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## Dentistry in Transition

*An Eye to the Future*



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**Gary R. Hartwell, D.D.S., M.S.**  
AAE President

## Endodontic Practice: Not One Size Fits All

Spending time with my grandchildren is a great blessing in life. I am lucky they live close, and I can participate in their daily routines. I've been taking my 9-year-old to swim team practice for the past two years, and watching him progress has been a delight.

Lately, I have been thinking about the parallels between what I've learned from my children and grandchildren and what I've learned from my students during 40 years as an endodontic educator, working in both military and civilian programs. My children were often my teacher when it came to new technology outside the world of endodontics. Like many people my age, at times they were my "tech support" at home. Now I see my grandchildren reading books and playing games on Kindles and iPads. Who knows what new changes await their generation?



## Important Dates and Deadlines

Visit [www.aae.org/events](http://www.aae.org/events) for more information.

### November 1

ABE Case History Examination Fall Deadline  
[www.aae.org/certboard](http://www.aae.org/certboard)

### November 14 - 16

AAE Fall Conference  
[www.aae.org/fallconference](http://www.aae.org/fallconference)

### December 2013

2013-2014 AAE Membership Directories Mail  
2014 Annual Session Program Posted Online\*  
2014 Annual Session Registration and  
Housing Opens

### January 3, 2014

2015 Award Nominations Deadline  
[www.aae.org/awards](http://www.aae.org/awards)

### February 7, 2014

Foundation Research Grant Spring Deadline  
[www.aae.org/foundation](http://www.aae.org/foundation)

\* The 2013 Annual Session Program will be mailed only to those AAE members who have requested a print copy from AAE Headquarters.

## With This Issue

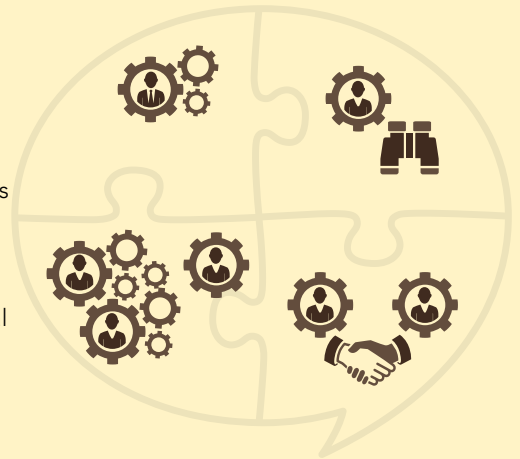
This issue includes the 2012-2013 Statement of Financial Position, the 2013 Order Form with all the latest product offerings, a Call for Nominations to serve on AAE committees and an offer from AAE endorsed vendor PBHS, Inc.

In the same way, much has changed in endodontics over the past 40 years. When I became a faculty member at the Medical College of Virginia/Virginia Commonwealth University School of Dentistry in 1987, rotary NiTi instruments were just being introduced. Microscopes, digital radiography, microsurgical instruments and dental CBCT technology were still in the future. Regenerative endodontics was considered to be “science fiction” as there would never be a way to grow new pulp inside a tooth. The vast majority of the early endodontic graduates from the MCV/VCU program went into solo or small group practice. “Hanging out your shingle” was the goal, and it was within reach at that time. Most of those residents already had worked in or had previously established general dentistry practices prior to becoming an endodontic resident, and that certainly helped.

In recent years, new dental practice models have emerged, and residents graduating today face many different choices when considering career opportunities. While the number of large multispecialty groups is increasing and “corporate dentistry” has expanded into big business, these new trends use many different models and vary significantly from state to state. In addition, millennials (18- to 34-year olds) are migrating to cities, and young endodontists are no exception. While many still open their own practices or work in group endodontic practices, some are participating in these new practice models. Some are even experimenting with newer models that do not require a “brick-and-mortar” practice.

There is a lot of speculation about whether young endodontists who choose these new practice models are doing it out of choice or necessity. There is no question that the recession created challenges for new endodontists coming out of residency programs. But I do not think that the career decision-making process is any different than it has ever been, even if the environmental and generational preferences have changed. Decisions are still based on individual considerations of a number of factors, some are economic and some are related to lifestyle and quality-of-life issues.

There is no “one size fits all” business model for practicing endodontics today. I have always emphasized with my residents the importance of practicing to the highest standards of patient care. That holds true whether an endodontist practices in a solo practice, a large group practice or any other practice arrangement. Under the ADA Code of Ethics, which also serves as the AAE Code of Ethics, dentists must protect and promote the best interests of the patient above all else. <





The AAE is committed to learning more about the technical aspects of these new practice models and we want to hear from members practicing in these new models. If you would like to share your story in strict confidence, please contact Helen Jameson at [hjameson@aae.org](mailto:hjameson@aae.org).





