JOURNAL OF DENTAL HUMANITIES

VOLUME 2: ISSUES 1/2 WINTER/SPRING 2018

JOURNAL OF DENTAL HUMANITIES

The Journal of Dental Humanities is dedicated to presenting thought provoking material connecting dentistry to the humanities, and the social sciences. The journal places a priority on publishing quality material that supports the objective of dental professionals who seek to provide a patient-centered approach to health care. The mission purpose of the Journal of Dental Humanities aligns with the position that a functional democracy requires ethical, highly skilled professionals who are engaged, active members within their community and the larger society.

EDITORIAL BOARD

ISSN 2573-8844

CONTENTS

EDITORIAL

DENTAL EDUCATION – IS IT TIME FOR A MORE AFFORDABLE OPTION?

ROBERT P. IOVINO, D.D.S., M.A.

The life of a dental student has always contained unique challenges: laboratory work and clinical requirements, for one; orchestrating patients, with required procedures, chair time with attendings, another. However, regarding the cost of professional education, I recognize just how comparatively 'easy' life as a dental student and post-graduate resident was 'way back' in the 1970s & early 1980s. My dental college tuition (three years thanks to the NYU College of Dentistry's short lived accelerated program) ranged upward from an initial year at approximately $3,500, to a last year at $7,500. Following a relatively well-paid general practice residency, I then completed a three-year OMS residency. After successfully orchestrating a 'from scratch' low-cost practice set-up, I then entered the private-practice dental workforce, practicing oral surgery solo, at age 29. With minimal indebtedness, I might add.

How different this state of affairs is today! Like many other full or part-time academics, I routinely encounter dental students and residents saddled with tuition loans ranging well up into the mid six-figures. Compounding this problem is the fact that the duration of many dental specialty programs (both salaried, tuition bearing, and a mixture of both) have expanded. Often, today's fourth year dental students must weigh their post-graduate options against such additional training's perceived cost-effectiveness. Time spent and finances invested all too often can dictate important career choices. It is no wonder that the corporate dental practice model is gaining traction, as modern technology and economic factors conspire to make the expense of starting-up a new practice cost-prohibitive.

Accordingly, I recently read with great interest a post on Stony Brook University's webpage announcing a "new medical training curriculum" enabling select students to complete their medical degree studies

in three years.[1] Unlike many other accelerated degree programs, where cumulative tuitions costs remain essentially the same whether the student is enrolled in the accelerated or traditional program, Stony Brook's accelerated M.D. degree can be acquired at a considerable savings. Lath Chandran, M.D., M.P.H., Vice-Dean of Academic and Faculty Affairs, projects that tuition savings for those students enrolled in the three-year program will range from $40,000 for New York state residents, to $65,000 for out-of-state residents.

Latha Chandran, MD, MPH, Vice Dean of Academic and Faculty Affairs, Stony Brook University

"We hope the three-year MD program becomes a stronger trend nationally for the benefit of the students, many of whom have significant debt before becoming physicians."

According to Dr. Chandran, the difference in tuition savings for the three-year tract students is essentially one year of tuition.

A number of law schools, faced with an applicant pool concerned about the diminished prospects and financial returns experienced by many recent graduates, now offer accelerated two-year degree programs. Brooklyn Law School is among those now offering a two-year option: however, unlike Stony Brook's accelerated M.D. program, tuition costs remain the same in the accelerated curriculum at Brooklyn Law School.[2] Savings are limited to a reduction of the valuable time invested and the cost of one year's living expenses.

---

[1] Stony Brook University Newsroom. "Stony Brook Launches Three-Year MD Program." 6 March 2018. < https://www.stonybrook.edu/newsroom/general/2018-03-06-Stony-Brook-Launches-Three-Year-MD-Program.php> Accessed 2 April 2018.

[2] Brooklyn Law School. "Our Degree Options." <https://www.brooklaw.edu/academics/ourdegreeoptions/2YearJDProgram> Accessed 2 April 2018.

There are eight approved three-year M.D. programs in the United States.[3] In contrast, there exists only one dental school offering applicants a three-year degree program. Since 1942, graduates of the University of the Pacific Dugoni School of Dentistry have provided proof that an accelerated three-year dental degree program can successfully work. Stressing the College's place as a "pioneer in competency-based dental education" the Arthur A. Dugoni School of Dentistry's webpage highlights its unique status, stating: "Because we offer the nation's only dental program that can be completed in three calendar years, our dental students pay tuition for three years as opposed to four years at all other dental schools…Tuition for the 2018-2019 academic year for the D.D.S., I.D.S., Ortho and Endo programs is $111,925."[4] No doubt, valuable time is saved; however, I will leave it to you to answer the question (after multiplying anticipated yearly tuition costs by three): how great is this advantage?

High student loan indebtedness extracts an unseen toll. Financial concerns can exert an influence on one's practice location, habits and ethics. As a result, prioritizing one's patient's needs can take a back seat to paying down one's student loan indebtedness. Graduates heavily in debt can experience difficulty in allocating time to participate in providing reduced-fee, or *pro bono*, needed oral health care. Given, mounting public pressure on the profession to fulfill its obligations, the time has arrived to ask: Should U.S. Dental Schools adopt tuition reduction measures, similar to Stony Brook Medical College's three-year degree program option?

---

[3] Cangiarella, Joan, M.D., Tonya Fancher, M.D., Betsy Jones, Ed.D., Lisa Dodson, M.D., Shou Ling Leong, M.D., Matthew Hunsaker, M.D., Robert Pallay, M.D., Robert Whyte, M.D., Amy Holthouser, M.D., and Steven B. Abramson, M.D. "Three-Year MD Programs: Perspectives From the Consortium of Accelerated Medical Pathway Programs (CAMPP)." *Academic Medicine.* April 2017, Volume 92, Issue 4, p. 483-490. <https://journals.lww.com/academicmedicine/Fulltext/2017/04000/Three_Year_MD_Programs___Perspectives_From_the.35.aspx > Accessed 2 April 2018.

[4] University of the Pacific, Arthur A. Dugoni School of Dentistry. "Three-Year DDS Program." <http://www.dental.pacific.edu/academic-programs/doctor-of-dental-surgery/tuition-and-fees> Accessed 2 April 2018.

THE COLLAPSE OF THE DOCTOR-PATIENT RELATIONSHIP DUE TO INSURANCE COMPANY INTRUSIONS

JOSEPH P. GRASKEMPER, D.D.S., J.D.[1]

Through recent modifications of their dental insurance provider agreements, various insurance companies have placed themselves, often through cryptic in-house rating systems, in a position to direct patients to dentists of their choosing. An example of such manipulation is encountered when insurance companies tier their panel providers.

Should insurance companies rate dentists and influence patients' choice of a dentist for profit? Most, if not all, dentists would answer a profound "NO!" But it is just not that easy. Many dentists suggest that it would be best to not sign on as a contracted insurance provider. That strategy may work for some but not for most, including the newly graduated dentist with an average school debt of over $200,000. According to the American Dental Education Association (ADEA) 2017 survey, the average debt per graduating senior is $287,331.[2]

Few practice management consultants, or organized dentistry leaders, would disagree with the position that it is advisable to have an attorney review any insurance provider contract before any dentist signs it. The Federal Trade Commission has made it very clear that dentists cannot group together to negotiate a fairer provider agreement or fee schedule. The Supreme Court has advised us that coordinated efforts by dentists and dental societies to thwart cost-containment efforts by

[1] D.A.B.M.M., D.A.B.L.M., F.A.G.D., F.A.E.S., F.I.C.O.I., F.A.S.O., F.A.C.L.M., F.A.C.D.; Clinical Associate Professor, School of Dental Medicine, Stony Brook University.

