorial law or a municipal by-law relevant to the member's suitability to practise.
35. Influencing a patient to change his or her will or other testamentary instrument.
36. Directly or indirectly benefiting from the practice of denturism while the member's certificate of registration is suspended unless full disclosure is made by the member to the College of the nature of the benefit to be obtained and prior approval is obtained from the Executive Committee.
37. Participating in an arrangement that would result in a member or former member committing the act of misconduct described in paragraph 36.
38. Failing to abide by a written undertaking given by the member to the College or failing to carry out an agreement entered into with the College.
39. Failing to attend an oral caution of the Complaints Committee or an oral reprimand of the Discipline Committee.
40. Failing to co-operate with a representative of the College upon production of an appointment in accordance with section 76 of the Health Professions Procedural Code and to provide access to and copies of all records, documents and things that are relevant to the investigation.
41. Failing to co-operate with a representative of another College upon production of an appointment in accordance with section 76 of the Health Professions Procedural Code and to provide access to and copies of all records, documents and things that are relevant to the investigation.
42. Failing to permit entry at a reasonable time and to co-operate with an authorized representative of the College conducting an inspection and examination of the member's office, records, equipment or practice.
43. Failing to take all reasonable steps to ensure that any information provided by or on behalf of the member to the College is accurate.
44. Failing to reply appropriately in writing within thirty days to any written communication from the College that requests a response.
45. Failing to pay a fee or amount owed to the College, including an amount under section 53.1 of the Health Professions Procedural Code, after reasonable notice of the payment due has been given to the member.
46. Where a member engages in the practice of denturism with another member, failing to prevent another member from committing an act of professional misconduct or incompetence unless the member did not know and, in the exercise of reasonable diligence, would not have known of the other member's misconduct or incompetence.

47. Engaging in conduct or performing an act, relevant to the practice of denturism, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful dishonourable, unethical or unprofessional.

Tooth Loss Linked to Stroke Risk

Date: 15 Dec 2002 01:52:57 GMT

Newsgroups: sci.med.dentistry

Size: 3,558 bytes

Jenniver Warner, WebMD Medical News

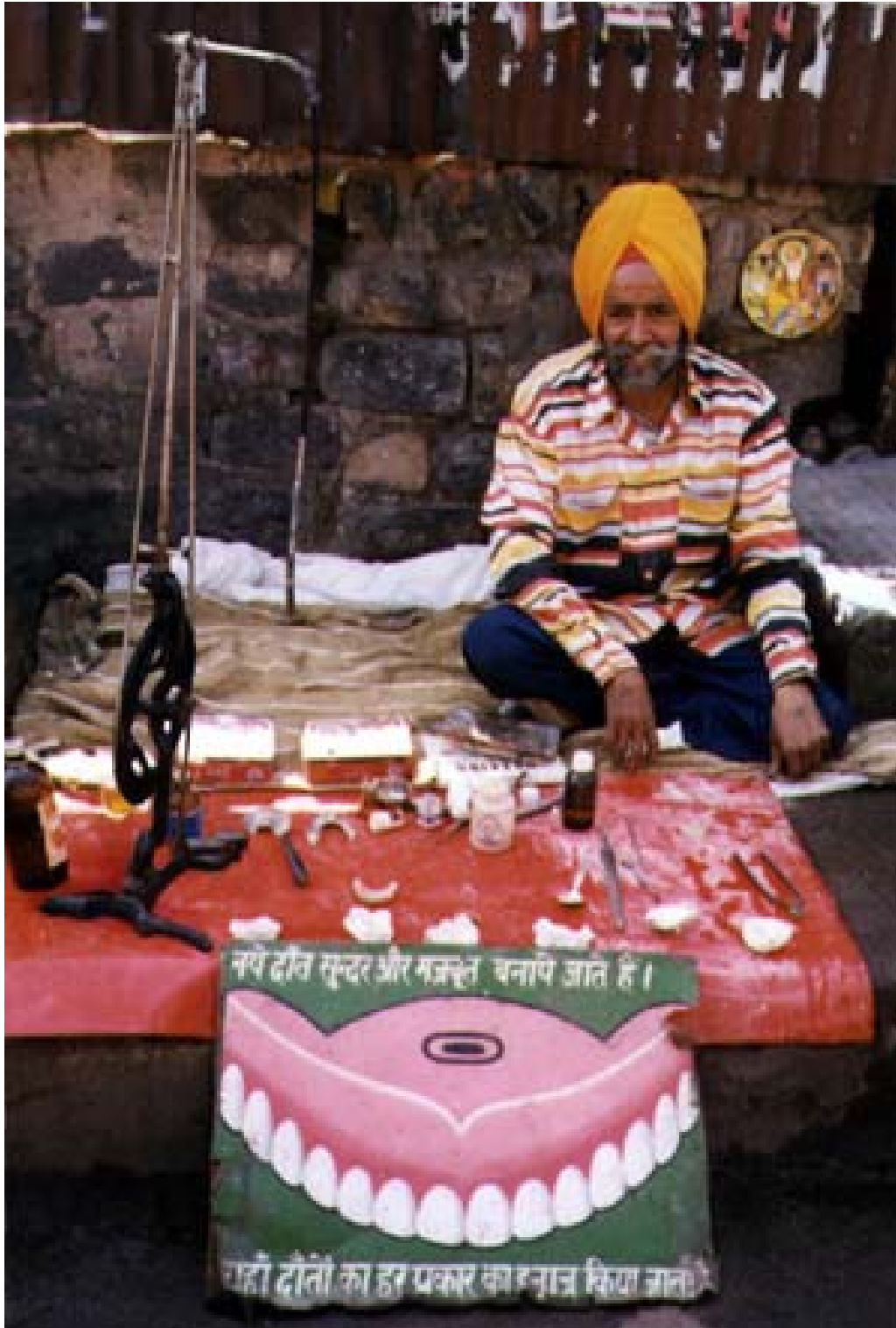
TOOTH LOSS LINKED TO STROKE RISK

Dec. 12) -- Losing your teeth may do more than just sacrifice your smile. A new study suggests tooth loss may increase the risk of stroke by as much as 74% compared with those who have a healthy mouthful of teeth.

The findings add more evidence to support the growing link between gum (periodontal) disease, which is caused by bacterial infections, and the risk of stroke and heart disease. Recent studies have shown that infections play a complex and important role in increasing the risk of these problems.

But researchers say this study is unique because it shows an association between tooth loss and heightened stroke risk that was over and above the risks associated with gum disease alone.

This noble man would be eligible to be a dental prosthetist in Perth: no literacy examination, no training just make a denture and you get Parliament's imprimatur of competency.



Empiricism is also the use of systematic observation in science to create inductive (Probabilistic) theories according to the view that experience, especially of the senses, is the only source of knowledge. In its most extreme form, positivism or radical behaviourism, it seeks to avoid all scientific theorizing, relying solely on operationalizable reports on data. More than 1000 years after the Eleatic philosophers invalidated the ability of the senses in lieu of rationalism, empiricism turns the tables on them.

Aristotle could have avoided the mistake of thinking that women have fewer teeth than men, by the simple device of asking Mrs. Aristotle to keep her mouth open while he counted.
 Bertrand Russell (1872-1970), British philosopher, mathematician. Unpopular Essays, "An Outline of Intellectual Rubbish" (1950).

Science, Politics, and the New Utopians

Rene Descartes' *Discourse on Method* (published in 1637), in which he first complains about politicians and academics, and then offers his scientific method as useful "not only for the invention of an infinity of artifices which would enable us to enjoy, without any pain, the fruits of the earth and all the commodities found there, but also and principally for the conservation of health, which is without doubt the primary good and the foundation of all other goods of this life." The new science, not the old politics, is the way to the good life, and along with health and wealth, it could also bring greater peace, he proposes. All that the benevolent scientist will ask in return for this bounty, Descartes writes, is that the community "furnish the expenses he needs, and otherwise prevent his leisure from being taken up by anybody's importunity."

a profound faith in reason, which led them to reject -- with venomous fervour -- both political and religious authority. "Men will not be free," wrote the prominent encyclopedist Denis Diderot, "until the last king is strangled with the entrails of the last priest." The French Revolution sought to achieve just that, and its hopeless (and bloody) utopian ambitions were motivated, among other things, by the dream of a science of politics that might emulate physics or chemistry in rationality and exactitude. This was the epitome of scientism (which Merriam Webster defines as "an exaggerated trust in the efficacy of the methods of natural science applied to all areas of investigation.")

Early Conservative reaction against the French Revolution, from men like Edmund Burke and Alexander Hamilton, had much to do with a revulsion at precisely this starry-eyed utopianism and cold-hearted rationalism -- the notion that a precise technique could replace the prudent muddling through of everyday political life.

But even in the wake of the murderous revolution, such zeal did not fade. Auguste Comte, in the early 19th century, argued quite explicitly for the replacement of politics by a kind of rational science. "The general situation of political science today," he wrote, "is exactly analogous to that of astrology in relation to astronomy, of alchemy in relation to chemistry, and the cure-all in relation to medicine."

that very utopian zeal, led to the birth of the most oppressive and intrusive governments in human history, culminating in the Soviet state. By the middle of the 20th century, the focus of most utopian fancies was government

The New Utopians

That battle having largely been won, however, divisions are again appearing between conservatives and libertarians in America, and we can learn something of the reason why from their slightly differing reactions to the utopian nightmares of the last century.

Most Conservatives opposed utopianism as such. Many libertarians did too, and they championed an ethic of humility toward large complicated systems like societies and economies. But some libertarians, in rejecting communism, were fundamentally opposed to

authoritarianism, not utopianism. They did not, and do not, essentially oppose the underlying zeal for science that -- carried too far -- made totalitarianism possible.

Today, in some limited but prominent libertarian circles, utopianism is back. The focus of its hopes and energies is not government, of course, but rather, once more, modern science -- in this case particularly biomedical science and biotechnology. Advances in biotechnology in recent decades, and the plausible promise of much more significant advances to come, has convinced some that the way to radical liberation leads through the laboratory. In its extreme form, the desire for this liberation has been expressed as a genuine wish to escape our human bonds -- in transhumanism and extropianism. In more moderate forms, it shows up as a profound enthusiasm for new biomedical possibilities beyond medicine, and an ardent committed desire to hold back all attempts at political regulation of biotechnological techniques.

To be sure, this does not appear to raise the prospect of a new social physics. Biotech is real science, not the misbegotten technocracy of the French philosophes and of Marx. But real though it may be, utopian dreams based upon it are still dangerous.

run amok. Yuval Levin is a senior editor of [The New Atlantis](#) magazine, and a member of the staff of the President's Council on Bioethics

It strikes me as remarkable that their left counterparts today should seek to deprive oppressed people not only of the joys of understanding and insight, but also of tools of emancipation, informing us that the "project of the Enlightenment" is dead, that we must abandon the "illusions" of science and rationality--a message that will gladden the hearts of the powerful, delighted to monopolize these instruments for their own use.