# dentistry in TRANSITION

*An Eye to the Future*

*If endodontists sometimes feel besieged by the ever-changing market forces that are impacting practice, they are not alone, according to a recent ADA study, *A Profession in Transition: Key Forces Reshaping the Dental Landscape*.*

*By Helen Jameson, J.D.*

The purpose of the report, which offers a comprehensive analysis of the dental care sector, was to aid the ADA in strategic planning, but it provides a snapshot on important trends impacting all of dentistry, including endodontics. Key aspects of the report are summarized below, with full details available on the ADA website.

#### **Impact of the Affordable Care Act**

While there is intense focus nationally on the roll-out of the Affordable Care Act, for the near-term, the ACA will have little impact on endodontic practices. The ACA expands comprehensive dental benefits for children and requires health exchanges to offer adult dental coverage, but it does not mandate the purchase of adult dental coverage.

#### **Trends in the Use of Dental Services**

More significant to AAE members is the report's key findings and takeaways about trends in the utilization of dental insurance for the past decade, and how they break down by age. Government data shows that the slowdown in total dental spending began in 2003 and has been driven significantly by a decline in utilization by non-elderly adults, particularly young adults. The recession may have magnified this, but it was not the cause. Beginning in the mid-2000s, dentists began to feel the decline in their pocket books, with average net incomes declining through 2009 and remaining flat since.

Young adults may be driving the decrease in utilization of dental services, but the report notes that if they seek care,

they are also more likely to search the Internet for health care information, including comparative cost information. They are active consumers.

Not surprisingly, the report also found that finances are a major factor in seeking or delaying dental care. Patients with some dental benefit also are much more likely to seek regular preventive care, but 75 percent of people with no dental benefit have had at most one visit to a dentist in the past 10 years.

The study projects that between 2010 and 2040, per capital dental expenditures will increase, but very slowly; seniors age 70-79 will account for twice the expenditures as they do now.

### New Practice Models

The ADA report includes “very preliminary” findings on the new, large group practice model. Multi-site practices and very large practices (median 154 dentists) still represent only a small percent of dentists, but they are growing, with dentists under 35 most likely to practice in such a model. The report acknowledges that the impact of these models is still not known.

### Dental Workforce

The report includes a cautionary note about dental workforce and dental school capacity. It concludes that there are a number of unknowns about the future demand for dental services, and that policymakers must be careful about expansion of dental school capacity given the slow growth in dental spending the past 10 years, and the continued expected slow growth into the future.

The ADA report is a reminder that complacency is not an option for endodontists in a competitive environment. Accepting dental insurance, offering patient financing and delivering specialty services to niche populations including the elderly are increasingly being discussed as proactive efforts to deal with the changes in the dental landscape.

Complacency is also not an option for the AAE as the voice and advocate for the specialty. At its November 2013 meeting, the AAE Board of Directors will review a knowledge-based governance paper developed by the Special Committee on Economics and the Future of Endodontics. The committee has been studying a number of the same issues reflected in the ADA report for the past year. “The ADA findings are in line with our committee report and drew on some of the same sources,” said Committee Chair Dr. Eric J. Hovland. We are presenting a number of possible choices to the Board on how best to help AAE members navigate this environment.”

AAE Professional Affairs staff actively monitor dental trends and legislation that may impact endodontics – if you have news to share about events unfolding in your state or region, or if you need support addressing these kinds of issues with your local dental society or professional groups, contact the AAE at [professionalaffairs@aae.org](mailto:professionalaffairs@aae.org). <

Visit [www.ada.org/escan](http://www.ada.org/escan) to download the full report, executive summary and video presentation.

## JOE Study Featured by The New York Times

A study published in the September 2013 *Journal of Endodontics* was the centerpiece of an August 2013 article published in *The New York Times* online titled “Increased Hospitalizations for Oral Infections.” The JOE study found that hospitalizations for periapical abscesses increased 40 percent from 2000 to 2008; 66 percent of those admitted died. Three AAE spokespeople were interviewed by the NYT reporter, each echoing the sentiment that more patients are delaying care for what is a treatable condition.

AAE President Dr. Gary R. Hartwell noted the increase in hospitalizations is part of a sea change in dental services utilization, with dental insurance, economic and access to care factors creating a perfect storm. “...Unless something’s bothering them or they’ve got pain, people say, ‘I’m just not going to go to the dentist.’”