[2] American Student Dental Association. "Dental Student Debt." <https://www.asdanet.org/index/get-involved/advocate/issues-and-legislative-priorities/Dental-Student-Debt> Accessed 2 February 2018.

insurance companies can readily run afoul of the antitrust laws.[3] Clearly, the times they are a-changing.

With the many recent changes in healthcare insurance, dentistry is coming under greater control by the insurance industry, and corporate dental providers. Such entities often take advantage of debt-laden graduates. More and more insurance pre-determinations are being routinely returned unprocessed, in a time-wasting strategy, often with a request for additional information **unrelated to** the requested Estimation of Benefits (EOB). Surely, for those who have insurance involved practices, this is nothing new. What is now occurring with little oversight is the rating of the insurance panel dentists, and the influencing of the insured patient to choose particular dentists for the benefit of the insurance company's **bottom line**.

Insurance companies, usually utilizing a subsidiary or contracted 3rd party, endeavor to rate their dental panel providers. They present this as an *opportunity* for their participating panel dentists to make patients *engaged consumers* of their services.[4] This creates a very real problem. It presents dental services as a commodity. It transforms dentists into sellers of services and/or merchants that an *engaged consumer* can shop among from a list of insurance company, self-interest rated, providers. Insurance companies inform their panel of dentists that this is a better *interactive patient-provider communication platform*.[5] However, they do not mention that they are the ones that have control of that communication through their rating system – not the dentist – not the patient. It is also pointed out by the insurance company that they are not going to charge the dentist for this rating system and that it is *offered as a courtesy for your relationship* with the insurance company.[6]

---

[3] American Dental Association. "The Antitrust Laws in Dentistry: A Primer of "Dos, Don'ts and How Tos" for Dentist and Dental Societies. <https://www.sfds.org/fileLibrary/file_135.pdf> Accessed 1 February 2018. See *Federal Trade Commission v Indiana Federation of Dentists, 476 U.S. 447, 450 fn.1 (1986)*, p. 2 ff.

[4] See Appendix I to this article: Frequently asked Questions (FAQ) form THN-D0010 (2016), p. 1.

[5] Ibid.

[6] Ibid.

Unfortunately, there is often no transparency on just who controls, or actually conducts, what arguably can be termed a subjective numeric rating system. Such a rating system, even being issued by a supposed impartial 3rd party, interferes with the doctor-patient relationship as well as the patient's autonomy. Such measures interfere with the insured patient being able to freely select their dentist, without being unduly influenced by an interested profit oriented party. This process poses a real ethical problem, by influencing, or skewing patients to select only those dentists subjectively rated high by the insurance company.

By what standards do insurance companies rate panel dentists? Upon investigation, I have found that there are 3 areas that are considered in their rating system: 1) Professional history, 2) Patient experiences, and 3) Affordability.[7]

The score is then somehow formatted from the 3 areas evaluated. In the area of professional history, the professional's practice and educational background, including license history and any advanced training is evaluated.[8] However, dentists practice in a wide array of practice settings from being an associate, a partner or a solo practitioner. Having practiced, on separate occasions, as an associate, as an owner of a multi-specialty practice, and as a solo practitioner, I can state that to compare the practice environments and experience is to compare an apple to a pineapple. They are definitely separate and distinct practices each with distinct positives and negatives for the practitioner and the patient. To group them together is a disservice to their clientele. Likewise, educational background and advanced training is so wide in scope that evaluating quality of education and training is nothing but a biased statement of who is better than whom; when all should be comparatively equal due to licensure and the maintenance of the standard of care that is required legally and ethically of all practitioners. How do you properly rate a dentist with numerous organizational Fellowships who practices over 45 - 50 hours per week and a dentist with a school-based Certificate who practices 3 days a week for approximately 20+ hours per week? Does the evaluation rate the various organizations that offer Fellowships and/or the quality of the school Certificate? How does a practitioner's experience

[7] See Appendix I to this article: Frequently asked Questions (FAQ) form THN-D0010 (2016), p. 3.
[8] Ibid.

go into the equation? The experience is not just the number of years one has practiced but what environment and type of practice again differs greatly.

Patient experience is rated by viewing *verified patient reviews*, advanced technologies, and office amenities. In a conversation with an insurance representative, I was told that even though I had a 5 out of 5 rating on the one online review of my practice that it was not enough to earn a high rating in this category, I was advised that in order to gain a high rating I should go out and gather additional favorable reviews. However, how do insurance companies verify that the patient reviews they utilize are not just those submitted by friends and family promoting their dentist friend or loved one? They effectively cannot. In-fact, an insurance company representative once suggested to me that I ask my friends and family to do this exactly. It is prudent to be cognizant of the fact that not all reviews posted on-line are legitimate.

Advanced technologies are great; but, is it not how these new technologies are being used that matters? Digital imaging is a wonderful advancement; however, the system software needs to be properly adjusted in order to best allow a skilled dentist to arrive at a proper diagnosis. Just because a dentist has many new technologies available does not mean they are better dentists. Next the rating service looks at amenities. Having foot massages available, free parking, free coffee, or a free toothbrush with your cleaning does not necessarily correlate with the type and quality of care actually being provided. Amenities are nice, patients appreciate them, and they make patients feel comfortable. However, should dental care be rated by what amenities are available? The next level of review for patient experiences is the dentist's online reputation. This is evaluated by the dentist's overall presence on the web. This evaluation has nothing to do with professionalism or patient care. Rather, this evaluation is influenced by who has the best web designers and the best search engine optimization (SEO). It is another way that the insurance company can sway their clients toward those dentists that they chose to work with more closely.

Affordability is based on your *negotiated fees* as they compare to the insurer's fee schedule, and the amount of out of pocket costs to their

clients.[9] To get a high rating the dentist must have the least patient out of pocket costs; the less expensive, the better. They evaluate this by your submitted fees. If you submit fees that actually match the insurance fee schedule, you are skewing the data base to a lower composite submitted fee, which, in turn, the insurance company then uses in their review of their offered fee schedule. This composite fee schedule is of course promoted as what is best for their clients, but it is actually in the best interests of the insurance company to help their bottom line with the lowest possible fee schedule. This enables insurance companies to claim that their fee schedule is fair in relation to these "highly rated" low fees when performing a composite survey of their participating dentists. As a result, an insurance company need not necessarily raise its fees. However, insurance companies are in line to still realize greater profits; traditionally, on a yearly basis, insurance plan premiums have historically increased, while dentist reimbursement fee schedules rarely rise.

To manipulate dental practitioners into accepting the position that an insurance company be permitted to influence the patient's choice of dentist, the insurance company will not issue a new fee schedule without the dentist's signed acceptance of this new addendum to the provider agreement. This new addendum may read*, "In addition, (insurance company) reserves the right to direct Participants to selected dentist and/or influence a Participant's choice of dentist. This may include, but is not limited to, the segmentation or tiering of the dental network."*[10] Sometimes these clauses are not in the contract but are referred to in the contract by having the dentist follow and abide to the insurance company Policy Manual, which would contain something similar to the above quote.[11] Hence, with this clause, the insurance company can even call your patient who is one of their clients; and, influence and direct them *out* of your office. This policy is a direct interference of the doctor-patient relationship. However, due to the dentist's signed agreement/contract there is nothing the dentist would be able to do. The end result is that the insurance company will have ultimate control over patients and those

[9] Ibid.
[10] See Appendix II to this article: Cigna Provider Agreement Section 5, subparagraph (2016).
[11] See Appendix III to this article: Cigna Provider Agreement, Section 16 (2015), p. 3.

practices involved in insurance: rewarding those that they deem favorable and punishing those they deem unfavorable.