Rationality/Science
Noam Chomsky
[Z Papers Special Issue](#), 1995

The Ethics of Empiricism

Dr Yolande Lucire

PhD MB BS DPM FRANZCP

Presented at Philosophy and Psychiatry Annual Conference Blackheath NSW, November 1977

Culver, Clouser and Get adapted rational choice theory to medical practice and argued that a direct but underground connection existed between rationality, and ethics so that only rational medical diagnosis and treatment were ethical behaviour

Decisions are made in accordance with beliefs about the body, and false beliefs abound. Some patients believe themselves to be diseased even though there is not evidence in the real world for such a state. They seem to seek out those physicians who will maintain them in the sick role in accord with their own beliefs. Physicians who are willing to enter into this pas de deux of simulation collusion act as magnets for somatizing patients, and extract a high toll, willingly paid, in the form of ambivalently grateful submission to empirical remedies. Such physicians are full of reasons, which we would call rationalisations and they are based on their idiosyncratic beliefs. They stop collecting evidence to

challenge their beliefs, when they know enough to justify their practice. The beliefs that they choose are those which conform with their own desires which might include research grants, large spheres of influence, the adulation of patients, big practices, influence, or simply the good feeling of being a member of a social movement aimed at the improvement of workplace conditions

errors are not made in emergencies. They are the consequences of irrational beliefs, firmly held, believed and disbelieved simultaneously but underpinning action. An irrational belief was one that is, firstly, held by a person with sufficient knowledge and intelligence to know that it was false; and secondly it is logically or empirically incompatible with a great number of beliefs that the person knew to be true and thirdly its incompatibility was apparent to almost everyone with similar knowledge and intelligence. Thus irrational beliefs were not merely false beliefs but they were beliefs whose falsehoods were obvious to people with the same training, the same intellectual backgrounds and capacities as the person holding them. It is necessary to collect evidence to support beliefs and when a physician refuses to collect information or chooses to disregard that which does not suit his or her personal desires, this behaviour might well be subjected to ethical analysis. The capacity to hold true beliefs about what is wrong with the patient is an index of one's medical competence and that a matter for ethics.

MacIntyre as provided a cumbersome definition of altruism in practice, the pursuit of goods internal to the practice, and this is the pursuit of health **Physicians need to be altruistic because, if they pursue goods external to the practice of medicine - money, fame and adulation - and they have more than enough willing partners in this pursuit and ill health will be the consequence of this pursuit.**

Anything less than altruism is a compromise of ethics.

Dr Yolande Lucire
PhD MB BS DPM FRANZCP

Are professional Boards slanted towards one's mates? Not likely! If it aren't broke don't fix it. Dental knowledge is essential in evaluating dental aberrations as evidenced by lay people consistently picking up the wrong end of the stick in controversies legal or journalistic.

In WA it is intended that the magistrates who determine town-planning matters will hear Dental Board matters when there has been no example of the Board not behaving correctly nor, I would wonder do they have the requisite understanding? Remember the dentist registration fees pay for the policing of dentists with no cost to the taxpayer. If prosthetists are to be under the Board, which is a necessary reform, their registration fees should pay for their own actions, not dentist funds. Taxpayers will fund the Tribunal but the Board should apportion its costs to each group according to their utilization of the Board's time and resources. Since 1984 the 30 active prosthetist have had a free trip as they only ever paid one licence fee for a lifetime. This means nobody knows their actual number, location or modus.

Comparison of Codes in Board Hearings (example given for sexual accusations)

Criminal Court Rules Of Evidence Presumption of innocence and complaint to be proved. Justice is justice for all. Information as Proof Absence of proof or reasonable hypothesis consistent with innocence should mean no case. Unproved case is dismissed Standard of proof of crime is beyond reasonable doubt Conflict of Interest Conflict of interest by parties to litigation is to be notified and avoided. Collusion is arguable. Prior knowledge of the accused or current acquaintance with Judges or expert witnessed must be declared Expert Issues Expert who needs to have some expertise in the matter at hand' He signs a declaration and swears his evidence. Evidence may be called on the consistency of the complaint with the doctors records and reports, as well as on the reliability of the complainant It is the truth and reliability that is to be tested Rarely able to use similar case evidence Criminal courts would be willing to look at consent on a case-by-case basis. Criminal Court	<h3 style="text-align: center;">Comparison Of Codes</h3> HCCC and Medical Board No Rules Of Evidence Complaint has to be assumed to be true unless it can be 'disproved' Protection of the public Balance of probabilities, which means convincing a Tribunal that it is 'probably' the case. Fine judgments may do irreparable harm. Spectral evidence is acceptable in the absence of proof. In the tribunal, if the vote is 2-2 the judge uses a second, casting vote and can convict. Sometimes tribunal member and peer reviewer have practiced together. Former colleagues and rivals are used against an accused doctor. Conflict of roles. Eg. A peer reviewer will sit on a Tribunal in a case he has peer-reviewed. Peer reviewer may be someone who is not in the same specialty, not in same sub specialty and, as well as that, he may be 20 years junior to the accused doctor. Before a hearing, the peer reviewer is asked to assume guilt and comment on what level of opprobrium is to be given. This is used as evidence before facts are established. Reliability is not put at issue and complaint support services are used to fortify the complainant. Similar case evidence can be brought in, including 'patterns of practice'. The Tribunals are constrained by their legislation and mandate that no patient is capable of giving consent, never ever, even after they are married. HCCC And Medical Board
Character Of The Accused Character is generally irrelevant unless raised by an accused. An accused and convicted person is assumed innocent and have sound mind unless evidence is led to the contrary. Evidence on the mental health status of the accused is called only in the case where the accused wishes to plead insanity or diminished responsibility or in mitigation. Propensity evidence is rare and limited in its use, although 'similar case' evidence may be admitted.. Evidence On Credibility Evidence enhancing the reliability or credibility of the complainant is not allowed. Accused assumed innocent	The character of the doctor is of primary concern and he can be sent for psychiatric examination The doctor charged with a sexual offence is assumed to be impaired and is sent for counselling. Impairment of the accused is almost assumed and evidence is called on his character, his therapy, his personality and his propensity to repeat. Examines treatment files, calls evidence on alleged 'propensity' when the doctor denies having done the act at all. Common practice to get advice from psychiatrists who effectively support the accuser's credibility while

and sane unless he raises it.

When the complainant is obviously deluded the case would not proceed without corroborating evidence. Other conditions leading to delusions and confabulations are recognized as suitable for expert evidence on reliability as they are 'outside common knowledge.'

There is a precedent in *Farrell v the Queen*, HCA 1998 allows an expert give evidence on 'reliability' of the complainant where a psychiatric condition influences it.

Appeals

Appeal is available to the CCA on 'unsafe and insecure' conviction and is often successful

Sentence, right or wrong is served and finished.

badmouthing the accused doctor.

'Obviously the presence of a psychiatric condition on the part of a victim does not discredit her story but it does make the investigation of the complaint extremely difficult, particularly if, for example, the victim suffers from some kind of delusional disorder.' (Kiel, HCCC, 1993).

'Psychiatrists use their tools of trade to discredit the accusers.' (Kiel, HCCC 1993)

Appeals on the facts were abolished on the basis that it would be inappropriate for such decisions to be made by a court consisting solely of judges without the benefit of medical opinion.

Falsely convicted doctors must admit their crime to be re-registered and promise not to do it again and some balk at confessing falsely and never will.

Conclusion: A health provider does not have an easy life should a dental patient complain to the Board.

Supply and Demand for Medical Care: or is the Health Care Market Perverse? Professor Jeff Richardson Health Education Unit Monash

Supplier Induced Demand implies that the simple competitive market will not generate efficiency. Price competition if it exists will be muted and there will be little if any incentive for doctors to use their influence to obtain low cost, best practice, services and inputs from elsewhere in the health system.

As of December 2001, CDC had received reports of **57 documented cases and 138 possible cases of occupationally acquired HIV infection among healthcare personnel in the United States since reporting began in 1985.**

1

Exposure to Blood

What Healthcare Personnel Need to Know

OCCUPATIONAL EXPOSURES TO BLOOD

Introduction

Healthcare personnel are at risk for occupational exposure to blood borne pathogens, including hepatitis B virus (HBV), hepatitis C virus (HCV), and human Immunodeficiency virus (HIV). Exposures occur through needle sticks or cuts from other sharp instruments contaminated with an infected patient's blood or through contact of the eye, nose, mouth, or skin with a patient's blood. Important factors that influence the overall risk for occupational exposures to bloodborne pathogens include the number of infected individuals in the patient population and the type and number of blood contacts. Most exposures do not result in infection. Following a specific exposure, the risk of infection may vary with factors such as these:

- ☛ The pathogen involved

- ☞ The type of exposure
- ☞ The amount of blood involved in the exposure
- ☞ The amount of virus in the patient's blood at the time of exposure

Your employer should have in place a system for reporting exposures in order to quickly evaluate the risk of infection, inform you about treatments available to help prevent infection, monitor you for side effects of treatments, and determine if infection occurs. This may involve testing your blood and that of the source patient and offering appropriate postexposure treatment.

How can occupational exposures be prevented?

Many needle sticks and other cuts can be prevented by using safer techniques (for example, not recapping needles by hand), disposing of used needles in appropriate sharps disposal containers, and using medical devices with safety features designed to prevent injuries. Using appropriate barriers such as gloves, eye and face protection, or gowns when contact with blood is expected can prevent many exposures to the eyes, nose, mouth, or skin.

2

IF AN EXPOSURE OCCURS

What should I do if I am exposed to the blood of a patient?

1. Immediately following an exposure to blood:

- ☞ Wash needle sticks and cuts with soap and water
- ☞ Flush splashes to the nose, mouth, or skin with water
- ☞ Irrigate eyes with clean water, saline, or sterile irrigants

No scientific evidence shows that using antiseptics or squeezing the wound will reduce the risk of transmission of a blood borne pathogen. Using a caustic agent such as bleach is not recommended.

2. **Report the exposure** to the department (e.g., occupational health, infection control) responsible for managing exposures. Prompt reporting is essential because, in some cases, postexposure treatment may be recommended and it should be started as soon as possible. Discuss the possible risks of acquiring HBV, HCV, and HIV and the need for postexposure treatment with the provider managing your exposure. You should have already received hepatitis B vaccine, which is extremely safe and effective in preventing HBV infection.

RISK OF INFECTION AFTER EXPOSURE

What is the risk of infection after an occupational exposure?

HBV

Healthcare personnel who have received hepatitis B vaccine and developed immunity to the virus are at virtually no risk for infection. For a susceptible person, the risk from a single needle stick or cut exposure to HBV-infected blood ranges from 6-30% and depends on the hepatitis B e antigen (HBeAg) status of the source individual. Hepatitis B surface antigen (HBsAg)-positive individuals who are HBeAg positive have more virus in their blood and are more likely to transmit HBV than those who are HBeAg negative. While there is a risk for HBV infection from exposures of mucous membranes or non-intact skin, there is no known risk for HBV infection from exposure to intact skin.

3

HCV

The average risk for infection after a needle stick or cut exposure to HCV-infected blood is approximately 1.8%. The risk following a blood exposure to the eye, nose or mouth is unknown, but is believed to be very small; however, HCV infection from blood splash to the eye has been reported. There also has been a report of HCV transmission that may have resulted from exposure to non-intact skin, but no known risk from exposure to intact skin.

HIV

- ☞ The average risk of HIV infection after a needle stick or cut exposure to HIV-infected blood is 0.3% (i.e., three-tenths of one percent, or about 1 in 300). Stated another way, 99.7% of needle stick/cut exposures do not lead to infection.
- ☞ The risk after exposure of the eye, nose, or mouth to HIV-infected blood is estimated to be, on average, 0.1% (1 in 1,000).

☞ The risk after exposure of non-intact skin to HIV-infected blood is estimated to be less than 0.1%. A small amount of blood on intact skin probably poses no risk at all. There have been no documented cases of HIV transmission due to an exposure involving a small amount of blood on intact skin (a few drops of blood on skin for a short period of time).

How many healthcare personnel have been infected with bloodborne pathogens?

HBV

The annual number of occupational infections has decreased 95% since hepatitis B vaccine became available in 1982, from >10,000 in 1983 to <400 in 2001 (CDC, unpublished data).

HCV

There are no exact estimates on the number of healthcare personnel occupationally infected with HCV. However, studies have shown that 1% of hospital healthcare personnel have evidence of HCV infection (about 3% of the U.S. population has evidence of infection). The number of these workers who may have been infected through an occupational exposure is unknown.