AAE spokespeople emphasized the willingness of endodontic specialists to be partners in patient care, including their frequent charitable work at numerous Mission of Mercy and other national events that address access to care for those in need.



# Real-Life Perspectives on Emerging Endodontic Practice Models

*Endodontists are practicing in more diverse settings than ever before. New practice models beyond the traditional solo and small group practice are being prompted by the changing professional landscape, rising levels of student debt and changing preferences of young specialists. The AAE's Special Committee on Economics and the Future of Endodontics, headed by Dr. Eric J. Hovland, director of the Louisiana State University School of Dentistry Office of Advanced Education, has investigated these complex relationships, focusing on research and data gathering.*

"We don't know how many of our members are associated with nontraditional practice models; we don't know the impact on referrals from these different models; and we don't know specifically how these practices operate," Dr. Hovland said. "We do know they're growing and they will have some impact."

The committee found there was a lack of detail and information, specifically for the specialty. "The ADA and ADEA gather data, but it kind of stops at the specialty level," Dr. Hovland said. "Our real task is to see what our members need, but we need to have some basic information to be able to address those needs better."

The committee will present its findings and recommend next steps at the Board's Interim Meeting, which is held in conjunction with the ADA Annual Session, October 31 – November 1.

In the meantime, endodontists continue to adjust and adapt to a new practice dynamic. Three AAE members working in nontraditional practice models shared their experiences with the *Communiqué*.



**Cameron M. Howard, D.M.D., M.S.D.**  
Tampa, Fla.

Dr. Cameron Howard works for Great Expressions, a network of dental care providers with more than 200 practices in nine states. He's the network's main endodontist in the Tampa, Fla. region, traveling to five different locations where general dentists and specialists float in and out to provide care. He chose to forgo opening a private practice for a few reasons – namely, because his wife is a medical doctor and was determining where she would do her residency.

"I didn't know where we'd be going," he said. "I kind of had a bunch of different companies in various cities lined up."

Another factor was his student debt. "When you come out of school and you're in as much debt as a resident is, to have the thought of buying into another \$400,000-500,000 practice is almost impossible," he said. "I think this is going to become more and more common with residents. It's a guaranteed paycheck, and you can start getting better at what you do."

Dr. Howard is paid a guaranteed base salary, then works on a percentage of production. Great Expressions covers malpractice insurance. As for patients'

insurance plans, the corporation takes nearly "every insurance under the sun," said Dr. Howard, and handles all insurance and billing operations.

For Dr. Howard, the practice model has a lot of benefits. He enjoys working with general dentists and other specialists, and was able to see patients as soon as he started. He also enjoys that the corporation pays for continuing education. "That they help with a lot of your initial expenses is quite nice," he said.

He does recognize a shortcoming of this mode of practice. "You're not really buying into anything," he said. "You're not technically the boss, you're not 100 percent calling the shots."

Still, this type of business model works for Dr. Howard in his current situation – where things may lead in the future are unknown, but for now, he's quite happy.

"I like where I am, I like the GPs I'm with," he said. "Long-term, I'll probably want to have my own practice, but not now. It's an interesting model that I think is growing. A lot of my friends are doing this."



**Michael J. Mindiola, D.D.S.**  
Waukesha, Wisc.



**Kerri L. Lawlor, D.D.S.**  
Highlands Ranch, Colo.

**Dr. Michael Mindiola** works in a multispecialty group with eight locations through Wisconsin. Locations have endodontists, periodontists and oral/maxillofacial surgeons under one roof. Dr. Mindiola spent 20 years with the U.S. Public Health Service, highlighted by serving as the director of the U.S. Public Health Service Advanced General Practice Residency in Dentistry and as the national consultant in endodontics. He also served as an educator at the Indian Health Service. When he completed 20 years in 2009, he and his family decided to move back to Wisconsin.

"In 2009, the ability to get a loan to start a practice, at least in Wisconsin, was nonexistent," he said. "I came out of the service, I had a wife, four kids, one kid in college... so I had to decide, do I do an associateship, or do I join a group like this? So I joined a group with a familiar structure to what I had in public health, which is providing health care with all dental specialties, being able to provide input at one site to provide optimum care for our patients."

Dr. Mindiola is compensated based on production, similar

to compensation in a private practice. All aspects of personal insurance, CE and licensure are covered by the group as benefits. A portion of his revenue does go to the group to cover overhead, and to American Dental Partners, who provide people, systems and capital to the dental group—which results in some loss of control, as well as risk sharing between ADP and the group, according to Dr. Mindiola.