There are many physician/dentist rating organizations but what is now occurring is that the insurance companies are starting to set up or support rating systems to guide patients to dentists for their financial benefit. This is a ethically questionable policy that interferes with a patient's right (based on the principle of autonomy) to select the proper dentist for their wants and needs. It is also highly questionable matter of concern as to just how the insurance company will influence their clients away from certain dentists. Will insurance companies endeavor to influence their clients by defaming so-called "unfavorable" dentists? The panel dentist will never know the possible new patient has gone elsewhere because of a rating system representative aggressively influenced the patient to go to the insurer's dentist of choice.

Another highly questionable ethical intrusion is the new clause showing up in many agreements and policy manuals that disallows treatment. This clause is a very clear intrusion into the doctor – patient relationship and patient autonomy. If agreed to, a disallow clause prevents the dentist from performing a needed procedure that the patient and doctor mutually agree to. A disallow clause not only eliminates any possible insurance benefit payment but also prohibits the dentist from charging or accepting any money from the patient. Under this new system, the patients and dentists become entirely subservient to the insurance company and its quest for profits.

This control over our patients, the care we provide them, and whether we are paid for our time and effort in providing that care is slowly being taken over by the insurance companies. It is the beginning of the collapse of the doctor-patient relationship and patient autonomy in dentistry.

Appendix I – Frequently Asked Questions (FAQ) form THN-D0010 (2016)

BRIGHTER PROFILE™

Cigna Dental

FREQUENTLY ASKED QUESTIONS

January 2016

Cigna recently entered into a licensing agreement with Brighter, Inc. to improve the online experience for Cigna Dental customers and to provide Brighter's free services to our network dentists. The new relationship with Brighter will help make practice management easier for dentists and their staff. Participating dental offices will be able to feature detailed practice profiles to help attract new patients. Online appointment scheduling and automated appointment reminders can also help to reduce practice administrative costs and time.

1. Who is Brighter and what is Cigna's relationship with them?

   Brighter is health care's first multi-sided platform that seamlessly connects patients, providers and payers through an interactive marketplace to transform passive customers into engaged consumers, increase the value of network participation for dental health care professionals, and enable payers to leverage innovative technologies to advance their consumer initiatives. Brighter was founded by Internet entrepreneur Jake Winebaum. For more information, visit www.brighter.com.

   Through a licensing agreement with Brighter, Inc., an innovative dental marketplace platform, all Cigna Dental customers will have access to improved cost and quality transparency tools, including dentist profiles and verified patient reviews to help compare dental offices and services.

2. What is changing with the Cigna Dental directory?

   The Cigna Dental online directory will be transforming from a basic listing of participating dental health care professionals to an interactive patient-provider communication platform. Cigna Dental customers will be able to select a dental office based upon a customized Brighter Profile™ "view" of the office. Some of the features you can make available to Cigna Dental customers include information about the dentist(s) and staff, a virtual office tour through videos and photos, a description of the dental technology and amenities offered by your office. You can even enable your patients to schedule their appointments online by using Brighter Schedule™.

3. When will these directory changes be visible to Cigna customers?

   Directory-based upgrades will begin in the spring of 2016 and will be phased in throughout the year.

4. What are the benefits of having a Brighter Profile?

   Your free Brighter Profile makes it easier for you to grow your practice and communicate with Cigna Dental customers. You can highlight your strengths and the services you offer, while optimizing attributes that contribute to the Brighter Score™. In addition, Brighter Schedule provides convenient appointment scheduling and automated appointment reminders to patients that are Cigna Dental customers, and helps improve administrative efficiency for your office.

5. Is there a cost associated with a Brighter Profile?

   The Brighter Profile features are absolutely free and offered as a courtesy for your relationship with Cigna.

Cigna

Brighter Profile™

6. **What is the Brighter Profile?**

   The Brighter Profile offers a summary of practice characteristics that may interest Cigna Dental customers (e.g., experience, technology and amenities). To enhance your profile, you can add key elements:

   - Photos (including office and staff to create a more inviting experience)
   - Professional history (including education, training, and certification)
   - Technology and amenities
   - Brighter Schedule – helps Cigna Dental customers when selecting a new dentist by offering the convenience of online appointment requests. Enabling this feature, where available, can also help you collect verified reviews.

   The basic profile is compiled through secondary research (e.g., your website and social media, NPI database, and state license database).

7. **How do I activate or update a Brighter Profile?**

   You can contact Brighter at 888.300.4742 or visit providers.brighter.com. Brighter's online provider portal allows you to directly manage your Brighter Profile. Multiple users are allowed on each practice account and Brighter can remove users, if needed.

8. **What information will appear on the Cigna dentist directory before my profile is completed?**

   Basic information that Brighter has collected through secondary practice research and verified sources (e.g., state license database, NPI database, practice's website, and social media) will be displayed.

9. **What data elements can be displayed in my Brighter Profile?**

   Practice Data Elements:

› Practice name	› Practice photos and videos	› Street address
› Phone number	› Website URL	› Email address
› Fax number	› Languages spoken (at the practice)	› Technologies
› Amenities and parking information	› Office hours	

   Dental Health Care Professional Elements:

› Provider name	› Provider photos and videos	› Gender
› National Provider Identification (NPI)	› Date began practicing	› Specialty
› License number, issuing state, and type	› Education (graduate and undergraduate; institution and year)	› Associations
› Certifications	› Ages treated	

10. **How quickly will my Brighter Profile information appear on Cigna's dentist directory?**

    Profile data is transmitted daily and could take up to 24 hours after your submission to be updated.

Brighter Profile™

11. How does Brighter verify a caller is authorized to update my profile?

    Brighter uses your practice's unique phone number to authenticate users when setting up initial access to the Brighter Provider Portal.

12. What is the Brighter Score?

    The Brighter Score is designed to meet the needs of patients who want more information – while also providing health care professionals with the opportunity to maximize their Brighter Score by ensuring it is based on an accurate, comprehensive, and continuously growing set of information.

    The methodology used to calculate the Brighter Score is based on research and collaboration with health care professionals, consumers, and dental industry leaders and associations who are dedicated to fostering strong and loyal relationships between patients and dentists. The Brighter Score shows a health care professional's strengths based on the information available in the Brighter Profile and comes from the health care professional directly, verified patients, public sources such as state licensing boards and consumer websites, and from Cigna.

    The Brighter Score is comprised of three categories, based on information populated in the Brighter Profile:

    1. Professional History – factors the health care professional's practice and educational background including their dental license history (where available) and any advanced training they have received
    2. Patient Experience – incorporates verified patient reviews, the advanced technologies and amenities that the practice makes available to patients, and the online reputation from other consumer websites
    3. Affordability – estimates the customer's financial responsibility for the most commonly performed dental procedures, based on the health care professional's negotiated fees with Cigna

    Brighter Scores are presented in a numerical format (1 - 10) with an underlying score assigned for each of the three categories, so that customers can easily understand how the score is compiled. We encourage Cigna Dental customers to consider all relevant factors when making dental care decisions and stress that the Brighter Score should not be the sole basis for selecting a dental provider.

13. How can I see my Brighter Score?

    You can view your baseline Brighter Score by logging into the Brighter Provider Portal at providers.brighter.com, clicking "Get Started" and following the prompts. Alternatively, you can reach out to Brighter at 888.300.4742 to set you up with access to the portal.