HIV

4

As of December 2001, CDC had received reports of **57 documented cases and 138 possible cases of occupationally acquired HIV infection among healthcare personnel in the United States since reporting began in 1985.**

Perth dental prosthetists don't use autoclaves. Is it because they don't know or just don't care? Do they have viral status checks? Do they know post-exposure protocols? Do they even know about these matters or their complexities? Do they know how to take a medical history for they have not been trained to do so and such a skill cannot be learnt doing a 1 hour course as it involves chemistry, virology, medicine, blood, pharmacology, biochemistry and a grounding in science. Nobody in Perth cares, not the Minister, not the Health Department not the Press, so let's fake a course of a couple of weekends, yes, even by remote learning so as not to interrupt your life. Remember dentists interrupted their life for 5 years with no income, no easy exams and no realistic political understanding of the rigours of their commitment!

TREATMENT FOR THE EXPOSURE

Is vaccine or treatment available to prevent infections with blood-borne pathogens?

HBV

As mentioned above, hepatitis B vaccine has been available since 1982 to prevent HBV infection. All healthcare personnel who have a reasonable chance of exposure to blood or body fluids should receive hepatitis B vaccine. Vaccination ideally should occur during the healthcare worker's training period. Workers should be tested 1-2 months after the vaccine series is complete to make sure that vaccination has provided immunity to HBV infection. Hepatitis B immune globulin (HBIG) alone or in combination with vaccine (if not previously vaccinated) is effective in preventing HBV infection after an exposure. The decision to begin treatment is based on several factors, such as:

- ☛ Whether the source individual is positive for hepatitis B surface antigen
- ☛ Whether you have been vaccinated
- ☛ Whether the vaccine provided you immunity

HCV

There is no vaccine against hepatitis C and no treatment after an exposure that will prevent infection. Neither immune globulin nor antiviral therapy is recommended after exposure. For these reasons, following recommended infection control practices to prevent percutaneous injuries is imperative.

HIV

There is no vaccine against HIV. However, results from a small number of studies suggest that the use of some antiretroviral drugs after certain occupational exposures may reduce the chance of HIV transmission. Postexposure prophylaxis (PEP) is recommended for certain occupational exposures that pose a risk of transmission. However, for those exposures without risk of HIV infection, PEP is not recommended because the drugs used to prevent infection may have serious side effects. You should discuss the risks and side effects with your healthcare provider before starting PEP for HIV.

How are exposures to blood from an individual whose infection status is unknown handled?

HBV-HCV-HIV

If the source individual cannot be identified or tested, decisions regarding follow-up should be based on the exposure risk and whether the source is likely to be infected with a blood borne pathogen. Follow-up testing should be available to all personnel who are concerned about possible infection through occupational exposure.

Dental prosthetists and denturists are advertising on the web to make and provide devices for bleaching teeth. These techniques devices, and chemicals are potentially dangerous to fillings, tissues and decaying teeth. A dentist is a mandatory diagnostic gatekeeper in the *possible* delivery of these devices; yet, the unregulated cadre of international opportunists will circumvent common sense and State regulations because they can turn a profit. Any Australian can mail order an American kit. These kits should be controlled by TGA and not admitted by Customs unless accompanied by a dentist's prescription.

Am J Dent. 1993 Dec;6(6):305-9.

[Related Articles, Links](#)

Mercury in solution following exposure of various amalgams to carbamide peroxides.

Hummert TW, Osborne JW, Norling BK, Cardenas HL.

Division of Biomaterials, University of Texas Health Science Center, Dental School, San Antonio 78284-7890.

Carbamide peroxide (CP) is an easily administered material for whitening teeth. Although toxicological research on CP alone has revealed no adverse health effects, possible oxidation and release of mercury from amalgams have not previously been investigated. This research evaluated the quantitative release of mercury from amalgams into solution by CP. CP preparations can generally be divided into two classes based on the presence or absence of carbopol, an oxygen-releasing inhibitor. Rembrandt (R), a 10% CP with carbopol and White and Brite (WB), a 10% CP without carbopol were used in this study. Four different types of amalgams [Dispersalloy (D), Sybraloy (S), Tytin (T) and Valiant Ph.D. (V)] were selected. Uniform samples of the four amalgams were prepared and stored at 37 degrees C for 1 week. Vials of saline (10 ml), R and WB were prepared. R and WB were mixed with saline to a 50:50 solution to reduce viscosity and facilitate stirring. Magnetic teflon coated stir bars were placed in all vials, and one amalgam specimen was placed in each non-control vial. After being stirred for 8 hours, solutions were analyzed for elemental mercury content using a Jerome Gold Film Mercury Analyzer. All background mercury levels were zero, but following the experiment there were significantly higher amounts of mercury in the CP solutions as compared to the 100% saline solutions. These results suggest there is an active oxidation of the amalgam releasing mercury ions into solution.

- [J Esthet Restor Dent. 2002;14\(4\):205.](#)



Greening of the tooth-amalgam interface during extended 10% carbamide peroxide bleaching of tetracycline-stained teeth: a case report.

Haywood VB.

Department of Oral Rehabilitation, School of Dentistry, Medical College of Georgia, Augusta, Georgia, USA. vhaywood@mail.mcg.edu

At-home bleaching with 10% carbamide peroxide in a custom-fitted tray has been shown to have some minor effects on certain brands of amalgam, pertaining to mercury release, but generally, effects on amalgam are not considered clinically significant. However, in this case report, a greening of the tooth structure in certain areas immediately adjacent to amalgam restorations in the maxillary and mandibular first molars occurred during tooth whitening. Other amalgam restorations in mandibular and maxillary second molars in the same mouth did not demonstrate any green discoloration of the teeth. Upon removal of the affected amalgam restorations, recurrent decay was present in the areas of tooth greening but not in other areas adjacent to the restoration. The teeth were restored with posterior composite restorations. Whether the green discoloration was a result of some loss of material from a particular brand of amalgam, indicating leakage, or indicative of original or recurrent tooth decay is unclear in this single-patient situation. Other patients in the same study did not demonstrate this occurrence. Dentists should be ready to replace amalgam restorations should this green discoloration in adjacent tooth structure occur during bleaching, in case decay is present. **CLINICAL SIGNIFICANCE:** The unusual discoloration cited suggests that amalgam restorations in potentially esthetic areas, including the lingual of anterior teeth, should be replaced prior to bleaching, to avoid the problem of difficult stain removal or translucency allowing restoration visibility following bleaching.

Gen Dent. 2003 Jul-Aug;51(4):356-9; quiz 360.

[Related Articles, Links](#)

The effect of bleaching agents on mercury release from spherical dental amalgam.

Certosimo A, Robertello F, Dishman M, Bogacki R, Wexel M.

Virginia Commonwealth University, Department of General Practice, Richmond, USA.

To investigate the effect of carbamide peroxide, hydrogen peroxide, and over-the-counter home bleaching products on the release of mercury from spherical dental amalgam, 150 uniform amalgam specimens were prepared in clear acrylic blocks, aged for one week at 37 degrees C, and placed into individual polystyrene jars containing 20 mL of sterile saline. The specimens were divided into

three groups of 50 and bleached in eight-hour cycles. All groups exposed to bleach showed increased mercury release over time.

J Biomed Mater Res. 2003 Oct 15;67B(1):627-31.

[Related Articles](#), [Links](#)



Influence of dental biofilm on release of mercury from amalgam exposed to carbamide peroxide.

Steinberg D, Blank O, Rotstein I.

Institute of Dental Sciences, Faculty of Dental Medicine, Hebrew University-Hadassah, Jerusalem, Israel. dorons@cc.huji.ac.il

Tooth bleaching is a popular procedure in modern aesthetic dentistry. Bleaching agents may affect amalgam restorations by altering the release of mercury. The aim of this study was to explore the effect of biofilm-coated amalgam restorations on the release of mercury in the presence of carbamide peroxide. Samples of SDI and Valliant amalgams were submerged for either 14 days or 7 months in buffered KCl after which they were coated with saliva, bacteria, and polysaccharides. The samples were exposed to 10% carbamide peroxide (CP) for 24 h. The amount of mercury released was examined for 120 h. Results showed that most of mercury release occurred within the first 24 h, after which the release rate decreased sharply. After 120 h the release of mercury from the tested samples was minimal and similar to the control group. The presence of biofilm coating on the amalgam samples did not induce the release of mercury but tended to reduce mercury release into the surrounding environment. CP induces the release of mercury from amalgam samples. However, the presence of biofilm did not prevent large amounts of mercury release from amalgam coated with biofilms and exposed to CP. This study indicates that dental biofilm may retard the release of mercury from amalgam restorations. Copyright 2003 Wiley Periodicals, Inc.

Oral Surg Oral Med Oral Pathol Oral Radiol Endod. 2000 Feb;89(2):216-9.

[Related Articles](#), [Links](#)



Mercury release from dental amalgam after treatment with 10% carbamide peroxide in vitro.

Rotstein I, Dogan H, Avron Y, Shemesh H, Steinberg D.

Department of Endodontics, Hebrew University-Hadassah Faculty of Dental Medicine, Jerusalem, Israel.

OBJECTIVES: The effect of 10% carbamide peroxide on mercury release from dental amalgams was assessed in vitro by using a cold-vapor atomic absorption Mercury Analyzer System. **STUDY DESIGN:** Samples of 4 commercial brands of dental amalgam, Megaloy (Dentsply/Caulk, Milford, Del), Mega+ (CFPM, Aulnaye, France), Nongama 2 (Silmet, Or Yehuda, Israel), and Valiant Ph.D. (Dentsply/Caulk, Milford, Del), were treated for 48 hours with 10% carbamide peroxide and compared with samples treated with phosphate buffer. **RESULTS:** Amalgam specimens exposed for 48 hours to 10% carbamide peroxide showed significantly higher concentrations of mercury in solution as compared with specimens treated with phosphate buffer ($P < .001$). Megaloy and Valiant Ph.D. yielded significantly higher mercury concentrations in solution than Mega+ and Nongama 2 ($P < .001$). Mega+ yielded significantly higher mercury concentrations in solution than Nongama 2 ($P < .05$). No significant differences were found in mercury concentrations in solution between Megaloy and Valiant Ph.D. **CONCLUSIONS:** Treatment with 10% carbamide peroxide bleaching agents caused an increase in mercury release from amalgam restorations, possibly increasing exposure of patients to its adverse effects. Amalgam brands differed in the amounts of mercury release after bleaching with carbamide peroxide.

Am J Dent. 1999 Oct;12(5):227-30.

[Related Articles](#), [Links](#)

Effect of home bleaching products on mercury release from an admixed amalgam.

Robertello FJ, Dishman MV, Sarrett DC, Epperly AC.

Department of General Practice, School of Dentistry, Virginia Commonwealth University, Richmond 23298-0566, USA. Frobertello@den1.den.vcu.edu

PURPOSE: To test the effect of three carbamide peroxide bleaching products, Opalescence (O), Nite White (N), and Platinum (P) on mercury release from amalgam (Valiant PhD). **MATERIALS AND METHODS:** Sixty uniform amalgam specimens were prepared in Acrylite clear acrylic blocks. After aging for 1 week at 37 degrees C, the specimens were placed in individual polystyrene jars containing 20 mL of sterile saline, and divided into three groups A, B, and C. Specimens were bleached in cycles by removing them from the jars, blotting to remove excess moisture, and covering with either O, N, P, or saline control (SC). After 8 hours, the specimens were cleaned with a toothbrush, rinsed with deionized water, and returned to the saline. Group A was tested for mercury release after 8 hours of bleaching, Group B after 40 total hours of bleaching, and Group C after 80 total hours of bleaching. Mercury testing was performed by first reducing the mercury in solution in each jar with 1 mL of SnCl₂, and then testing the remaining headspace with a Gold Film Mercury Vapor Analyzer. **RESULTS:** ANOVA indicated there was no significant difference between the bleaches and controls at 8 and 40 hours, however at 80 hours, O caused significantly more mercury release ($P < 0.05$). Means at 80 hours in mg/m³ were: O = 0.98 +/- 0.36; N = 0.58 +/- 0.20; P = 0.47 +/- 0.11; SC = 0.52 +/- 0.14.