One thing he appreciates is that he has a lot of freedom. "I love endodontics, and they let me practice the way I want," he said. "You're pretty much left alone, you run your specialty and you just practice health care. You don't deal with insurance, office management, hiring or firing."

But at the same time, Dr. Mindiola doesn't enjoy traditional privileges of practice ownership. "You have to work within the group," he said. "Even as a partner, I can't go into the group and say, 'I'm going to open an office in this location, because I think it's the best location.' That doesn't work."

Group practice suits Dr. Mindiola's personal and professional goals, and he plans to continue to work with his company.

**Dr. Kerri Lawlor** practices in Colorado, working for a large corporation that has offices in three states. The corporation employs general dentists and specialists across more than 70 locations.

She chose this model because she and her family wanted to live in the area, which is saturated with endodontists. "I took the job as a 'we'll try it and see how it goes' type of thing," she said.

Dr. Lawlor is a contract employee, so she earns a base minimum guarantee per month and then a percent of net collections if she produces over her base. The corporation accepts many different insurance plans. "Some of them pay pretty well for endodontists, others don't pay too well at all," she said. "I can't pick and choose since the corporation has the say in that." The company also pays for her malpractice insurance in industry-standard form. When she leaves the company, she must purchase tail coverage, which is a cost of several thousand dollars.

Dr. Lawlor enjoys working with other endodontists because it means she doesn't get overloaded with emergency cases and it's not difficult to take time off. Another advantage? "My cases aren't always crazy difficult," she said. "Several of the GPs don't do any endo, so I get some easier cases."

However, the pay is not as high as it would be if she were practicing in her own office. Some other downfalls include a lower budget for endodontic supplies, which means working with older equipment, and corporate bureaucracy, which can make it difficult to make changes and suggestions.

There's also instability. "It's unknown about the future with the company," Dr. Lawlor said. "They could close locations, condense offices, decide they don't need you anymore."

She already thinks that her current practice model may not be her long-term professional goal. "Eventually I will likely do my own practice, but right now, I'm just trying to pay down debt," she said. <



# Why I Serve: A Profile of an Endodontic Leader in Organized Dentistry



**Eva Dahl, D.D.S., M.S.**

Dr. Eva Dahl is in private practice with a group of three endodontists at Endodontic Specialists of La Crosse, Ltd. in Onalaska, Wisc. She has been a leader in organized dentistry and shares her experiences.

## **How have you been involved in organized dentistry?**

I have been involved in organized dentistry since I was a student in the early 1970s. I served as a student representative in the Iowa Dental Association and on the student council of ADEA (then AADS), and subsequently served as president of the American Association of Women Dentists in 1985. I then was appointed to the Wisconsin Dental Examining Board for eight years and became involved in the American Association of Dental Editors. Since I was also an oral pathologist, I served on committees in Academy of Oral and Maxillofacial Pathology and the AAE, followed by a term on the AAE Foundation. In 1995, I was the first woman endodontist to be elected to the AAE Board of Directors. Following my experience in the AAE, I decided to return to the state level for involvement in the American Dental Association.

I have had the opportunity to be a member of the ADA Council of Scientific Affairs and the ADA Council on Dental Education and Licensure. One of my most interesting experiences was being appointed by the ADA to serve as one of the private practitioners on the Institute of Medicine Committee on the Future of Dental Education in 1993. I served on the Board of Trustees of the Wisconsin Dental Association, eventually rising through the executive committee ladder to become president in 2006. I have also had the privilege to represent the University of Iowa College of Dentistry on the Board of

Directors of the University of Iowa Alumni Association for seven years, serving as chair in 2002. Having been involved in political fundraising and lobbying for more than 25 years, I continue to support the WDA on their Legislative Committee and WIDPAC Board.

## **What compelled you to get involved in dental organizations?**

I love my career in dentistry and I have always wanted to be actively engaged in determining my future. I am decisive and passionate about any endeavor to which I commit, and as a dentist I wanted to be involved in determining the future of the profession. I have always enjoyed leadership and appreciate the opportunities I have had to give back to the profession with my time and determination.

## **What is the best part of your involvement in dental organizations?**

The best part is meeting so many wonderful people who are committed and enthusiastic about our profession. I know I have received more than I have given in the opportunities that I have had to be involved. Along the way, I learned so much about organizational leadership from observing others, and administration of organizations from the professional staff. I also feel good, years later, to see that some programs and decisions that were made with my involvement were positive and beneficial for the members and the organization.

## **How does volunteering with dental organizations help you in your daily work?**

I feel my involvement with organized dentistry certainly makes me more informed and knowledgeable about not only the practice of dentistry, but also the environmental conditions (such as political forces, legislation, regulation and economic factors) that affect our profession and our practices. I can better inform my patients about issues and represent my profession in the community through my experiences in dental organizations.