14. How do I increase my Brighter Score?

    This comprehensive score quantifies several attributes of a dental provider and their practice. The more information provided to Brighter, the more complete the score will be (e.g., education, certifications, online reviews). A member of Brighter's Provider Relations team can also provide tips to help improve your score over time.

15. Can my Brighter Score be reconsidered?

    Before requesting reconsideration, please ensure that all of the information in your Brighter Profile is accurate and up-to-date. You can request reconsideration of the Brighter Score tabulation, or any component of it, by notifying Brighter by email at providers@brighter.com or by fax at 310.362.0300. The notification should include detailed information including:

    - Name
    - Practice location(s)
    - State/license number *or* NPI
    - Preferred contact phone number

Brighter Profile™

- Portion of the score to reconsider (i.e., Professional History, Patient Experience, Affordability, any other relevant information or category)
- Detailed description of the basis for the reconsideration, including any links to public information or other documentation to be considered

Brighter's Provider Relations team will review the request, contact you for any additional detail and respond to you within 90 days.

16. **Can I opt-out?**

Yes, you can opt-out of creating an enhanced Brighter Profile which includes the Brighter Score. However, your basic demographic information will still be displayed on Cigna's dentist directory. You do have the option of opting back in and creating an enhanced Brighter Profile if you change your mind.

If you choose to opt out of displaying a Brighter Score you will also be opting out of the other enhanced features of the Brighter Profile (e.g., photos, office hours, Brighter Schedule).

17. **Who can post verified Brighter reviews?**

After an appointment, a customer will receive a survey by email regarding their experience. A valid email address must be on file with Cigna to receive the survey.

18. **How does online appointment scheduling work?**

Brighter Schedule works with your practice management software to present available times to Cigna Dental customers through your Brighter Profile. Cigna Dental customers can then make scheduling requests at their convenience, whether day or night. This added convenience can help you attract and retain more patients, and increase the number of verified patient reviews on your Brighter Profile.

While customers will not have access to use Brighter Schedule until mid-2016, you are encouraged to contact Brighter for advance setup.

19. **How do I access the schedule information?**

Once you activate Brighter Schedule, you will be notified by email once any appointment requests are made. Appointments are not automatically added to your office calendar. Brighter Schedule does not write to your practice management software – it merely works with your calendar and your preferences to display available appointment times on your Brighter Profile.

20. **Are there differences in the online directory enhancements for Total Cigna Dental PPO and Cigna Dental Care® (DHMO)?**

Yes, these differences are dependent on the product:

- The majority of Total Cigna Dental PPO customers will be able to view the enhanced Brighter Profile, use Brighter Schedule if enabled, and the treatment cost estimator.
- Cigna Dental Care® (DHMO) customers will be able to view the enhanced Brighter Profile and the treatment cost estimator. General dentists and specialists will have an abridged profile setup.

Additional capabilities are being evaluated for future inclusion.

Appendix II – Cigna Provider Agreement Section 5 (2016)

Plan descriptions

As a dentist in a Cigna Network, you can expect new patients from a number of different programs. They are all based on providing Members with a discounted fee-for-service benefit. All of the Plans we offer will help you build your patient base by leveraging the discounts that you have agreed to accept under your Network Dentist Agreement. The common theme across the programs is that all of your compensation is based on your Cigna Fee Schedule. This may include, but is not limited to, the segmentation or tiering of the Dental Network. It is important that your office verify patient eligibility and benefits specific to their plan in your office prior to delivering dental care. Cigna makes no representations or guarantees to dentist regarding the number and/or identity of covered persons or prospective income to be derived by dentist for providing dental services to Members. In addition, Cigna reserves the right to direct Members to selected dentists and/or influence a Member's choice of dentist.

The choice is yours!

Your participation in Cigna programs can be as broad or as narrow as you wish. Again, we want to be a partner who assists you in building a patient base that is consistent with your business goals. The following options can be added to or removed from your Cigna Plan participation by simply calling the Cigna Dental Provider Service Unit at 800.244.6224 (800.Cigna24) or by using the secure Cigna for Health Care Professionals website. For more information on the website, log in to **CignaforHCP.com**.

CignaPlus Savings

Dental Shared Administration

In no case does your nonparticipation in any of these options jeopardize your participation in the Cigna PPO Network.

PPO dental plans

PPO dental plans: Dental Plans that provide coverage to Members whether they receive services from a Network Dentist or an out-of-network dentist. Typically, the Plans contain financial incentives for Members to choose to receive services from a Network Dentist. Members are responsible for paying a portion of the fees on your Fee Schedule, which they typically pay in the form of Deductible and Coinsurance payments. There is no balance billing for any services provided to Members in these Plans.

Exclusive provider organization (EPO) dental plans

EPO dental plans: Dental Plans that provide a coverage to Members only when they receive services from a Network Dentist. Members are responsible for paying a portion of the fees on your Fee Schedule, which they typically pay in the form of Deductible and Coinsurance payments. There is no balance billing for any services provided to Members in these Plans.

The Dental Network Savings Program is a cost containment program that may be a feature with some DPPO and Indemnity products. This program enables Plan participants to receive discounts for services received from a participating dentist. Your compensation will be based upon your negotiated discount. The Dental Plan payment will be calculated based on out-of-network benefits after Deductibles, Coinsurance, alternate benefits, and other plan limitations have been applied. You may not balance bill the Member for the amount of the discount.

Appendix III – Cigna Provider Agreement Section 16 (2015)

the agents or subcontractors of CH or Affiliates or from disclosing the terms and conditions of this Agreement, including Contract Fees, to existing or potential Participants or customers of CH or Affiliates or their representatives. This provision shall survive the termination of this Agreement. Nothing in this provision shall be construed to prohibit communications necessary or appropriate for the delivery of dental health services, communications regarding applicable appeals rights to appeal coverage determinations or any other communications expressly protected under applicable law.

15. COMPENSATION AFTER TERMINATION

Upon termination of this Agreement or Participant's disenrollment from the Dental Plan, Dentist shall complete any procedure which was started prior to the termination or disenrollment date, unless the Participant elects to have such procedure completed by a different dentist. For any Covered Service completed within 90 days of the date of termination or disenrollment, Payor shall compensate Dentist in accordance with the applicable Fee Schedule. Participant shall be solely responsible for Dentist's charges for any dental services rendered after the expiration of such 90 day period. Notwithstanding the above, in the case of covered orthodontic treatment for which the Participant is banded prior to the Dentist's termination date, the Dentist shall complete such orthodontic treatment and accept the applicable Contract Fee as payment in full in accordance with this Agreement. Participants who disenroll prior to the completion of orthodontic treatment shall be solely responsible for payment of the Dentist's usual fee prorated for the number of months of treatment remaining after the date of disenrollment.

16. MISCELLANEOUS

(A) This Agreement together with the Cigna Dental Office Reference Guide and any program requirements, attachments, schedules, and amendments contains all the terms and conditions agreed upon by the parties, and supersedes all other agreements, express or implied, regarding the subject matter.

(B) This Agreement shall be interpreted and enforced under the laws of the state of Dentist's principal dental office.[1]

(C) The validity and enforceability of any term or provision of this Agreement shall in no way affect the validity or enforceability of any other term or provision. The waiver by either party of a breach of any provision of this Agreement shall not operate as or be construed as a waiver of any subsequent breach thereof.

(D) Notices required hereunder shall be in writing and shall be sent by U.S. mail, postage prepaid, to Dentist at the address set forth below, and to CH as set forth in the Notice Attachment. However, with respect to notifications by CH other than notifications of termination, CH may utilize an electronic notice to Dentist with automatic receipt verification to Dentist's e-mail address as specified below.