Endod Dent Traumatol. 2000 Jun;16(3):107-10.

[Related Articles, Links](#)

Protective effect of Copalite surface coating on mercury release from dental amalgam following treatment with carbamide peroxide.

Rotstein I, Dogan H, Avron Y, Shemesh H, Mor C, Steinberg D.

Department of Endodontics, Hebrew University-Hadassah Faculty of Dental Medicine, Jerusalem, Israel. rotstein@cc.huji.ac.il

The effect of Copalite coating on mercury release from dental amalgam following treatment with 10%, 20%, 30% and 40% carbamide peroxide was assessed in vitro, using a cold-vapour atomic absorption Mercury Analyzer System. Eighty samples of dental amalgam were automatically mixed in a dental amalgamator and condensed into silicon embedding molds. Forty amalgam samples were coated with three uniform layers of Copalite intermediary varnish and the other 40 samples were left uncoated. The coated and non-coated amalgam samples were exposed for 24 h to 10%, 20%, 30% or 40% carbamide peroxide preparations and compared with samples exposed to phosphate buffer. In the non-coated samples a significant increase of mercury concentration in solution was found following exposure to all carbamide peroxide preparations tested. Mercury concentration was directly related to carbamide peroxide concentration. In the Copalite-coated samples, significantly lower concentrations of mercury in solution were found as compared to the non-coated samples ($P < 0.01$). In conclusion, exposure of amalgam restorations to 10%-40% carbamide peroxide-based bleaching agents increased the mercury release. Pre-coating of the external amalgam surfaces with Copalite significantly reduced the release of mercury.

No articles have been published to show the effects of these gels on decayed teeth or open pulps or untreated gum disease which would be the prosthetists field of play and no dentist would provide that bleaching treatment until the mouth was healthy. Can a prosthetist understand the above science and statistics to evaluate these articles? No, unless they have done dentistry. For them, the less they know, the more they want to do!

<http://handbooks.uwa.edu.au/rules/meddent/part2/division7/table27a>

Course work for University of WA 5 years Dental School Faculty Medicine and Dentistry

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- [800.104](#) Fundamentals of Clinical Dentistry 1 104 (5 points)
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A person who successfully completes the above is a *true* dental professional.

Insurance companies

Involved in the *doctor patient* contractual relationship = litigation

...industry leviathan that will cover one out of ten Americans and will downsize patient care to unreasonable levels, unduly leverage physicians, undermine competition and cause the potential for unfair business practices

Aetna has been forcing doctors to accept "all-or-nothing" contracts -- where doctors must either accept all of Aetna's plans or will not be able to work under any of them. This shows a market dominance, which could lead to doctors being forced to accept onerous contracts that are harmful to their patients simply to survive

if rebates are based on charging profile, a dentist who discounts a fee will be disadvantaged as his profiled charges will drop so next review will cause ALL patients to receive less than appropriate rebates. ie it places pressure on dentists to keep their fee profiles **as high as possible**.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
Miami Division

MDL NO.: 1334
MASTER FILE NO.: 00-1334-MD-MORENO

WHAT IS THE LITIGATION ABOUT?

The Action has been brought by the representative plaintiffs, who are practicing dentists, and the ADA, on behalf of dentists and dentist groups, against Aetna. The complaint alleges that between 1995 and 2003, Aetna improperly denied, delayed and/or reduced payment to dentists by engaging in several types of allegedly improper conduct, such as alleged improper automatic bundling and downcoding of dental procedure codes, alleged violation of applicable prompt pay statutes, and alleged underpayment for out-of-network services. The complaint seeks relief on behalf of a purported nationwide class under various theories arising under federal and state statutory and common law.

payments. Contrary to its obligations, Aetna covertly diminishes payments to both its in-network and out-of-network providers in several ways. For example, Aetna utilizes automated programs to process claims submitted by Plaintiffs. These automated claims processing programs manipulate

payments. Contrary to its obligations, Aetna covertly diminishes payments to both its in-network and out-of-network providers in several ways. For example, Aetna utilizes automated programs to process claims submitted by Plaintiffs. These automated claims processing programs manipulate

2. The Settlement Fund

Another component of the consideration to be provided to members of the Class under the proposed settlement is the establishment of a settlement fund in the aggregate amount of \$5 million, \$1 million of which will be paid directly to the ADA Foundation, which is the charitable arm of the ADA, and \$4 million of which will be available for payments to Class Members. If the settlement is approved by the Court, members of the Class will be entitled to payments from the settlement fund in an amount based on the number of estimated members of the Class, as detailed in the Settlement Agreement. The base amount of the settlement payment to (or on behalf of) each Class member (the "Base Amount") shall be equal to \$4 million divided by the number of Class members who receive a Mailed Notice. Each Class member who retired from the practice of dentistry on or before the Preliminary Approval Date shall be entitled to elect to receive payment from the settlement fund in the amount of two times the Base Amount. To the extent dentists do not submit a claim form to obtain such cash payments, the amounts will be contributed to the ADA Foundation. All dentists may elect to contribute their payments to the ADA Foundation.

ADA, Aetna settlement finalized

By Joe Hoyle

The U.S. District Court for the Southern District of Florida gave final approval July 20 to an agreement settling the ADA's class-action lawsuit against insurance industry giant Aetna, Inc.

Approval of the settlement agreement brings to a close the lawsuit filed by the Association in August 2001 claiming Aetna was unlawfully interfering in the dentist-patient relationship and will foster improved communication between practitioners and patients while streamlining claims processing.

"We are extremely pleased with the court's decision," said Dr. Eugene Sekiguchi, ADA president. "The terms of the settlement agreement are unprecedented in the insurance industry and will significantly strengthen the relationship between dentists and their patients. The ADA looks forward to a new level of cooperation between Aetna and organized dentistry, which will greatly benefit people who are enrolled in Aetna dental plans."

The agreement requires Aetna to pay a settlement of \$5 million, including \$1 million paid directly to the ADA Foundation, the Association's charitable arm, and an additional \$4 million made available for payments to class-member dentists. Class-members include practitioners who treated Aetna members between Aug. 15, 1995, and March 26, 2004.

In addition to the financial settlement, the agreement calls for sweeping changes to the company's business practices. Among the initiatives, Aetna is directed to:

- establish a Dental Advisory Committee to advise the company with respect to downcoding and bundling procedures; the committee will include nine members, three chosen by the ADA, three by Aetna and the remaining three by the first six;
- no longer automatically downcode or bundle claims for covered services;
- invest in a system of automated claims processing to expedite processing of "clean claims for covered services";
- implement initiatives to reduce claims resubmissions;
- disclose downcoding and bundling methods and rules;
- increase electronic connectivity and direct Web-enabled access to Aetna systems to verify reimbursement information and track claims.

"The agreement marks a turning point in the relationship between Aetna and dentists across the country, where the dental patient will be the ultimate beneficiary," said Peter M. Sfikas, ADA chief legal counsel. "The ADA could not more proud of the terms of the agreement."

Class-members received Proof of Claim forms in May to either claim their shares of the settlement or indicate that their shares were to be donated directly to ADAF for dental health education, research, access-to-care and other charitable programs.

California Regulators Called Upon To Stop Aetna-Prudential Merger

Testimony of Jamie Court and Doug Heller

Consumers For Quality Care called upon the California Department Of Corporations to halt its approval of the Aetna-Prudential merger at hearings in Los Angeles today. (Testimony available upon request)

The health care watchdog group claimed that merger would result in an HMO industry leviathan that will cover one out of ten Americans and will downsize patient care to unreasonable levels, unduly leverage physicians, undermine competition and cause the potential for unfair business practices.

If the buyout is allowed, Aetna will triple its presence in California, further consolidating the health care market in the state. A four company oligopoly -- Aetna, Inc., Kaiser, Pacificare and Health Systems International -- will control healthcare for over 12.5 million Californians in HMOs if the pending buyout is allowed.

"This buyout is certain to limit the healthcare options for patients and employers, erode the bargaining position of doctors and hospitals, and threaten the quality of care patients receive," said Jamie Court, director of Consumers For Quality Care. "Allowing this buyout to proceed is to hand over a key ingredient for market dominance to a corporation which has routinely compromised patient care and disregarded doctors' concerns in the pursuit of profit. A bad actor like Aetna should not be given a license to have more leverage over patients and their doctors."

The group pointed to recent evidence of Aetna's poor conduct to bolster its case against allowing the company to grow:

- Hundreds of doctors across California have defected from Aetna recently because Aetna has foisted upon doctors reimbursement rates that appear to be inadequate to patient care needs;
- Aetna has been forcing doctors to accept "all-or-nothing" contracts -- where doctors must either accept all of Aetna's plans or will not be able to work under any of them. This shows a market dominance which could lead to doctors being forced to accept onerous contracts that are harmful to their patients simply to survive.
- Aetna U.S. Healthcare was the subject in January of the largest jury award ever issued against an HMO for not treating a dying cancer patient fairly, after which the company's CEO publicly attacked the widow and the civil justice system.

Consumers For Quality Care is a project of the non-partisan, non-profit Foundation for Taxpayer and Consumer Rights.

Testimony of Jamie Court and Doug Heller:

Regarding Proposed Aquisition of Prudential Health Care Plan of California, Inc. by Aetna Inc.

Thank you for inviting Consumers for Quality Care to testify today. Consumers for Quality Care is a non-profit consumer watchdog group created in 1994 to protect and to promote the public interest in higher quality health care.

Consumers for Quality Care urges you to deny the proposed acquisition of Prudential Health Care Plan of California, Inc. by Aetna Inc.

If this buyout is allowed, Aetna will triple its presence in California, further consolidating the health care market in the state. A four company oligopoly -- Aetna, Inc., Kaiser, Pacificare and Health Systems International-- will control healthcare for over 12.5 million Californians in HMOs if the pending buyout is allowed.

The proposal is a dangerous move in the direction of a private healthcare monopoly. This buyout is certain to limit the healthcare options for patients and employers, erode the bargaining position of doctors and hospitals, and threaten the maintenance of a free market.

The newly forged company would have over 22 million enrollees (more than 18 million in "managed care" plans) and contracts with approximately 400,000 doctors -- two-thirds of the physicians in the country. Additionally, Aetna will become the nation's second largest dental insurer with 15 million enrollees.

This buyout should be disallowed because Aetna will crowd out competition simply by its new bulk, not by operating effectively. The fact that Aetna has grown so quickly based on a track record of poor quality care (see below) suggests the free market has already been compromised.

This merger will undermine competition in the managed care marketplace and sentence consumers to fewer choices, fewer services and the potential for greater price fixing and unfair business practices.

Impact on consumer choice and patient care

The concentration of healthcare into the hands of very few HMO corporations will spell disaster for the goal of competitively priced and quality healthcare. If a patient or employer cannot shop around, there will be no competitive pressure on HMOs to offer affordable premiums. With such a powerful market position, Aetna will decrease the level of coverage offered for a basic premium and make optional certain benefits that would be part of a basic premium in a more competitive market. Patients would be subject to higher premiums and lower levels of care as a result.

Aetna has already foisted upon doctors capitation rates that appear to be inadequate to patient care needs. That is why 600 physicians in San Mateo recently defected from Aetna on January 1st. Thousands of doctors across the country have, in fact, defected from Aetna because reimbursements do not allow them to provide quality care. At least 575 doctors and health care providers in Long Beach, California left Aetna recently and 400 doctors defected from Aetna in North Texas, while similar walkouts or threats to leave have occurred in Ohio and Georgia. If this merger is approved, physicians will have few other places to go when they object to Aetna's conditions and cut-rate reimbursements. This will be a serious blow to patient care.

If this merger is approved without guarantees about Aetna's conduct and authorization practices, the new company would be in a position to downsize the level of care even further. Aetna was already ranked worst by California doctors in a survey conducted by the Pacific Business Group on Health Negotiating Alliance. This poor report card is bolstered by evidence from other regions.