## **How likely are you to continue to volunteer with dental organizations in the future?**

I will continue to represent dentists and our issues to the state legislature through the WDA. I have also returned to dental education recently as an adjunct faculty member at Marquette University School of Dentistry. I don't aspire to any particular roles at this time, but am enjoying sharing my more than 30 years of practice and leadership experience with the endodontic residents.

## **Why do you feel it is important to volunteer with dental organizations?**

If you don't become involved in the organizations that represent you and your profession, you really have no voice in your future, and others will be carrying your load for you. We all have to do our part, whether that be time or treasure—I feel everyone as a professional has an obligation to be involved. <



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*Dr. Bushell at a Connecticut Mission of Mercy Event.*

*Dr. Bushell accepting the Spirit of Service Award at the 2010 AAE Annual Session with Past President Dr. Gerald N. Glickman.*

## Adolph Bushell, D.D.S. | 1923-2013

*AAE Life Member and Spirit of Service Award recipient Dr. Adolph Bushell, of Bloomfield, Conn., passed away on July 26, 2013.*

Dr. Bushell graduated from The Ohio State University in 1943. He was awarded a Purple Heart for his service in the U.S. Army during World War II, during which he was a prisoner of war in Germany. Following the war, he attended Temple University School of Dental Medicine from 1946 to 1950.

Dr. Bushell was considered the “father of endodontics” in Connecticut, practicing in West Hartford during his long and distinguished career. He made significant contributions to the profession, including his role as a founding member of the Connecticut Association of Endodontists. He was also a member of the Connecticut State Dental Association and the International College of Dentists, as well as a Fellow of both the American and International College of Dentists and the Pierre Fauchard Academy.

An award-winning humanitarian, Dr. Bushell volunteered in third-world countries in Asia, Latin America and the Caribbean to provide dental care. He served with the hospital ship, HOPE, in Sri Lanka and the West Indies, provided dental services in Guatemala and Cambodia with Heal the Children, worked to establish a dental clinic in Haiti with the Haitian Health Foundation and led a group of University of Connecticut dental students to Peru. Most recently, Dr. Bushell worked with Connecticut’s Mission of Mercy Program. His work earned him the AAE’s Spirit of Service Award in 2010.

He was also a dedicated educator, involved in the first decade of the University of Connecticut’s endodontic program. He lectured and performed demonstrations at dental schools in the U.S. and abroad. Before his retirement in 2011, he was on the courtesy staff of the Connecticut Children’s Hospital and on the staff of the University of Connecticut School of Dental Medicine, teaching at the Hartford Hospital dental residency program. Donations can be made to the Dr. Adolph Bushell Fund, University of Connecticut Foundation, 10 Talcott Notch Road, Suite 100, Farmington, CT 06032

*“Adolph Bushell was way ahead of his time, always thinking of ways to improve equipment or procedures that would benefit the profession he loved. He was an extremely talented endodontist and surgeon. I have never met another individual with the concern and compassion for mankind and the willingness to share with others. He was truly one of a kind.”*

— Martin J. Ungar, D.M.D.

*“Sometimes you meet someone who positively changes your life, your perspective, your attitudes, your professional goals. This was the way for so many people whose lives Adolph Bushell touched. He lived and breathed the discipline of endodontics and truly loved his life’s work. We’re all in his professional debt and will forever miss him.”*

— Robert A. Balla, D.M.D.

*“Adolph Bushell was a consummate professional and gentleman. He was always willing to share his knowledge with the dental community in a life of constant learning and teaching. Referring dentists and patients alike knew that they could depend on his honesty, integrity and concern. In professional dental organizations, he was the voice of decency and reason.”*

— Henry P. Cohen, D.D.S.



Dr. Siroky speaking at the 2005 AAE Annual Session.

Dr. Siroky with Dr. Denis E. Simon at the 2005 AAE Annual Session.

## Charles L. Siroky, D.D.S. | 1937-2013

*AAE Life member and past AAE Foundation President Dr. Charles L. Siroky, of Phoenix, Ariz., passed away on September 10, 2013.*

Dr. Siroky completed the pre-dentistry program at the University of Arizona before being admitted a year early to the University of Southern California School of Dentistry in 1958. He graduated with honors in 1962, and was awarded admission to the Alpha Tau Epsilon and Omicron Kappa Upsilon, both honorary dental organizations, as well as Phi Kappa Phi honor society.