(E) None of the provisions of this Agreement is intended to nor shall be deemed or construed to (1) offer an inducement to Dentist to reduce or limit medically necessary health care services to a Participant, or (2) penalize Dentist for assisting a Participant to seek a reconsideration of Payor's decision to deny or limit benefits to the Participant.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as indicated below.

PPO Dentist signature _____ Date _____

Name (print) _____ License # _____

Social Security # _____ Alternate Payee _____

Alternate Payee's tax ID # (must be provided if payee is named)

NOTE: Payments due hereunder to Dentist by Payor shall be made payable to Dentist unless Dentist identifies the name and federal tax identification number of another payee ("Alternate Payee") above. By naming said Alternate Payee, Dentist authorizes Payor to pay Alternate Payee all amounts due hereunder and releases Payor from any and all obligation to make payments to Dentist.

Name of primary dental office (as it should appear in the Dental Office Directory) _____

Address of dental office:

Street _____ Suite _____ City _____

County _____ State _____ Zip Code _____ Telephone _____

Email Address _____

CIGNA HEALTH AND LIFE INSURANCE COMPANY

By _____

Title _____ Date _____

(Effective Date of this Agreement)

NOTICE ATTACHMENT:

FOR ALL STATES

Cigna Dental
Attn: Credentialing Department
1571 Sawgrass Corporate Parkway, Suite 140
Sunrise, FL 33323

[1] For Dentists providing Covered Services in Ohio, terms used in this Agreement and that are defined in Chapter 1751 of the Ohio Revised Code shall be construed in a manner consistent with those

HUMANITIES AND ETHICS:

LOBBYING FOR THE ORAL HEALTH CARE OF INDIVIDUALS WITH DISABILITIES

H. BARRY WALDMAN, D.D.S., M.P.H., PH.D.[1] AND STEVEN P. PERLMAN, D.D.S., M.SC.D., D.H.L.(HON.)[2]

Humanities: *the factor or quality of being humane; kindness; mercy; sympathy*

Ethics**:** *conforming to the standards of conduct of a given profession*

Morality: *related to dealing with or capable of making the distinction between right and wrong in conduct* [3]

When we of speak of ethics, it's most often to describe an individual's behavior. Ethics, however, also reflects upon a group's actions or moral performance in a range of evolving circumstances. While a group is a totality of individuals, the performance of a small or even a large group may be quite different with the addition of the characteristics of one new member. For example: "Safety experts recommend that newly licensed teenage drivers do not transport teenage passengers for the first 1,000 miles, or 6 months, of unsupervised driving. The risk of a fatal crash for a teen driver doubles

---

[1] SUNY Distinguished Teaching Professor, Department of General Dentistry, Stony Brook University.
[2] Global Clinical Director, Special Olympics, Special Smiles, Clinical Professor of Pediatric Dentistry, the Boston University Goldman School of Dental Medicine.
[3] *Webster's New World College Dictionary*.
<http://www.yourdictionary.com/ethical> Accessed 14 July 2017.

with the presence of just one teen passenger. Each additional passenger increases the risk of a fatal crash."[4]

How does emphasis on humanities and ethics apply to dental care? *Especially for individuals with disabilities*.

A profession is defined as an occupation requiring a long and specialized course of higher education, and one that is governed by a special code of ethics.[5] Professions serve the public good. A prerequisite for membership in the American Dental Association (ADA) is an individual's voluntary willingness to abide by the ADA Principles of Ethics and Code of Professional Conduct.[6] The code is a 'written expression of the obligations arising from the implied contract between the dental profession and society.

Approximately 56.7 million people living in the United States in 2010 (18.7% of the population) had some kind of disability. About 12.6% or 39.9 million people had a severe disability in 2015.[7] This number has continued to increase and will become even larger as the expanding aging population reaches into the 70s, 80s, 90s and beyond.[8] In 2010, almost 29% of individuals with disabilities (many of whom are dependent upon the Medicaid program for care) did not

[4] New York Department of Health. "Teen Drivers and Passengers Safety, Teens Ages 15 to 19 Years." <http://www.health.ny.gov/prevention/injury_prevention/children/fact_sheets/teens_15-19_years/teen_drivers_passenger_safety_15-19_years.htm> Accessed 17 July 2017.

[5] Gurley, J.E. *The Evolution of Professional Ethics in Dentistry*. St Louis: American College of Dentists, 1961.

[6] Council on Bylaws and Judicial Affairs. "Advisory opinions to the ADA Principles of Ethics and Code of Professional Conduct." *Journal of the American Dental Association*, vol. 103, no. 2, August, 1981, p. 253.

[7] National Center for Health Statistics. *Health, United States, 2016: With Chartbook on Long-term Trends in Health.* Hyattsville, MD, 2017.

[8] Brault, Matthew W. "Americans With Disabilities: 2010." <https://www2.census.gov/library/publications/2012/demo/p70-131.pdf> Accessed 15 July 2017, p. 70-131.

obtain dental services because of cost.[9] Medicaid dentistry is not a required service for adults. Because of low reimbursement costs Medicaid dentists are "…so hard to find."[10]

Unfortunately, the use of "mega numbers" (whether it is millions of individuals with disabilities, billions of dollars for needed services, the annual carnage of tens of thousands killed in automobile accidents, or the thousands of children brought to emergency rooms as a result of playground accidents) it is difficult for any person to place the numbers in proper perspective. For example:

> The average lifetime cost for one person with mental retardation is estimated to be $1,014,000 (in 2003 dollars). This represents costs over and above those experienced by a person who does not have a disability… It is estimated that the lifetime costs of all people with mental retardation who were born in 2000 will cost $51.2 billion.[11]

We tend to trivialize and repress such numbers, unable to comprehend the impact of these costs, and the particular conditions and events impacting these individuals and their families (see Table 1 for an overview of the numbers of U.S. residents with varying types of severe disabilities by demographic characteristics). The fact that there are millions of children and adults with a wide range of disabilities becomes "just numbers" – not actual people. But rather than "just" presenting incomprehensible millions of individuals with varying disabilities, and needed services that range in tens of billions of dollars, legislative representatives need to be lobbied with particular information about the residents in their states, and, if possible, the

---

[9] National Center for Health Statistics. Health, United States, 2011: With Special Feature on Socioeconomic Status and Health. Hyattsville, MD, 2012. <http://www.cdc.gov/nchs/data/hus/hus11.pdf> Accessed 14 July 2017.
[10] Otto, Mary. "For want of a dentist." *The Washington Post*. 27 February 2007. <http://www.washingtonpost.com/wp-dyn/content/article/2007/02/27/AR2007022702116.html> Accessed 16 June 2017.
[11] Centers for Disease Control and Prevention. "Facts About Intellectual Disability." <http://www.cdc.gov/ncbddd/dd/ddmr.htm> Accessed 16 May 2017.

constituents in their respective districts (note: the U.S. Census Bureau also provides these data by state, Congressional District, county, metropolitan area and school district).

And the future will not be better.

The projected estimated proportion and number of individuals with severe disabilities are not available for the year 2030. A projection of 45.8 million residents with severe disabilities was developed using Census Bureau general total national population and state projections for the year 2030. 2015 proportional rates for individuals with disabilities were used to provide an appreciation of the realities that numeric increases in the total general population [particularly among the older aged population] can (and will) increase the number of individuals with disabilities.

In 2015**,** the proportion of individuals with disabilities ranged from 9.9% in Utah and 10.3% in Colorado, to 19.4% in West Virginia and 21.4% in Puerto Rico. The estimated number of individuals with severe disabilities ranged from 71,000 in Wyoming and 76,000 in the District of Columbia, to 3,126,000 in Texas and 4,097,000 in California.