Impact on doctors

The buyout of Prudential would severely weaken the position of doctors when they negotiate contracts with Aetna and other HMOs. With so few companies managing so many patients, doctors would not be able to effectively leverage Aetna into sufficiently compensating them. Doctors will lose much needed bargaining power when seeking a fair and patient-oriented contract and when pressing Aetna to provide medically necessary treatments. The combined Aetna-Prudential would be in a powerful position to grind its capitated rates so low that physicians could not possibly adequately care for their patients.

Most recently, Aetna has been forcing doctors to accept "all-or-nothing" contracts -- where doctors must either accept all of Aetna's plans or will not be able to work under any of them. This shows a market dominance which could lead to doctors being forced to accept onerous contracts that are harmful to their patients simply to survive. Aetna has shown a willingness to do foist such contracts on doctors and the state of California should not give the company a greater way to do this.

Aetna is already overextended from previous mergers

Aetna has yet to recover internally from both its 1996 merger with US Healthcare and the 1998 merger with New York Life. Aetna cannot absorb another 6 million members nationwide, nearly one million of them in California alone, without degrading the quality of care provided to those patients. Two years after the US Healthcare merger, Aetna Inc. continues to have problems bringing US Healthcare patients and doctors into their system. This has led to under-served patients and frustrated doctors. Moreover, Aetna is not likely to have even integrated the New York Life database with their main database until well into the year 2000. In its haste to dominate the HMO industry, Aetna has allowed patient services to erode. Aetna has neither the structural nor technological capacity to buy Prudential without curtailing care for patients. Aetna cannot serve new members before they have begun to effectively operate their system as it stands today.

Aetna: Defiant corporate citizen

Allowing this buyout to proceed is to hand over a key ingredient for market dominance to a corporation which has routinely compromised patient care and disregarded doctors' concerns in the pursuit of profit. The combined Prudential-Aetna entity would be in a position to further compromise medical decisions with administrative and fiscal concerns, a violation of the Knox Keene Act. In addition, Aetna has recently exhibited a genuine disregard for civil authority which suggests that it cannot be trusted with greater market leverage.

Aetna has been challenged for various abuses of the public's trust and numerous transgressions of the law. Each of these instances demonstrates both the antitrust and public health risks associated with stifling the competitive market by allowing this buyout to proceed.

- In one of the greatest spectacles of rapacious greed this century, Aetna paid former U.S. HealthCare Chief Leonard Abramson nearly \$1 billion in the \$9 billion merger of U.S. HealthCare and Aetna in 1996. This has caused significant ramifications for Aetna patients who have been forced to endure severe health care rationing in order to pay for Mr. Abramson's buyout bonus. (Abramson currently serves on Aetna's board) This company has a demonstrated track record of usurping money from the medical system to extravagantly compensate its administrative arm. This merger again poses another serious threat to patient care dollars. We urge you to closely scrutinize the proposed executive compensation package.
- Aetna U.S. Healthcare was the subject in January of the largest jury award ever issued against an HMO. A San Bernardino County jury last month sent a \$ 120 million message to the company in the case of schoolteacher Teresa Goodrich, whose husband, a district attorney, died after an ordeal from June 1992 to March 1995 trying to get Aetna to approve treatment, not all of it experimental, recommended by his Aetna doctors for his rare form of stomach cancer, leiomyosarcoma. When David Goodrich could wait no longer, those doctors administered the treatment without HMO approval. The patient died believing he had left his wife with \$750,000 in medical bills. The jury's award included \$4.5 million to the widow to cover the medical bills and for loss of companionship. The \$116 million balance was the jury's decision to punish Aetna for, among other things, the finding that Aetna acted in bad faith and with malice toward Goodrich in denying him coverage based on a treatment exclusion that never existed in his contract. Most troubling is the fact that Aetna still claims it did nothing wrong and that the company was the victim. CEO Richard Huber responded to the verdict, "This is a travesty of justice. You had a skillful, ambulance-chasing lawyer, a politically motivated judge and a weeping widow." According to Los Angeles Times columnist Ken Reich, Huber said, "Juries are customarily not intelligent enough to consider complicated contractual issues and that this one in particular was too ill-informed, as a result of the judge's evidentiary rulings, to render a sound verdict." Aetna's unwillingness to defer to civil authority suggests that the new leviathan to result from this merger will continue to run rampant over civil dictates at the expense of patients.
- In a video of an Aetna training for claims managers uncovered in *Fisher v. Aetna*, Aetna lawyers tells claims managers to perform a reasonable investigation of claims only for patients who have the right to sue. The video is the best direct evidence to date that, following the U.S. Supreme Court ruling in 1987 setting up a shield of legal immunity for HMOs covering patients with employer-paid coverage under the Employee Retirement Income Security Act of 1974 or ERISA, Aetna became more callous toward policyholders. The company dropped its field investigation force, eliminated claims handling guidelines and increased its claims personnel caseloads four to 4.5 times the industry average. The burden of proving that a claim is payable shifted from the company to the disabled patient, who is often unable to properly document his or her own case.
- In Texas, the state Attorney General has named six HMOs in a lawsuit charging the corporations with rewarding physicians for withholding care. Four of the six HMOs are owned by Aetna. The AG also charges that "Aetna penalizes doctors who speak frankly with patients about the insurer's coverage."
- Aetna has been targeted by medical groups and patient groups for contractual gag-clauses -- which prevent doctors from informing patients about certain treatments-- and for Aetna's narrow definition of medically necessary care used when the company determines levels of treatment provided to patients.
- In Florida, regulators warned Aetna that its contracts with doctors were not in compliance with state law. Aetna's violations included "contract language about emergency room referrals, privacy of patient records and so-called gag rules."
- Aetna has recently seen a spate of doctors across the country defect from the company due to mishandling of claims and lack of compliance with contracts. Psychologists have publicly challenged Aetna for forcing drugs on patients while cutting down on allowable doctor visits. Additionally, in a number of lawsuits around the country, psychologists allege that Aetna not only promises more therapy sessions than they actually cover, the

company squeezes out psychologists and replaces their services with the lower cost counseling of social workers.

- In a survey by the New York Attorney General, Aetna failed to comply with a state law requiring them to provide its HMO plan's subscriber contract to consumers when asked.

A bad actor like Aetna should not be given a license to have more leverage over patients and their doctors. With greater market share in key cities, Aetna will have put itself in a position to offer more patients less coverage for ever higher premiums. In light of the rapid consolidation of private healthcare companies, and considering Aetna's aggressive maneuvering to dominate the HMO industry over the last two years, we urge you to disallow the proposed buyout.

Aetna Facing Lawsuit

Racketeering Case May Be First Of Kind

A California consumer group filed a racketeering lawsuit against Aetna Inc. Monday, saying the nation's largest health insurer routinely makes widespread, false claims about the quality of its medical coverage.

The lawsuit, which further heats an already torrid battle about health insurance, is seeking class-action status on behalf of millions of Aetna HMO customers.

Between 1996 and now, the lawsuit said, Aetna "engaged in a nationwide fraudulent scheme designed to induce individuals to enroll in Aetna's HMO plan by representing that Aetna's primary commitment . . . is to maintain and improve the quality of care."

By contrast, the lawsuit said, Aetna's policies "severely intrude upon the physician-patient relationship and seriously restrict the ability of Aetna physicians to provide . . . high-quality healthcare." The Foundation for Taxpayer and Consumer Rights, which filed the lawsuit in U.S. District Court in Philadelphia, said the action is the first lawsuit against an HMO under federal racketeering statutes.

At the heart of the issue is the foundation's assertion that Aetna's advertising and public relations statements have been false since Aetna took over U.S. Healthcare in 1996. Aetna, the lawsuit noted, has come under strong criticism from physicians, including the American Medical Association, for policies that critics say are overly restrictive.

Aetna to settle suit filed by physicians;

Health plan agrees to pay doctors faster, ease authorizations

Leading health insurer Aetna Inc. yesterday agreed to settle a class-action lawsuit filed by 700,000 physicians by promising to pay them faster and remove authorization burdens the doctors said delayed and even harmed patient care. In the settlement, Aetna agreed to pay \$100 million to 700,000 physicians.. It also will set up a committee of practicing physicians to influence Aetna policies. prompt payment and reduced need for authorization time will translate to \$300 million in savings to physicians. Aetna also agreed to pay \$50 million in legal fees. Physician groups from 13 states complained the health plans failed to provide written explanations of how they reimbursed doctors, frequently changed the rules mid-contract and required physicians' staffs to spend hours on the phone getting authorization for needed procedures, tests or drugs...recent changes in state law protect physicians from health plan retaliation if they inform patients about treatment options not available under the plan.

Aetna has been forcing doctors to accept "all-or-nothing" contracts -- where doctors must either accept all of Aetna's plans or will not be able to work under any of them. This shows a market dominance which could lead to doctors being forced to accept onerous contracts that are harmful to their patients simply to survive

<http://www.consumerwatchdog.org/searchsw.cgi> gives a huge litigation indication of the unresolved problems between insurance companies, provider and patients' standards of care.

Don't Let HMOs Privatize Reforms

San Diego Union-Tribune
Jan 20, 1999

Opinion Editorial by Jamie Court

Should the life-and-death appeals of HMO patients really be in the hands of private reviewers who are hired by the HMO and use private protocols to reach their decisions?

Privatization advocates have long tried to turn public control of our schools, courts, public assistance systems and

municipal services over to private corporations in the name of greater efficiency. But this week, Aetna, and other of the nation's largest HMOs, have actually tried to privatize legislative reforms of their own industry by promising to implement private "independent" review systems, where the HMO voluntarily pays a third party to review patient problems, rather than submit to public mandates.

State and federal legislators cannot trust the HMO industry's promise to reform itself through private efforts. Nowhere can the perils of privatization as a substitute for public accountability be seen more clearly than in the HMO's reliance on independent review systems, which purport to give patients facing delays and denials an appeal but deliver far too infrequently.



**STATE OF NEW YORK
INSURANCE DEPARTMENT**
25 BEAVER STREET
NEW YORK, NEW YORK 10004

The Office of General Counsel issued the following informal opinion on June 15, 2001, representing the position of the New York State Insurance Department.

Re: Dental Services

Question Presented:

Does the proposed dental program constitute the "doing of an insurance business" for which licensing is required pursuant to N.Y. Ins. Law § 1102 (McKinney 2000)?

Conclusion:

If each separate fee charged by a dentist for services that are dependent upon a fortuitous event, covers the cost of rendition to the dentist, including reasonable overhead, then such a program would not constitute the "doing of an insurance business" for which licensing is required.

Facts:

A New York licensed mutual life and health insurance company seeks confirmation that the product described below is (1) not an insurance product and (2) does not violate the insurance laws or any other laws of which we are aware.

The following facts have been provided:

The [insurer] has contracted with various dentists ("Participating Dentists") in many states, including yours. The Participating Dentists have agreed to provide dental services for certain persons pursuant to a reduced fee schedule.

An entity ("Card Entity") would like to offer its customers ("Card Customers") the opportunity to receive services from the Participating Dentists pursuant to the reduced fee schedule. The Card Entity proposes to issue an identification card which will bear the name of the [insurer] and the Card Entity. Card Customers will

present the card to the Participating Dentist so that the Card Customer can pay pursuant to the reduced fee schedule.

The Card Entity will pay an administrative access fee to [insurer] for the right to have Card Customers access the reduced fee schedule and for the services provided by the [insurer] in administering its contracts with Participating Dentists. The fee will be calculated on the number of Card Customers that purchase the product.

The reasons for why, in your view, the proposed product is not insurance:

Card Customers will be entirely responsible for paying the professional fees to the Participating Dentists pursuant to the reduced fee schedule. The Card Entity's enrollment information will state that the Card Customer acknowledges that there is no other entity that will pay the fees for any professional services. Therefore, as there is no responsibility for the Card Entity or the [insurer] to reimburse nor pay for any professional fees, the product should not be considered to be an insurance product.