He served four years in the U.S. Army Dental Corps after graduation, where he practiced dentistry for three years in Nuremberg, Germany and one year in Fort Irwin, Calif. Following his honorable discharge in 1966, Dr. Siroky settled in Phoenix with his family, where he set up a private endodontic practice and practiced for 48 years, retiring at the age of 71 in 2009.

Dr. Siroky served as president of the AAE Foundation from 2003-2006 and the Foundation Board of Trustees from 2001-2007; he was active in AAE committees as well. He also served as president of the Arizona Dental Association, was the 14th District trustee of the ADA, and served as second vice president of the ADA in 1993. He was a Fellow of the American and International Colleges of Dentists, the Academy of Dentistry International and the Pierre Fauchard Academy. He was most active in the ICD, serving at both the national and international levels, and as president in 2011. During that time, he traveled worldwide, speaking to nearly 12,000 Fellows. He was currently serving a three-year term as speaker of the ICD council.

Dr. Siroky was also active in his church, serving as senior and junior warden, vestryman, lay reader and chalice bearer at St. Paul's Church in Phoenix, then later serving at Christ Church of the Ascension in Paradise Valley, Ariz., and The Episcopal Church of the Epiphany in Flagstaff, Ariz. He also served as president of the Phoenix Rotary Club, volunteered at St. Joseph's Hospital Mercy Care Dental Clinic, mentored local dental students and received countless awards and honors for his unwavering commitment to his community and profession. Donations may be made to either of the following charities: The International College of Dentists' Global Visionary Fund for Dental Education and Humanitarian Care Projects, G3535 Beecher Road, Suite G, Flint, MI 48532, or Central Arizona Dental Society Foundation's Arizona Dental Mission of Mercy, 3193 N. Drinkwater Drive, Scottsdale, AZ 85251.

*"Dr. Charles Siroky was a terrific member/friend of our specialty, the profession, and the people we serve. His calm measured leadership skills set the tone, whether as president of the American Association of Endodontists Foundation, the International College of Dentists or as vice president and subsequently a trustee of the American Dental Association. His Southwestern style, wit, humor and thoughtful guidance helped advance our profession immeasurably. Dr. Siroky was a terrific example of what members of our specialty may aspire to in the civic sector also, where along with his wonderful wife Gayle, advanced the cultural landscape*

*wherever they lived. I was honored and privileged to have known and been inspired, while working with him along several of our profession's trails. We will miss the fine example of how his life, as a proud endodontist, has inspired others to follow."*  
— James C. McGraw, D.D.S.

*"I was privileged to serve with Charley on the AAEF Board of Trustees. He was always an advocate for our AAEF and also the ADA, where he served admirably for many years. He will be missed by our AAE, ADA, and ICD families."*  
— Denis E. Simon, D.D.S., M.S.

*I have known Charley Siroky for the last 20 years and he has been a wonderful colleague and mentor for me. It is rare to find someone who has such dedication to his patients, his practice, and his profession and yet finds time to help out whenever he is asked. While his achievements are vast, it was his caring attitude and commitment to ethics that had such an impact on me. He was the consummate gentleman, professional, and leader and I will miss him greatly. We have lost a giant.*

— Robert S. Roda, D.D.S., M.S.





# Revising CODA Endodontic Standards: **A Lengthy, But Necessary, Process**

Although the revised Commission on Dental Accreditation Standards for Advanced Education Programs in Endodontics were approved by CODA at its winter 2013 meeting, the process to update the standards began back in 2011. The process is rigorous and designed to include all stakeholders so that endodontic resident education is of the highest quality and agreed upon by educators; so although it may seem overly lengthy, it is necessary. In 2011, a special AAE committee was appointed to review the standards and incorporate CODA-required language and other pertinent changes. Through multiple surveys and calls for comments, the special committee culled data to determine which standards needed revision, and then proposed their changes.

The proposed changes were distributed to endodontic program directors, and the committee again reviewed the feedback and adjusted the proposed revisions. At the 2011 Program Directors Workshop, the special committee presented the proposed revisions to program directors again for additional comment. Finally, the proposed revisions were sent to a random sampling of the general membership for a final call for comment. CODA approves that the revisions be sent to all CODA communities of interest electronically and via open hearings at the ADA and ADEA meetings over a period of six to 12 months. The CODA Review Committee on Endodontics Education reviewed all comments, approved final revised document and

submitted it to CODA at its February 2013 meeting, where they were approved for implementation January 1, 2014.