In 2030, based on both the total number of state residents and proportion with disabilities for 2015, the estimated number of residents with severe disabilities will range from 65,000 in North Dakota and Wyoming, to 3,865,000 in Texas and 4,382,000 in California (See Table 2).

Among adults, 18-64 years, and those 65 years and over, compared to individuals with no disabilities, a significantly smaller proportion of individuals with disabilities reported a dental visit in the past year (see table 3).

Challenges:

The first issue is economics - How we pay for dental services is a major problem. Out-of-pocket spending represented 44% of all dental service costs. By contrast, out-of-pocket spending represented 14% for all health care expenditures for the total population (including 17% of the costs for youngsters < 18 years; 15% for the 18-64 year population and 12% for the 65+ year population). In essence, spending for dental services "is felt" to a greater extent than for total health services.

- Private insurance does not cover 54% of dental expenses.
- Medicaid provided 6% of all expenditures for dental services. However it represented 42% of costs for children less than 5 years, 21% for the Hispanic population, 38% for the poor population and 73% for the 65+ population with public insurance.

Studies suggest that fewer than 25% of all dentists accept Medicaid patients and fewer than 10% have at least 30% of their practice represented by Medicaid beneficiaries.[12]

[12] Waldman, H. Barry and Steven P. Perlman. "Ethics, economics and dentistry for individuals with disabilities in NY State." *New York State Dental Journal*, vol. 82, no. 3, March, 2016, pp. 38-42;
Carper, Kelly and Steven R. Machlin. "National Health Care Expenses in the U.S. Civilian Noninstitutionalized Population, 2010." Medical Expenditure Panel Survey Statistical Brief #396. January 2013. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.meps.ahrq.gov/mepsweb/data_files/publications/st396/stat396.pdf> Accessed April 5, 2017;
Friedman, Emily. "Access to dental care: a national scandal." *Hospital & Health Networks Daily*. Chicago, 2012. < https://www.hhnmag.com/articles/5359-access-to-dental-care-a-national-scandal> Accessed 30 March 2017.

The second issue is public policy - While many practitioners do provide care for individuals with disabilities, the dual challenge is for the dental profession to expand services to individuals beyond the traditional patient, and to make Congressional legislators aware of the need to provide the essential financial resources for these services. Lobbying is a competitive effort directed at reaching legislators who are attempting to balance the demands of individuals, organized groups, political parties and the complex economic realities of our times. In such an environment, any effort that can personalize the needs of a large special group among the constituents of the home district and state of a member of the Congress (as well as state legislators) enhances the potential for success.

The initial step in lobbying for change is to present the drama of the need, but in understandable and personable terms. Highlighting the number and proportion of individuals with disabilities in the communities of dental practitioners and as constituents in a politician's district is one such avenue. Indeed, the numbers do speak for themselves![13]

The concepts of humanities, ethics and morality are all relevant to the issue of access to health care for individuals with disabilities. Yes, there are explanations, including inadequate fee schedules and Byzantine bureaucratic impediments. However, from the prospective of the public, in particular for those with disabilities, the results are significant limitations in the availability of dentists to provide access to care.

If we acknowledge the view that "professions serve the public good" then our profession (and individual practitioners) need to join in the effort to support oral health services for residents with disabilities, so many of whom are their constituents.

[13] Waldman, H. Barry and Steven P. Perlman. "Ethics, economics and dentistry for individuals with disabilities in NY State." *New York State Dental Journal*, vol. 82, no. 3, March, 2016, pp. 38-42.

Table 1. Number (in 000s and rounded) and prevalence of non-institutionalized residents with severe disabilities by demographic characteristics and types of disabilities, 2015. [14]

	Number	Percent
Total	39,906	12.6%
Male	19,308	12.5
Female	20,598	12.7
Race/Hispanic origin		
White alone	30,413	13.1
Black alone	5,535	14.0
American Indian & Alaska Native alone	424	16.8
Asian alone	1,186	6.9
Native Hawaiian & Pacific Islanders	58	10.6
Other races	1,222	8.0
Two or more races	1,067	10.9
Hispanic (of any race)	4,889	8.8
Age		
Under 5 years *	149	0.8
5-17 years	2,885	5.4
18-34 years	4,433	6.0
35-64 years	15,978	13.0
65-74 years	6,918	25.4
75+ years	9,543	49.8
Type of disability		
Hearing	11,267	3.6
Vision	7,334	2.3
Cognitive	15,115	5.1
Ambulatory	20,920	7.1
Self-care	7,974	2.7
Independent living	14,185	5.8

Note: Individuals may have more than one disability
* Includes only sight and hearing disabilities

[14] U.S. Census Bureau. "2015 American Community Survey 1 year estimates." <http://www2.census.gov/programs-surveys/acs/tech_docs/table_shells/2015/DRVD/S1810.xls> Accessed 10 June 2017.

Table 2. Disability rates and estimated number (in 000s and rounded) of non-institutionalized U.S. and state residents with severe disabilities 2015, 2030.[15]

	Statewide		
	2015 Disability rate	2015 Disability number	2030 Disability number
United States	**12.6%**	**39,906**	**45,812**
Alabama	16.7	799	814
Alaska	11.6	83	138
Arizona	12.9	864	1,382
Arkansas	17.1	500	554
California	10.6	4.097	4,382
Colorado	10.3	553	596
Conn.	11.0	390	405
Delaware	12.2	114	124
Dist. Col.	11.5	76	50
Florida	13.4	2,669	3,844
Georgia	12.2	1,224	1,466
Hawaii	10.8	148	158
Idaho	13.8	225	272
Illinois	10.7	1,355	1,437
Indiana	13.8	899	940
Iowa	11.9	368	352
Kansas	12.8	366	376
Kentucky	17.0	738	774
Louisiana	14.9	681	716
Maine	16.3	215	230

[15] U.S. Census Bureau. "Interim projections of the total population for the United States and States: April 1, 2000 to July 1, 2030." <https://wonder.cdc.gov/wonder/help/populations/population-projections/SummaryTabA1.xls> Accessed 6 April 2017;
U.S. Census Bureau. "2015 American Community Survey 1 year estimates." <http://www2.census.gov/programs-surveys/acs/tech_docs/table_shells/2015/DRVD/S1810.xls> Accessed 10 June 2017.

Maryland	10.9	644	765
Mass.	11.7	785	820
Michigan	14.4	1,413	1,540
Minn.	10.9	594	687
Miss.	16.2	474	501
Missouri	14.5	868	932
Montana	13.7	140	143
Nebraska	11.2	209	204
Nevada	13.4	383	573
New Hamp.	12.9	170	212
New Jersey	10.4	921	1,019
New Mexico	15.0	307	315
New York	11.4	2,223	2,220
N. Carolina	13.9	1,369	1,700
N. Dakota	10.7	79	65
Ohio	13.9%	1,593	1,605
Oklahoma	15.6	597	610
Oregon	15.2	605	734
Penn.	13.9	1,747	1,775
Puerto Rico	21.4	738	807
Rhode Island	13.4	140	161
S. Carolina	14.8	713	762
S. Dakota	12.0	101	96
Tennessee	15.5	1,009	1,210
Texas	16.6	3,126	3,865
Utah	9.9	293	345
Vermont	14.8	92	105
Virginia	11.5	935	1,130
Washington	12.9	909	1,113
W. Virginia	19.4	352	334
Wisconsin	12.0	681	738
Wyoming	12.4	71	65

Table 3. Percent of the civilian noninstitutionalized population with a dental visit in the past year by age: 1997, 2015.[16]

	18-64 yrs		65+ yrs	
	1997	2015	1997	2015
Disability	55.1%	55.1%	49.6%	56.0%
No disability	67.4	67.2	64.2	73.3

[16] National Center for Health Statistics. *Health, United States, 2016: With Chartbook on Long-term Trends in Health.* Hyattsville, MD, 2017.