Furthermore, there are two product choices which both require the payment of an annual membership fee to the Card Entity. These are:

Flat Fee- On a fixed schedule (e.g. monthly) the Card Customer will either pay: (i) a flat amount to the Card Entity for the right to receive services pursuant to the reduced fee schedule; or (ii) a flat amount per visit. For example, the Card Customer will pay \$10 to the Card Entity each month or each time a visit is made to the Participating Dentists (in addition to paying the Participating Dentists the professional fees owed).

Percentage of Fee- Each time that a fee is incurred for a professional service, the Card Customer must pay the Card Entity a fixed percentage of the fee that is listed on the reduced fee schedule. For example, if the discounted fee is \$100, a Card Customer may be required to pay 10% of such fee, or \$10, to the Card Entity (in addition to paying \$100 to the Participating Dentists).

Analysis:

N.Y. Ins. Law § 1101 (McKinney 2000) states that the making of any insurance contract constitutes the doing of an insurance business in this state. N.Y. Ins. Law § 1101(a) (McKinney 2000) defines the terms "insurance contract" and "fortuitous event" as follows:

(1) "Insurance contract" means any agreements or other transaction whereby one party, the "insurer", is obligated to confer a benefit of pecuniary value upon another party, the "insured" or "beneficiary", dependent upon the happening of a fortuitous event in which the insured or beneficiary has, or is expected to have at the time of such happening, a material interest which will be adversely affected by the happening of such event.

(2) "Fortuitous event" means any occurrence or failure to occur which is, or is assumed by the parties to be, to a substantial extent beyond the control of either party.

The making of a service plan that, for a pre-paid fee, obligates one party to provide a benefit dependent upon a fortuitous event, would constitute insurance under N.Y. Ins. Law § 1101 (McKinney 2000) and require a license pursuant to N.Y. Ins. Law § 1102 (McKinney 2000), unless the fee covered the cost of the rendition of services plus the cost of reasonable overhead expenses.

Regarding the proposed dental program, the dentist and the Card Entity would be acting as insurers unless the dentist received the actual cost of rendering the service (plus overhead costs) as a fee. This is because certain of the services provided under the dental program would be dependent upon the happening of a fortuitous event, that being the need for dental care, which is beyond the control of either party.

This Department expresses no opinion as to how the proposed dental program would be impacted by other applicable statutes.

ADA sues major insurers, defends 'in-network' dentists, invokes RICO
'Fraud, extortion, racketeering'

Posted 05/20/2003

By James Berry

Invoking a set of laws originally adopted to fight organized crime, the ADA May 19 filed a class-action federal suit, alleging that some of the nation's largest insurers have conspired to "deny, reduce and delay" payments to dentists under contract to the plans.

This latest civil complaint, filed in South Florida's U.S. District Court, Miami Division, is the third ADA lawsuit aimed at defending the dentist-patient relationship and halting what the Association sees as unlawful insurance industry practices.

The ADA's earlier class actions, against Aetna Inc. and Wellpoint Health Networks Inc., went after business practices that allegedly harmed nonplan or "out-of-network" dentists.

This new complaint pursues alleged transgressions against "in-network" dentists and seeks redress under the Racketeer Influenced and Corrupt Organizations Act, better known as RICO. The suit also invokes state statutes.

"This latest lawsuit is another example of the Association's advocacy for its members, for our profession and for the patients we serve," said Dr. T. Howard Jones, ADA president.

“These are important issues that affect dental health care, and the ADA rightly should be stepping in to address them,” added Dr. Jones. “Our case alleges a conspiracy among insurers who dominate the marketplace. These insurers are not living up to their contractual agreements with participating dentists, and that is bound to have a negative effect on their patients and the dental health care system.”

The seven-count complaint targets some of the best-known insurers in health care and levels a stunning array of charges: unlawful “bundling and downcoding” of dental claims, mail and wire fraud, extortion, conspiracy, racketeering, and violations of state breach of contract and “prompt-pay” laws.

Named as defendants in the complaint are:

- Cigna Corp., its subsidiary Cigna Dental Health Inc., and Cigna affiliate, Connecticut General Life Insurance Co.;
- MetLife Inc. and its subsidiary, Metropolitan Life Insurance Co.;
- Mutual of Omaha Insurance Co.

Together, these companies underwrite dental and other health coverage for millions of Americans and include thousands of dentists as plan providers. MetLife’s Preferred Dentist Program, for example, serves nearly 13 million patients and has more than 57,000 general and specialty dentists under contract.

Joining the Association as plaintiffs in this latest suit are two ADA-member dentists who represent the class of in-network, plan providers allegedly harmed by the defendants’ business practices.

Identified as “class plaintiffs” in the suit are Dr. John Milgram, a general dentist from the Chicago suburb of Kenilworth, Ill.; and Dr. Scott A. Trapp, a general dentist from Omaha, Neb. Both men are under contract to one or more of the insurers named as defendants.

“Drs. Milgram and Trapp are to be commended for stepping forward to represent their colleagues in this complaint,” said Dr. James B. Bramson, ADA executive director. “With their assistance, we want the insurance carriers to know that the Association is going to work hard to protect both the patients and the practitioners. In short, the carriers need to play fair, and by using these business practices, they aren’t.”

Added Dr. Bramson, “The Association will use the judicial system to prevent carriers from undercutting or delaying compensation to the dentists.”

The suit alleges that the defendants “aided and abetted each other” in a conspiratorial “dental enterprise” to obtain “money and property belonging to the plaintiffs.”

Specifically, the complaint says the insurers:

- used automated claims processing systems and software to “downcode” legitimate claims to less costly procedures;
- undercounted the patients included in their capitation plans as a way to trim the “per-member, per-month” fees paid to the class plaintiffs;
- used undisclosed “cost-based” or other actuarial criteria unrelated to covered procedures or services to approve or deny claims;
- denied or reduced claims by “bundling” two or more procedures into one procedure billed at a lower rate;
- used systems that automatically “pend” claims, suspending them even when no additional information is required or requested;
- intentionally understaffed their claims processing departments in order to slow payments;

- mailed plaintiffs Explanation of Benefits statements that “misrepresent or conceal” the way a claim actually was processed.
- used their economic power and marketplace dominance to “coerce plaintiffs, with the threat of being denied patient referrals,” forcing dentists to provide care on a “take-it-or-leave-it basis.”
- used their market dominance to amend contracts without the providers’ consent, with no mechanism for review.

“If only one defendant engaged in these activities,” the ADA notes in its complaint, “dental providers could and would refuse to do business with that defendant.”

By working together, however, the insurers were able “to effect and perpetuate their schemes,” the ADA says.

Peter M. Sfikas, the Association’s chief counsel, said the ADA’s earlier complaints against Aetna and Wellpoint, originally filed in Illinois, were combined with similar suits across the country and transferred to the federal court in Miami “for pretrial discovery and pretrial motions.”

As a time-saver, the ADA’s latest suit was filed directly in the Miami federal court.

“The conduct that we have found with reference to the defendants in this lawsuit is pervasive, unfair to patients and the profession, and, I believe, illegal,” said the ADA’s chief attorney. “These are matters that should be brought to the attention of the federal courts and rectified there.”

Model Managed Care Contract © 2002, American Medical Association

American Medical Association Model Managed Care Contract: Supplement 2

Insurance companies interposed between the patient and the provider =

Profound complexities =

More litigation =

More legal costs =

Higher fees to patients =

More corporate profits and more income to lawyers, accountants, advert
agents =

Overloaded courts =

Enmeshment of responsibilities =

Provider distraction from patient care =

Drop in clinical standards, code gorging =

Overturning of a provider’s contractual *right*

to determine a reasonable fee and then negotiate an acceptable fee to the patient

This is not *progress*; it is unfettered corporate induced madness peddled under the guise of *controlling costs*. The real problem is that HBF have failed to increase their rebates inline with premiums for 10 years.

Silent PPOs

What is a “silent PPO”?

A “silent PPO” refers to a situation where, unbeknownst to its contracting physicians, a managed care organization (MCO) “sells” or “rents” its Preferred Provider Organization (PPO) network of providers to a third party (typically a third party administrator, insurance broker, or smaller PPO) and that third party gets the advantage of whatever discount the MCO has negotiated with the physician. The physician becomes aware of this only after he or she provides services to a patient who is not covered by the PPO. After filing a claim for his or her services with the patient’s health plan or insurer, the physician receives less than full payment and an explanation of benefits (EOB) referencing the discount with the original MCO PPO. Both the “seller” and the “purchaser” of the discount rely heavily on the fact that a busy physician practice will have difficulty spotting this anomaly on an EOB. Depending on the terms of the physician’s contract, silent PPO activity may constitute a breach of contract. The AMA also believes that silent PPO activity may be fraudulent. Because of the potentially significant sums of money involved, physicians should take special precautions to assure that their managed care agreements do not contain “all payor” clauses that allow the MCO to rent or lease its physicians’ services to non-contracted entities. Section 1.0 of the Addendum to the AMA Model Managed Care Contract includes an example of a contract definition of “payor” that could potentially allow the MCO to rent or sell the discount.

Why are silent PPOs harmful to physicians?

Silent PPOs are financially harmful to physicians (and hospitals), and they violate fundamental concepts of fair business dealing. The silent PPO

takes discounts to which it is not entitled, without negotiation, and without the physician's consent or knowledge. Silent PPOs cut out the main incentive that induces physicians to enter into managed care contracts – patients.

When contracting for a PPO product, physicians and the managed care company engage in a deal. The physician offers a negotiated fee discount in exchange for access to a base of patients, as well as other benefits that result from participation on a PPO panel, such as inclusion in the PPO's physician directory. In return, the PPO agrees to direct and encourage its patients to visit participating network physicians in exchange for discounted rates.

In a silent PPO, the physician or physician group/network unknowingly gives up a valuable asset—the discount—but does not receive a patient base in return. Patients may also be harmed because they may be paying inflated or incorrect copayments.

How does a silent PPO operate?

The following example demonstrates how a physician may become a victim of a silent PPO.

- Dr. Y is an internist who is a member of ABC PPO's network and has negotiated a 25% discount for services rendered to PPO patients.

American Medical Association © 2002, American Medical Association

Silent PPOs, continued

- Patient X, who is covered by an indemnity plan (*not* ABC PPO), presents to Dr. Y for an office visit. Dr. Y treats the patient and presents a bill to the indemnity insurer for the reasonable and customary charge of \$100.
 - The indemnity insurer, after receiving the bill, contacts a third party administrator, broker, or any PPO to determine whether Dr. Y is on a physician network with a negotiated discount.
 - ABC PPO offers to allow the indemnity insurer to use its negotiated 25% discount, for a fee.
 - Instead of reimbursing Dr. Y the indemnity fee he is entitled to, the indemnity insurer then remits its portion of the discounted fee negotiated by ABC PPO, with a EOB. Dr. Y is instructed to collect the copayment from the patient.
- Dr. Y is unlikely to realize what has happened.

Most physicians do not have the computer technology or personnel required to compare each EOB statement to the patient's insurance coverage.

This example illustrates one type of silent PPO scenario. It is important for physicians to be alert to other situations where payment received is less than payment negotiated in the contract.

What is the financial impact of silent PPOs?

Given the difficulty in detecting the use of silent PPOs, it is impossible to determine the amount of money physicians have lost due to this practice. However, it has been estimated that physicians and non-physician health care providers nationwide have lost between \$750 million and \$3 billion annually since the practice began in the early 1990s.

How can physicians recognize a silent PPO in a managed care contract?

Provisions for silent PPOs may appear in contracts in a variety of forms, or they may not be a part of the physician's contract at all. Physicians should first scrutinize their managed care contracts for "all payor" clauses. These clauses typically require the physician to accept the discounted rate as payment in full from any payor.