Most of the changes were to adopt language that was common to all advanced specialties, conform to a revision of the definitions for levels of didactic and clinical education, and editorial revisions. For curriculum, instruction and clinical education for implant dentistry was elevated slightly to the middle of three levels; and revascularization/regenerative endodontics was added as a curriculum topic at the highest instructional level and middle clinical training. <



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## Risk Management Considerations for **Traveling Dental Specialists**

*The following is a condensed version of a longer article that appeared in the Summer 2013 TDIC Liability Lifeline newsletter. Review the full TDIC article, including recommendations from risk management analysts for each area listed below, at [http://www.thedentists.com/library/risk%20management/lifeline\\_summer2013.pdf](http://www.thedentists.com/library/risk%20management/lifeline_summer2013.pdf).*

"We've heard enough from general dentists and specialists to know it's becoming more common," said Greg Alterton, a policy analyst for the California Dental Association, which has the topic on its policy radar. According to Alterton, the arrangement is typically on a contract basis where a specialist visits a general practice on a periodic basis such as once or twice a month.

Risk management analysts and legal experts advise having thorough documentation involving any independent contractor agreements addressing staff, equipment, billing, patient communication, follow-up care, emergency response, insurance coverage and use of provider numbers.

"The vast majority of specialists and general dentists are doing things properly, but there is work to be done to enhance safety and quality and make sure everyone is on the same page and following the same protocol and processes," Alterton said.

Risk management analysts say patients have a reasonable expectation to receive help in the event of a treatment-related complication, and advise both general dentists and specialists to consider the following before entering into an independent contractor agreement.

### **Pretreatment Considerations**

- How will the specialist develop rapport with staff and patients before beginning treatment?
- How are patients notified of the separation between the practice and the traveling specialist?.
- How will billing be handled?
- What if a patient wants a refund?
- What if a patient cancels an appointment with a visiting specialist? Does the patient still receive a bill? Does the specialist receive compensation for showing up even if a patient does not?
- What happens if the specialist separates from the practice?

### **Treatment Protocol**

- Is the staff person assisting the specialist familiar with the procedures he or she will be performing?
- What happens in the event of an emergency? Does the specialist know where all of the emergency equipment is located? Does the specialist's emergency protocol differ from the office's emergency protocol?

### **Post Treatment Protocol**

- After a procedure, will the specialist complete the post-op check or will the practice owner? Is a protocol in place when responding to issues related to the specialist's treatment?
- What is the protocol if a patient calls after a procedure with a treatment-related issue? How will the office notify the treating specialist? How will they confirm that the specialist has responded?
- Is the practice owner capable of handling complications? What is the practice owner's expectation of the specialist when a patient experiences a complication?
- If a post-treatment concern arises, will the specialist be available to address it?

These are serious issues that deserve careful attention and planning. A thorough and signed contract should outline provisions that both the dentist and specialist agree to, and that keep the best interest of the patient in mind. <



*Dr. Alejandro M. Aguirre, third from left, with volunteers and a patient at a June 2013 Mission of Mercy event in Bemidji, Minn.*



# Rewarding Work: A Behind-the-Scenes Glimpse at **Mission of Mercy Events**

*Many AAE members volunteer at Mission of Mercy dental clinics, helping to provide free root canals to patients in their states that need it most. More than half of U.S. states have Mission of Mercy clinics or similar programs, and these events have helped more than 100,000 patients and provided nearly 50 million dollars in free services since 2000. All this comes together through the work of many, acting behind to scenes to coordinate logistics, funding, equipment and more.*

Dr. Alejandro Aguirre helped establish a MOM event in Minnesota. He said the beginning was difficult because volunteers had to first work out logistics and budgets before they could secure funding.

"It's very difficult," said Dr. Alejandro M. Aguirre, who helped establish a MOM event in Minnesota. "You take the plunge, you throw yourself into the abyss, and then you start building the plane to fly."

To start the initial event in Michigan, Dr. Scott J. Hodges and other volunteers began work two years before the event, visiting MOMs in other states, navigating licensing issues and then determining how and where to hold the event in their home state.

"You have to develop your state's home identity," Dr. Hodges said. "For Michigan, the best thing we could give the patient was education. They had to sit down with a dental hygiene student or dental student and had dietary counseling and one-on-one toothbrush instruction."

Patients also left with information on area dental facilities and how to continue to receive treatment.

Other things to consider include licensing for both dentists and equipment. For example, all radiation machines in Michigan must be licensed in that state—which can prove difficult when borrowing equipment from neighboring, already-established clinic organizers in other states.

But both MOM organizers stressed the importance of visiting other Mission events to learn from colleagues, and delegating work to ensure everything runs smoothly.