EDITOR'S INTRODUCTION

The Journal of Dental Humanities is pleased to publish an original poem by the accomplished poet / dentist Dr. Daniel Moran. The author of ten published collections of poetry,[1] Dr. Moran's work has appeared in numerous publications including *The New York Times*, the *Journal of the American Medical Association*, *Literary Matters* (Oxford University Press), and the *Medical Humanities Journal*.

As an oral surgeon in Southampton, New York, I have had the distinct pleasure of knowing and working closely with Dan going back to his days as a "country dentist' on Shelter Island. Besides being an extremely talented poet and dentist, Dr. Moran is respected by his dental peers, appreciated by his former patients, and honored as an exemplary teacher by his students. Ever thoughtful and courteous, Dr. Moran's life and career exemplifies and personifies a life well lived at the intersection between the humanities and dentistry.

–Robert P. Iovino, D.D.S., M.A, Editor

[1] Dr. Moran's eleventh collection of poetry will be published in January 2019 by Salmon Poetry in Ireland.

ONE POET'S STORY

DANIEL THOMAS MORAN, D.D.S.[1]

Back around 2003, I was contacted by the Medical/ Dental Librarian at The University of Michigan, who told me that she had been involved in an interesting bit of research. She was trying to find out about the history between dentistry and poetry, and specifically trying to find evidence of poet/dentists in the world. She had found several, going back into the 19th Century but she had found out something else. I was the only living American poet/dentist. I must admit that it did not surprise me. All of my life I had always felt like a man alone. I will not suggest that there are not perhaps many dentists who write poems, but I could not decide whether I was a poet who practiced dentistry, or a dentist who wrote poetry. The fact is that I was fully both. I had two careers, each equally challenging, each equally consuming in the dedication required. I was very lucky to have found a spot on the planet where I could actually live out both of those lives in a somewhat strained harmony. I took over a small dental practice on an island called Shelter Island which sat at the eastern end of Long Island, New York, in a place that is frequently referred to as The Hamptons.

The Hamptons is very different these days in many important ways. For me, the most important is that, when I went there in 1987 and started to practice in an office with a single operatory with no auxiliaries of any kind, The Hamptons was still an artist's colony. The place was teeming with writers, and poets, and painters and sculptors

[1] Clinical Assistant Professor, Henry M. Goldman School of Dental Medicine, Boston University

and playwrights and filmmakers, and composers. As they say, you could not swing a dead cat without hitting some luminary. I have long told the story of driving down the street in Sag Harbor and seeing, on one block but not together, Kurt Vonnegut, E.L. Doctorow, George Plimpton, and Betty Friedan. I could spend the rest of this piece simply naming all the renowned people one might run into in a restaurant, at a party, in a gallery, at a reading, people like Edward Albee, Robert Berks, Julian Schnabel, Steven Spielberg, Adolph Green and Betty Comden, Billy Joel, Jann Wenner and Paul McCartney, Eli Wallach and Anne Jackson, Ben Bradlee and Katherine Graham, and Lauren Bacall. Had I been there a little earlier, I might have run into John Steinbeck, Jackson Pollack and Truman Capote. The creative engine of America was living in The Hamptons, especially in the summer months, and they went there because it was the place to be if you were trying to make art, and initially because it was cheap living in a truly bucolic place. It was not long before I had found myself in the middle of it all, rubbing elbows in the evenings and on weekends, and trying to be the best doctor I could be during the day for all the people on Shelter Island who were counting on my care.

I was lucky in very many ways. For the most part, the people on Shelter Island who came to me for their dental care quickly realized that I was not the dentist of their childhood. Many thought that any man who could write such lovely words must be a good doctor as well, and I felt that was accurate. In the times gone by, dentists and physicians were multi-dimension. They were literary and musical, and well-read, and the way they approached their medical work was, in the clearest sense, creative and humanistic. There actually was a term which described. “The Art of Medicine”. In the days, no so long ago, when the world was not rife and teeming with technology, people had to care for people using their imagination and their wits. So, it all seemed quite appropriate to me. When I let my hair grow into a long ponytail, grew a beard, got an earring, and started riding a motorcycle to the office, it seemed, in a bizarre way, normal to the patients in my practice. I do recall vividly, two woman coming to me for the first time. One of them came back and the other never did. I asked the one who stayed my patient what had happened that her friend did not return. She told me that her friend had suggested that she did not want

some guy with his head in the clouds poking around in her mouth. I accepted that, I had to. But the funny thing is that I was never thinking about poems when I was working. It was too consuming of my consciousness and what I did all day required far too much concentration. I only recall one occasion when I excused myself from a patient to run into my private office to scribble some lines that had just presented themselves, likely from something that the patient had said to me. In those early days, people would come in to my office and say, "Someone told me that you write poems". I was always happy when that happened and saw it as a recognition of who I was. In the late 1980's a patient who was a well-known Psychiatrist in New York City, wrote a piece for The East Hampton Star called, "My Poet the Dentist". I loved it. Some years later, as I was reading my poems to an audience in New York City, or Boston, or Salzburg, or Vienna, or Dublin, or London, or Rome, people would approach me to ask, "I heard that you are a dentist".

In 2005, I was chosen, by The Legislature of Suffolk County, NY to be only their second poet laureate. The word quickly got out all over and it was not long before it was The New York Times, Newsday, The Boston Globe, and Public Television who were coming ask questions of this kind of living unicorn, and I was being asked to come speak at all kinds of places, from colleges to kindergartens. I was happy for the attention, but I was most happy to be able to try and inspire young people, and to comfort them as well. I wanted them to see that it was alright to feel odd and out of place, to feel that there were parts of you that people maybe did not understand, and that it was frightening to feel the churning inside that artists feel but that it would all work out. I wanted them to care about themselves, to forgive themselves for feeling different and see it as a gift, and a strength. I wanted them to see that I was one of them, once overburdened with questions and doubts, but that I had figured it out.

I continued to doctor and to poet for many more years and I found that my connection to the people I cared for was rich and profound. I learned from them and tried my best to really get to know them, to learn from them. I have long bragged about the longest I ever had someone in my dental chair without actually doing any dentistry.

An elderly patient had been dropped off by his wife for an extensive amount of work, and I had made him the last patient of the day so I could take the necessary time to do it right. He was a retired Cardiologist who loved poetry and we got talking. When his wife returned four hours later I had to report good news and bad news. The bad news was that I had not even started doing the work on his teeth. The good news is that we had just spent a really wonderful four hours talking. She might have gotten annoyed but she could see just how happy the two of us were.

Over the years, in my one chair practice, with no one but myself, I met many amazing people, learned many amazing things, and enriched myself as a human being and as a poet. Many artists came to me over the years and many of them became friends. Many of them gave me works of art as tokens of their appreciation, and today the walls our home are festooned with the memory of all of them.