This may permit "selling" or "renting" the negotiated discount. However, simply because a contract does not contain an obvious "all payor" clause does not provide full protection from silent PPO activity. Therefore, physicians should try to gather as much information from the PPO representative before signing a contract, including asking direct and pointed questions about the PPO's relationship with its payors.

The AMA offers several suggestions physicians can use to protect themselves from the unauthorized use of negotiated discounts by silent PPOs.

1. Ensure that all PPO patients eligible for discounts are steered toward using in-network physicians. For example, PPO patients commonly receive a financial incentive to use network physicians.
2. Extend discounts only to patients with PPO identification cards.
3. Require the PPO (within the physician contract) to provide timely notice of changes to the list of payors authorized to receive the network discount.

4. Require the PPO to disclose any discounts applicable to a PPO patient at the time the physician verifies coverage.

How do “silent PPOs” relate to companies that “reprice” claims for insurance companies?

A number of large “repricing” companies have developed healthcare networks that allow them to offer “custom” networks to MCOs, at a significant discount. In a typical example, an MCO (or self-insured employer) seeks access to providers in an area where the MCO has a limited number of covered lives. Therefore, the MCO may not have the leverage to extract discounts from providers. Instead it “rents” the network of the “repricing” company.

The primary difference between silent PPOs and repricing arrangements is that physicians have actually entered into a contractual agreement with the “repricing” company and agreed to allow their services to be “rented” to the company’s clients. Physicians need to be aware of what it means to sign a contract with one of these entities and the impact the agreed-upon discounts will have on their practices.

How does the AMA Model Managed Care Contract deal with silent PPOs?

Section 1.11 of the AMA Model Managed Care Agreement specifically restricts MCOs from selling or renting their networks to others not entitled to the negotiated discounts and does not include an “all payors” clause.

What is being done to combat silent PPOs?

The American Medical Association (AMA) is attacking this practice on a number of levels. The AMA succeeded in getting silent PPOs banned from all Federal Employee Health Benefits Plan (FEHBP) contracts, which was an important victory in light of the federal government’s liberal use of silent PPOs as a cost savings mechanism in the FEHBP.

In addition, the AMA Litigation Center and the Medical Association of Georgia filed “friend of the court” briefs in *HCA Health Services of Georgia v. Employers Health Insurance, Co*, which involved a challenge by a medical center to a silent PPO arrangement whereby an insurance company reduced the plaintiff’s payment by 25%. In February 2001, the U.S. Court of Appeals for the Eleventh Circuit rejected the defendant’s

arguments that the plaintiff did not have “standing” to sue the insurance plan and held that the defendant’s interpretation of the provider contract was arbitrary and capricious. The AMA Litigation Center continues to look for other possible legal challenges to silent PPO arrangements. One state, North Carolina, has implemented a law specifically addressing silent PPOs. The North Carolina law (N.C. Gen. Stat. 58-63-700) makes it an “unfair trade practice” for insurers to make a “material misrepresentation to a health care physician to the effect that the insurer or service corporation is entitled to a certain preferred physician or other discount off the fees charged for medical services, procedures, or supplies provided by the health care physician, when the insurer or service corporation is not entitled to any discount or is entitled to a lesser discount from the physician on those fees.”

Is this progress? Is this in Australian’s interest?

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

THE AMERICAN DENTAL ASSOCIATION, on its own behalf and in an ~~its own~~ official capacity on behalf of its members, and FRANK S. ARNOLD, D.M.D., DAVID W. RICHARDS, D.D.S, AND JAMES SWANSON, D.D.S, individually and on behalf of all others similarly situated,
WELLPOINT HEALTH NETWORKS INC. and BLUE CROSS OF CALIFORNIA,

Civil Action No.

Defendants.

CLASS ACTION COMPLAINT

plaintiffs raise a pendant state law claim of trade libel, and tortious interference with contractual relations and with existing and prospective business expectancies by wrongfully interfering with the dentist-patient relationship the Class Plaintiffs are not “in-network” or “participating” providers who have agreed to receive discounted, or negotiated, rates for providing dental services to Wellpoint subscribers in full payment for their services. Instead, the Class Plaintiffs are “out-of-network” providers who provide dental services to Wellpoint subscribers pursuant to the terms and conditions of their subscriber agreements covering their dental plans

. Under these subscriber agreements, which have standard or uniform language concerning payment

for dental services provided by out-of-network providers, Wellpoint must pay its subscribers or their out-of-network providers the actual amount these providers charge for their services, assuming the annual deductible is met, and minus any applicable co-payment amount paid by the subscriber.

3. The only instance in which Wellpoint may pay less than the out-of-network providers' actual charges is where Wellpoint may demonstrate, using valid data, that the actual charges by the treating dentist "exceeds the customary and reasonable allowance" for the particular procedure in question. Traditionally, the term "customary and reasonable allowance" is referred to as "UCR" for "usual, customary and reasonable." Wellpoint must make available the underlying data supporting its UCR determinations to subscribers and their providers when they issue reduced reimbursements for out-of-network health care. Notwithstanding Wellpoint's contractual obligations, where Wellpoint has paid a UCR amount rather than a dentist's actual charges, Wellpoint does not possess and has failed to come forward with valid data substantiating payment of the UCR amount. Under the terms of the subscriber agreements, Wellpoint is therefore required to pay the out-of-network providers their actual charges. The Class Plaintiffs sue on behalf of all similarly situated out-of-network providers who were paid less than their actual charges based on undisclosed and non-existent or flawed UCR data.

remark code "908" which states that the dentist's "fee exceeds the customary and reasonable allowance for this procedure." As a result, Wellpoint informs its subscribers, who are patients of such out-of-network dentists, that these dentists' charges are excessive or unreasonable. By providing false information that is harmful to providers' reputation, and disparaging the value of dental services rendered by providers, Wellpoint's statements constitute trade libel, and tortious interference with contractual relations and with existing and prospective business expectancies by wrongfully interfering with the dentist-patient relationship.

whether Wellpoint breached, and continues to breach, its contractual obligations by systematically paying out-of-network dental providers less than their actual charges without a reasonable basis for doing so; and whether, in communicating to subscribers that their out-of-network providers' charges were in excess of "customary and reasonable" charges

As part of their standard practices, the Class Plaintiffs receive assignments from subscribers, pursuant to which they are entitled to receive payments directly from Wellpoint. Through its course of conduct with the Class Plaintiffs, Wellpoint has recognized **the validity of such assignments.**

1. fails to segregate dental procedures by geographical area, and instead reports procedures by only the first three digits of a provider's zip code, thus obscuring important differences in actual charges over relatively large geographical areas with diverse population and demographics, and including charges for dental procedures from non-comparable areas in which the provider charges were lower;
- b. systematically under-reports the actual number of procedures performed in a geographical area, and often eliminates the highest charges for each type of dental procedure maintained in the PHCS database;

- c. fails to segregate dental procedures performed by providers of the same or similar skill and experience level, but rather, indiscriminately aggregates all provider charges by procedure code without regard to skill or experience level;
- d. includes charges for various procedures which incorporate in-network providers' discounts to their "usual" charges based on anticipated increase in patient volume, thus skewing the data below the true UCR rates; and
- e. incorporates "conversion factors" and "derived charges" in the database rather than actual fees charged by dental providers, in order to "fill[] the gaps where actual charge data is unavailable." Such conversion factors are based on "ranges of procedure codes aggregated by . . . categories of dental services and geographical areas," thus further evincing the failure to segregate procedures by procedure code – a fundamental requirement in order to determine the "usual and customary" charge for a specific procedure – and to segregate procedures by geographical area. Conversion factors also include the Resource-Based Relative Value System ("RBRVS") used for Medicare reimbursements, which are irrelevant to private insurance payments. "Derived charges" are amounts manipulated by HIAA or Ingenix and designed to substitute for actual fees when such data do not exist.

statements constitute trade libel, and have and continue to cause harm to plaintiffs and members of the Class

49. The Class Plaintiffs and each out-of-network dental provider has a valid contractual or business relationship with their Wellpoint patients.

50. Wellpoint knew of these contractual or business relationships and intentionally, purposefully, and unjustifiably interfered with them by falsely representing and continuing to falsely represent to the patients of the Class Plaintiffs and out-of-network dental providers whose actual fee was reduced to reflect UCR rates that these providers' fees were unusual, not customary, and therefore excessive and unreasonable. Wellpoint has disparaged the value of the performance rendered by Class Plaintiffs and members of the Class under their contracts and business relationships with Wellpoint

patients, and interfered with the dentist-patient relationship.

In so doing, Wellpoint has tortiously interfered with contract and with existing and prospective business expectancies of Class Plaintiffs and members of the Class.

Plaintiffs have suffered damages as a result of Wellpoint's tortious interference with contract and with existing and prospective business expectancies. Plaintiffs have lost long-standing, paying patients who, believing that their dentist attempted to charge an unusual, excessive, and unreasonable fee, chose to go elsewhere or forego treatment altogether.

51. Wellpoint's conduct constitutes tortious interference with contract and business expectancies, and it has and continues to cause harm to Class Plaintiffs

Awarding the Class Plaintiffs and members of the Class compensatory and exemplary damages, and granting plaintiffs and members of the Class injunctive and declaratory relief, for Wellpoint's tortious interference with contract and with existing and prospective business expectancies;

G. Ordering disgorgement of the profits improperly earned by Wellpoint;

H. Awarding plaintiffs and members of the Class the amount by which Wellpoint has been unjustly enriched;

I. Awarding plaintiffs and members of the Class the costs and disbursements of this action, including reasonable attorneys' fees and reimbursement of expenses, including expert fees, in amounts to be determined by the Court;

State Prohibitions Against Corporate Practice of Medicine

by Robert V. West, MD JD FAAEM

The corporate practice of medicine doctrine prohibits a corporation from practicing medicine or employing a physician to do so on its behalf. The dangers inherent in such arrangements are the loss of autonomy of physicians, commercial exploitation of the doctor-patient relationship by lay persons, and the interference with "medical decision making." While many state and federal laws require that only "licensed individuals" may provide, bill for, and receive payments for medical care, these laws are rarely enforced absent overbilling or fraud on the part of the lay entity.

Accordingly, private and public corporations have created a complex web of contractual arrangements through contract management companies, their billing subsidiaries, their sham professional associations, and emergency care physicians. This web of illegal contracts camouflages the alignment between corporations, hospitals, and doctors. Restrictive employment agreements position the corporations to directly interfere with the emergency care physician's relationship with the hospital where the physician practices. Moreover, the unauthorized practice of medicine impedes the ability of physicians to provide the highest quality of care to patients and diverts massive amounts of income away from the physicians.

Physicians have only recently challenged the status quo despite glaring inconsistencies in the law and actual practices. Physicians have allowed their practices to be eroded by continual corporate encroachment. Currently, the majority of hospitals refuse to contract with any emergency care physician unless the physician is contracted to a sham professional association. This arrangement allows the hospital to limit its administrative responsibilities to the physicians and to their patients. The physicians feel powerless, while a substantial percentage of the physician's fee is diverted to huge public corporations through the funnel of the sham professional associations. However, illegal contracts are non-enforceable and the fees garnered under them are subject to forfeiture.

Do Australians really want big insurance companies running Health as in America?

<http://www.yourdoctorinthefamily.com/grandtheory/section12.htm>

The chief aim of capitalism

The chief aim of capitalism, as we all know, is to increase capital. Of course, needing to make money isn't really new for any health care organization, whether it's for-profit or not-for-profit. Both varieties have always had to be vitally concerned about where the money is coming from. Forget that, for even a moment, and you're lost forever, no matter what sort of good works you may perform.

What's new for contemporary HMOs is that making money is no longer something to be whispered about, or a topic unsuitable for public discussion, or a necessary evil. Making money is now more than okay. It's expected, celebrated and rewarded; it's become why HMOs exist in the first place. In fact, making money is the means by which HMOs will save the American health care system. And the better they are at making money, the better they are for society.