"You get great mentors from other MOMs that taught us how to do the event," said Dr. Aguirre. "We did not need to reinvent the wheel. It looks overwhelming—and it is, and it takes a lot of work—but if you divide everything into little parts, it gets way easier."

So is the work worth it? Absolutely, according to Drs. Aguirre and Hodges.

"You become a MOM addict, you want to go to other events, you want to help people," said Dr. Aguirre. "This is about working together and changing people's lives. And you certainly help people that in pain... but actually, volunteers have thanked us for having the event."

"My brother (an endodontist) did six root canals for a patient in an hour," he added. "You've got to see it... you can go and observe, but then you just want to start helping out."

If you are interested in starting a MOM event in your state, or want to plan a smaller-scale volunteer event, Dr. Hodges has some advice.

"Send a small team to a current MOM," he said. "What will happen is they will get addicted. It's very rewarding. And you're hanging around with other dentists, assistances, hygienists. There's a lot of legwork, and it seems overwhelming, but there's enough experience and history. They can hook you up." <



## Volunteer in New Orleans at the ADA Annual Session

5:30 a.m. – 5:30 p.m.

November 3

Mardi Gras World

1830 Port of New Orleans Place, New Orleans

Volunteers are still needed for the Mission of Mercy dental clinic in conjunction with the ADA Annual Session in New Orleans. For the first time at its Annual Session, the ADA hopes to serve about 1,000 patients in need of dental care on the last day of the meeting. The clinic will be hosted by the ADA and America's Dentists Care Foundation with support from the Louisiana and New Orleans dental associations. Endodontists, dental team members, students, office staff, families and friends (age 18 and older) are encouraged to volunteer.

Learn more and register to volunteer at [www.ada.org/MOM](http://www.ada.org/MOM).



## UPCOMING INTERNATIONAL MEETINGS

### ADA Annual Session

[www.ada.org](http://www.ada.org)

October 31 – November 3

New Orleans

### Italian Endodontic Society National Congress

[www.endodonzia.it](http://www.endodonzia.it)

November 7 – 9

Torino, Italy

### Lebanese Society of Endodontology 3rd Pan Arab Endodontic Congress

[www.paec2013.org](http://www.paec2013.org)

November 28 – 30

Beirut, Lebanon

### Hellenic Society of Endodontology International Congress

[www.endodontics2013.gr](http://www.endodontics2013.gr)

November 29 – December 1

Athens, Greece

## New Members

### Active

Regina H. Rocha, Chicago, Ill.

Jason C. Cho, Irvine, Calif.

Andrew E. Abide Jr., Southaven, Miss.

### Associate

David M. Caldwell, Beaumont, Texas

Gregory A. Cumberland, Calgary, AB  
Canada

Paul H. Kim, APO, AE

Jason S. Bullock, Kapolei, Hawaii

Hooman Rabiee, Wilrijk, Belgium

### International

Yeon-Jee Yoo, Seoul, South Korea

Marcelo dos Santos, Sao Paulo, Brazil

Alicja Maria Nowicka, Bezrzecze  
Zachodniopomorskie, Poland

Fernando S. Daviz, Soledade, Brazil

Fusanosuke Fukuyama,

Higashinada-Ku, Hyogo Japan



## Call for 2015 Award Nominations

*The Honors and Awards Committee encourages you to submit your nominations for 2015 AAE honors and awards. All nominations, supporting documentation and letters of recommendation must be submitted by Friday, January 3, 2014 to:*

### Dr. Shepard S. Goldstein

Chair, Honors and Awards Committee

c/o Casey Petersen

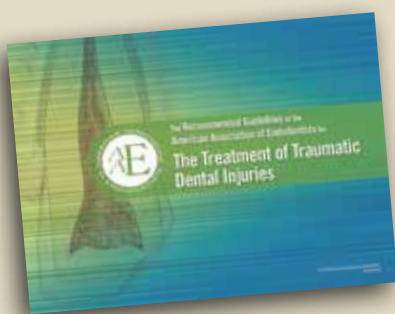
American Association of Endodontists

211 E. Chicago Ave., Suite 1100

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Details on award categories and nominations are available on the AAE website or by contacting Casey Petersen, executive coordinator, by phone at 800/872-3636 (U.S., Canada, Mexico) or 312/266-7255, ext. 3030, or email at [cpetersen@aae.org](mailto:cpetersen@aae.org). <



## New Trauma Guidelines Available Soon

The AAE has updated *The Recommended Guidelines of the American Association of Endodontists for the Treatment of Traumatic Dental Injuries*, which will be available as an e-book this November at [www.aae.org/guidelines](http://www.aae.org/guidelines).