As time went on, I was slowly beginning to suffer a kind of burnout that happens to many people in the medical field. I had been practicing on Shelter Island for twenty-two years, been living another life as a poet for even longer, and living on a literal island, something that takes living in a small town to an even higher level of confinement. My body was hurting and I was finding it harder to be the doctor I had dedicated myself to being, and the little island I loved had changed in very profound ways. It happens. My wife, Karen and I did a crazy thing and decided to buy an apartment in Boston, partly as an investment, and partly as an escape, a place we could go to a couple of weekends a month to be anonymous in someplace new. I was in my mid-fifties. Then something happened that I could not have anticipated. I applied for a part-time faculty position at Boston University's School of Dental Medicine which was only blocks from our new apartment. I was called in for an interview with the Chair of the Department of General Dentistry and I did what I always do. I tore myself open and emptied myself onto her desk. I told her who I was, all the things I had done, and why I thought I might be able to teach. In my time, Dental School faculty walked at least two feet off the ground. We often were sure that they lived in some place like Mount Olympus and only came down to earth out of some sense of dedication or guilt.

We all know that feeling. I told the Chair that I was not even sure I knew anything and she assured me that after some 25 years of practice, I surely did. Then I said something outrageous.

I told her that if she were to give me a chance to teach, that I would not be a good teacher, and I would not even be a great teacher. I told her that I would do everything in my power to make sure that I was the greatest teacher who ever taught at Boston University's School of Dental Medicine. She might have been shocked by that, but she did not let on. I was hired as a Clinical Instructor for The Pre-Clinical Simulation Class in Fixed Prosthetics. I had to reacquaint myself with mannequins and plastic teeth but I did it. Then a miracle occurred. Not only did I realize within only a couple of classes that I loved to teach but I could feel something change within me that I could not have imagined. I was no longer a person with two brains, two disparate identities, I was a teacher. I quickly realized that here was the place where I could be both of the things I had always been, and for the benefit of students. I could not only teach them to be dentists, I could teach them how to be doctors, how to make the deep connections with the humanity of their patients, to be actual healers. I went back to my Chair and told her that if she would give me a full-time position, I would sell my practice, my house and move to Boston. There was a hiring freeze in place for the entire university following the financial collapse in 2008, and so she told that she would hire me as soon as she could be free to do it. For close to a year, I taught as a volunteer on Fridays in Boston while I continued to practice in New York four days a week. The commute was not easy, but Karen and I did it somehow. In the summer of 2009 an opening occurred and I was offered a full-time position as Clinical Assistant Professor, now adding Clinical Dentistry to my duties. My fellow faculty members warned me that I must be crazy to go into the clinic, but I did not hesitate. It was one of the most stressful, invigorating and inspiring things I had ever attempted. I came home each night completely drained, consumed my mind day and night with how I was going to accomplish all the things I wanted to teach the students about life and the truest caring of their fellow human beings. I read everything I could to be sure I was telling

them things that were accurate, came in with quotes of poetry and philosophy, photos, and stories, anything I could think of to to make them see all the things I wanted them to see.

After my first year, I was given the honor of being a Graduation Marshal. As I stood there watching it all in my doctoral regalia with the colors of dentistry flowing down in the cowl on my back, I could not have felt better. I watched a man deliver the commencement address to all of those new doctors and their loved ones in the stands, and I wondered what that must be like. It gave me chills to even think about it. The next year The Dean called me to his office in the spring to ask me to deliver the 2012 Commencement Address, that I had been the unanimous recommendation of the graduating class. That year and the following year I was given two national awards for excellence in clinical teaching. Maybe I was having an effect in changing the way dentists were being educated at Boston University. But I had more ambition than that. I wanted to change the way dentists were being educated in The United States and I had been attending the conferences of The American Dental Education Association. I had a major supporter, Dr. Paula Friedman, who was a former President of ADEA and the President of the Massachusetts Dental Society. Simply stated, I wanted The Humanities and The Arts to become part of the education of dentists as was already beginning to be done in Medical Schools. It was a steep hill to climb and trying to do so meant that I would first have to succeed at Boston University. The results were clearly good with regard to the students and their interest in what I was trying to do for them, to make them better clinicians but also to make them better human beings, with more fulfilling lives, and a greater empathy with regard to the place they were assuming in our society. Sadly, after just about five years into my time in academia, I found that I no longer had the energy to carry on the battle. New things, and new ways of thinking, can seem like a challenge to the established attitudes, and I will readily admit that I was doing precisely that. I was also a threat to the status quo and there were some who did not appreciate it. The Academy is not an easy place in which to function, especially for a man who had worked alone for nearly thirty years. In 2013, I resigned, and I retired from dentistry altogether.

But what I finally came to realize is that thing that what allowed me to be a good doctor as well as a good poet and teacher was really just one thing. I had a very acute sense of empathy, sometimes even too sensitized for me to bear. I could always see into the thinking and emotions of other people, even live in their shoes to a degree that was enlightening and also draining. My empathy for the students I was teaching drained me even further. I could not separate myself from their concern and anxiety and their fear as well. I did my best to make every patient of mine feel as though they were the only patient I had, and I tried to make my students feel the same way. It wore me out in the most profound way and I would not have changed any of it. I wanted to matter. I wanted to believe that one day in the future, each of them might say to themselves, "I remember something Dr. Moran once said to me." And for me, I had resolved something of the conflict that was in me all those years, that I was a poet in a dentist's body. Now, I was still those things, but I was also something that maybe brought me together. I was a teacher.

I have been interviewed many times, and spoken to student groups many times. I told them that through many years of diligence, and sacrifice and study, my hands have come to be able to do things that are almost unimaginable. All dentists have such skills and they only get better over time. But I also tell them that were I to be given two choices, to give up my ability to write poems, to live the life of a poet and all that means, or give up my right hand, I would give up my hand. I could manage the rest of my life without the hand. But to not be a poet would be something unbearable. So, this is what I want you all to know. To be a doctor is to be an artist. To be an artist is also to be a doctor of sorts, a doctor of the human spirit. To be good at either, one must be good at both. In your life, find something that fills you with passion,that makes you feel more alive, that makes your existence resonate with meaning. You will be a better doctor and a better human being. And, you will be living life with all your might. You will also come to realize that the world needs you, and when you come to that understanding, teach it to others. The world will give much to you. Find ways to give it all back, and then give a little more.

WAITING IN NEW ORLEANS

for Karen

I recall with soft clarity,
the spring day we traveled,
together and briefly,
that tiny voyage from
Shelter Island to Sag Harbor.
Side by side in our automobiles,
we chatted only a few sentences,
through rolled down windows.
We both bore the long and
lingering scents of mourning.

You asked
where I was headed, and
I said to New Orleans to
see an old friend.

On a dappled sidestreet in
the French Quarter, through
a window populated with odd
trappings of voodoo and souvenirs,
I found a crudely carved angel
in a long orange dress,
embroidered with painted stars,
which I carried home again.

I hung it high up
above my window,
letting it float over me, in
a room I used to sit.
I hoped it might watch me,
through many long days when
no one was watching.

Now, years later, we sit
side by side in our home,
far from ferries and short voyages,
far from accumulated sadness, in
a place of rivers and mountains,
where angels live among
tall trees and moss-coated stones.

My angel has become
our angel, pitched slightly forward,
high above a new window which
looks out to a whispering paradise.

We no longer wander separate.
You no longer ask
where it is I am going. Now,
our chairs nested side by side,
our dinner plates rest side by side,
We sleep side by side in
a bottomless contentment,
Free to forget that
we don’t believe in angels.

2014

The Journal of Dental Humanities is published quarterly. All correspondence may be addressed to:

Journal of Dental Humanities
351 Meetinghouse Lane
Southampton, New York 11968

Telephone – (631) 283-5626

www.journalofdentalhumanities.com

Original material may be submitted for review and possible publication. Please send submissions via email to rpiovino@gmail.com . Materials submitted for review must not have been previously published or currently under review for publication elsewhere.

Submissions of interest will undergo a blind review process.

Journal of Dental Humanities
351 Meetinghouse Lane
Southampton, N.Y. 11968