This new paradigm is uniquely American. Every other western nation has bent the market to accommodate the needs of health care. We are bending health care to accommodate the needs of market. And it's drastically affecting the way HMOs operate.

To see how, let's create a portrait of an imaginary, modern-day HMO called "For the Patient" (FTP).

For The Patient (FTP) - 1995

It's 1995. The Clinton health care reform plan has just gone down in flames, and it's a new era for HMOs – HMOs like FTP.

FTP, established in 1993, has already gained a foothold in eight cities along the eastern seaboard. Following the original business plan, FTP was taken public last year.

But FTP is in trouble. Earnings, and consequently stock prices, have been stagnant. Enrollments have not grown to expectations; the physicians on FTP's panel (most of whom are new to managed care) have been reluctant to change their inefficient patterns of practice; and it's been difficult to get hospitals in the FTP system (some of which have been rivals for decades) to cooperate with one another. The shareholders are restless, and in response the board has just fired the old CEO (a physician and one of the FTP's founders) to bring in a hard-nosed businessman who will know how to put things right.

That new CEO is Gregory Gekko (no relation to Gordon). He doesn't know much about health care – but then, the last CEO knew plenty about health care, and look where it got him. Besides, Gekko didn't know anything about greeting cards either before he developed a tiny greeting card company called Greetings-Schmeettings into a multibillion dollar corporation that's giving Hallmark a run for its money. What Gekko does know is business. And health care, everyone now recognizes, is just a business like any other business.

Gekko immediately sizes things up. He begins with the three fundamental steps that must always be taken when building a business: First, define your customers. Second, define the scope of your business (i.e., decide what it is you do to make your customers happy). Third, figure out how to maximize your revenues and minimize your expenditures, while applying your scope of business to your customer base.

Defining the customers

To Gekko, making money is everything – but not because conservative Republicans have recently swept Congress, or because it's the new paradigm for health care. Making money is everything to Gekko because that's what the stockholders of FTP have put him on this earth to do.

Thus, Gekko is acutely aware that, from the his own personal standpoint, **his primary customers are, and can only be, the shareholders of FTP**. Every last decision he makes must be geared toward pleasing those shareholders.

Gekko knows this is where FTP's original CEO had made his big mistake. The poor man had considered his primary customers to be the patients enrolled in FTP, and the doctors who took care of them. It wasn't until his final shareholders' meeting that the old fool had finally got it. Of course, it had been too late for him by then.

The shareholders are always the ultimate customer for any corporation, Gekko realized. At the same time, to keep those shareholders happy, Gekko also had to identify the business customers - the ones who purchase the product sold by FTP.

Gekko's predecessor had blown this one, too, because he had thought the patients who enrolled in FTP were the purchasers. But patients don't really choose health insurance. They just sign up for whatever insurance product is chosen by their employers.

The people who actually make the decision to buy FTP, Gekko knows, are the V.P.s in charge of benefits - the corporate officers who negotiate the employee health insurance contracts for their companies. Gekko fully understands how important this relatively small and easily identified core of people is to FTP, and he will do whatever is necessary to convince them to offer FTP to their employees as one of their insurance options – or better yet, as their *only* insurance option. Gekko is not worried. He knows these people - they're corporate executives, like him. He knows what he needs to do to get their business.

At some level, Gekko supposes, the doctors and patients of FTP also have to be considered his customers. But this feels wrong to him. **The doctors and patients, after all, are the ones who spend his money.** Keeping them happy implies that he's letting them spend more money than they might otherwise get to spend. Keeping them happy therefore feels counterproductive. As he learns more about the business of health care, Gekko tells himself, he'll have to figure out ways to make it matter as little as possible about keeping doctors and patients happy.

Defining the scope of business

This is also pretty straightforward for Gekko. FTP's main business is to take in money in the form of health insurance premiums, and in return, to arrange for the provision of health care to the individuals for whom the insurance is paid. How FTP should go about providing that health care is a completely open question for Gekko. There are a lot of ways to do it, and he's not married to any one of them. The only criterion is that whatever method he uses needs to satisfy his customers (i.e., the shareholders and the corporate V.P.s). Since his main goal is to make money for the shareholders, Gekko also understands that he needs to be alert to any other opportunities that may present themselves for increasing the value of FTP. Focusing *only* on providing health care may prove to be a disservice to his ultimate customers. When you are sick, shouldn't you be entitled to the same protections as when you rob a 7-eleven?

Most of us think so. And the doctor-patient relationship is supposed to see that you are.

Doctors are expected to fill for their patients the very same role that lawyers fill for their clients. This role is necessary, because sick people are no more capable of navigating the complex health care system than are accused felons the complex legal system, and are no less in peril if they run afoul of that system. And a patient's need of an advocate, a professional whose job it is to protect the patient's own best interests, is no less vital than that of the felon.

Over the ages the doctor-patient relationship has been defined, through rules of ethics and rules of law, as a fiduciary one, as a relationship founded in trust. When a patient seeks a physician's help and the physician agrees to give that help, **a special covenant** is made. The patient agrees to take the physician into her confidence, to reveal to him even the most secret and intimate information related to her health. The physician, in turn, agrees to honor that trust, and to become the patient's advocate in all matters related to her health, placing her interests above all others – including his own personal or financial concerns.

Now, to be sure, the doctor-patient relationship was never completely pure in actual practice, even in "the good old days." But a strong fiduciary relationship has been what patients have expected, what most doctors have striven for, and what everyone else (the medical ethicists, professional societies, and those who write and enforce the laws of the land) have traditionally agreed – and even demanded – should be the standard. It represents the fundamental expectation of how doctors and patients are supposed to behave toward one another.

Whenever you are a patient, the traditional doctor-patient relationship guarantees there is **at least one knowledgeable professional who is looking out, above all, for your interests** – not the interests of the insurance plan you're in, or of your demographic group, or even of society at large, but the interests of the individual, you. The loss of such an advocate, especially at a time when the interests of all the other parties within the health care system are centered on cutting costs (and therefore have never been less likely to coincide with your own needs), would be catastrophic.

Physicians, too, rely totally on the integrity of the doctor-patient relationship, since their role as their patients' advocate is the foundation of their profession. This role is far more than just an ethical and a legal obligation. It is their duty as advocates that imparts any and all claims physicians may have to the title "professional," and to the perquisites and considerations that flow from that title. Without this role, physicians are no longer professionals. They truly are reduced to mere commodities in a vast healthcare marketplace.

Thus, the traditional doctor-patient relationship is vital to the professional survival of the physician, and to the physical survival of the patient. If we lose this relationship, we lose everything

The importance of the doctor-patient relationship, and why we can't have it anymore

A deadly wedge is being driven today between patients and their doctors, destroying the sanctity of their time-honored relationship, leaving each to fend for themselves in an increasingly hostile health care environment, and placing each at the mercy of powerful interests whose only real concerns are costs, profit and power. As a result, both doctors and patients are being shunted aside, separated from one another, marginalized, and reduced to mere ciphers.

This assertion may very well resonate with many of you. It certainly will if you're a doctor with a reasonably well-developed sense of professional purpose. And it probably will if you're a patient who has had a significant encounter with the health care system within the past few years. What may not immediately resonate is the reason for it. Why is the doctor-patient relationship being undermined?

It would be natural to assume that erosion of this relationship is merely one of the unpleasant side effects of the radical changes we are now seeing in our health care system. But that assumption would be wrong. Destruction of the doctor-patient relationship is not merely a side effect of these changes – rather, it is their centerpiece. It is necessary.

"Necessary?" You may be asking, eyebrows raised.

Yes, I reply, and wait 'till you hear why

Destroying the doctor-patient relationship is necessary because doing so is central to – and indeed, is the fundamental mechanism by which we accomplish – covert rationing. And in the United States today, doctors, hospitals, health insurers, HMOs, and the government, with the subconscious collusion of us all, are fully committed to and vigorously engaged in the covert rationing of our health care.

Controlling the flow of dollars

Before beginning Phase 4 of his plan, Gekko continues paying his physicians on a discounted fee-for-service basis (i.e., they get paid for every service they provide, at a somewhat lower fee schedule than for Medicare). But for any HMO in the mid 1990s, the pot of gold at the end of the rainbow is capitation. And Gekko institutes capitation with great relish during Phase 4.

Under his capitation plan, FTP primary care physicians (PCPs) get paid a fixed amount per month for every FTP patient they follow in their practice. No matter how much or how little medical care they provide for that patient, the PCP makes only the capitated amount. But Gekko doesn't actually pay them the full capitated rate up front – they get only 90%. He keeps the last 10% as a "withhold," which he fashions as an additional incentive.

Thus, at the end of the year, if FTP meets its financial goals and the PCP meets certain performance requirements, Gekko distributes the last 10%. If not, FTP keeps the money. It is possible, of course (if FTP's financial goals are exceeded and the physician's performance is rated "excellent,") for the PCP to receive a bonus in addition to the 10% withhold. And Gekko sees to it that at least a few PCPs get such a bonus each year, just to let his physicians know that such a thing is within the realm of possibility. Capitation fee schedules are renegotiated each year with each PCP, based on how "well" the PCP has done in the previous year.

It's a shame Gekko's accountants can't yet figure out a way to capitate specialists as well, but so far it's too complicated. The accountants cannot guarantee him that he'd make money capitating

specialists. Some day they'll have sufficient data to pull it off, but for now he continues paying his specialists on a modified fee-for-service basis. Gekko knows he needs alternative measures to control the behavior of the specialists.

The performance measures that determine whether the PCP does or does not get the 10% withhold at the end of the year are a vital part of Gekko's plan. There are a few token "health care performance measures," of course, that monitor whether the doctors are aggressively treating hypertension and screening for high cholesterol and the like. But Gekko wants to make sure his doctors know what he really means by performance, so he doesn't try to disguise the fact that **the bulk of FTP's performance measures have to do with fiscal performance.**

Each quarter, a dark-suited FTP representative (a "Practice Consultant") visits each PCP with a "Performance Report." The Performance Report accounts for every dollar that FTP has had to spend during the past quarter on patients enrolled in the PCP's practice.

"Your patients cost us a mean of \$439 apiece during the past quarter, Dr. Smith," the Practice Consultant might say. "That compares unfavorably with the mean of \$348 achieved by your peer PCPs, and even less favorably with the target of \$264 that would be required for you to receive your portion of the year-end withhold. Now, Dr. Smith, let's examine this report in more detail to see if we can figure out where all that money is going."

So Dr. Smith and the helpful Practice Consultant look things over. They notice that Dr. Smith referred four patients to cardiology practices during the past quarter. The Valley View Practice ended up spending \$3429 on the two patients Smith sent them, but the Cormatic Practice only spent \$2453 taking care of the other two. They both agree that substantial savings could be realized by referring more patients to Cormatic, and fewer to Valley View.

"Of course," the Practice Consultant says, "we would never ask you to send FTP patients to an inferior group of cardiologists."

"Of course," Dr. Smith replies.

It is a thing of beauty. Look what Gekko has accomplished here. By rapidly gaining control of physicians' means of livelihood (i.e., their access to patients), he is able to essentially dictate the terms of their surrender.

Those terms put fiscal pressure on doctors at several levels.

Making destruction of the doctor-patient relationship legally binding - The Gag Clause

Gekko is happy with the results of his 18 month plan, but wishes to reinforce and formalize the message he has successfully delivered to FTP's physicians. He wishes to make that message legally binding. When it is time for him to rework his physician contracts, Gekko asks his attorneys to come up with language that does just that, and they are happy to accommodate him:

"The physician agrees not to take any action or make any communication with patients or patients' families, potential patients or potential patients' families, employers, unions, the media or the public that would tend to undermine, disparage, or otherwise criticize FTP or FTP's health care coverage. The physician further agrees to keep all proprietary information such as payment rates, reimbursement procedures, utilization-review procedures, etc., strictly confidential."

Gekko likes the language. It is plain and straightforward.

Big money and
Unqualified operators
Should be kept out of Health