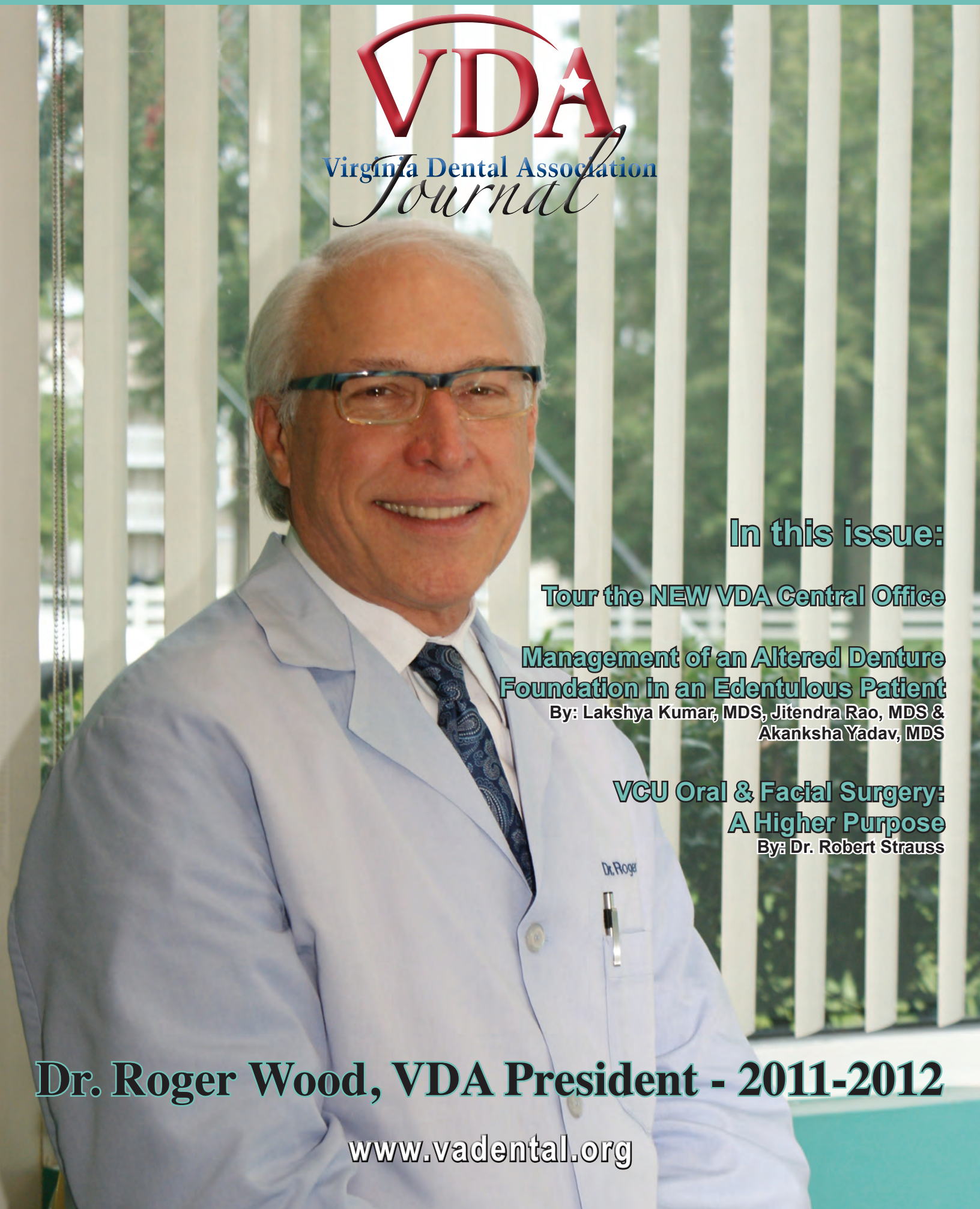
Volume 88, Number 4 • October, November & December 2011

VDA Virginia Dental Association Journal



In this issue:

Tour the NEW VDA Central Office

Management of an Altered Denture Foundation in an Edentulous Patient
By: Lakshya Kumar, MDS, Jitendra Rao, MDS & Akanksha Yadav, MDS

VCU Oral & Facial Surgery: A Higher Purpose
By: Dr. Robert Strauss

Dr. Roger Wood, VDA President - 2011-2012

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Virginia Dental Journal

Member Publication
AADE
American Association of Dental Editors

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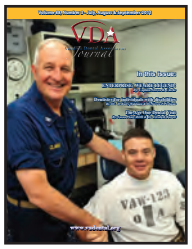
VDA Board of Directors Welcomes Student Member

Jo Koontz is currently a fourth-year dental student at the VCU School of Dentistry in Richmond. She now serves as the student representative on the VDA Board of Directors, and recently attended the VDA Governance Meeting in Fredericksburg. Jo grew up in Culpeper, Virginia on a dairy farm with her parents and two older sisters. After graduating from the University of Virginia, Jo decided to pursue a career in dentistry. She received her Master of Science degree from the Medical College of Virginia in 2008, the same year she began her dental education at VCU. Jo is currently the Vice-President of her class and has volunteered at various Missions of Mercy Projects around the state. She is also the student representative for the Dental Health and Public Information Committee. Last year she served as the student coordinator for Give Kids a Smile® Day at the VCU Pediatric Dental Clinic. Jo is applying to pediatric dental residency programs, and intends to continue her involvement with the VDA throughout her dental career.



CORRECTION;
Please make note of the following correction:

Volume 88 Number 3, July, August and September 2011

Article: The Debate on the Opening of New Dental Schools

By: David C. Sarrett, DMD, MS, Dean - VCU School of Dentistry
Page: 24

Second paragraph, 4th sentence:
Second, there is a concern the impending retirement of dentists (who graduated in the days of over ~~8000~~ 6000 graduates per year) will only worsen the perceived shortage.

Cover photo courtesy:
Linda Gilliam

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Volume 88, Number 4 • October, November & December 2011

THE VIRGINIA DENTAL JOURNAL
(Periodical Permit #660-300, ISSN 0049 6472) is published quarterly (January-March, April-June, July-September, October-December) by the Virginia Dental Association, 3460 Mayland Ct, Unit 110, Henrico, VA 23233, Phone (804)288-5750.

SUBSCRIPTION RATES:
Members $6.00 included in your annual membership dues.
Members – Additional Copy: $3.00
Non-Members- Single Copy: $6.00
Non-Member outside the US: $12.00
Annual Subscriptions
in the US: $24.00
outside the US: $48.00

Second class postage paid at Richmond, Virginia.

POSTMASTER: Send address changes to: Virginia Dental Journal, 3460 Mayland Ct, Unit 110, Henrico, VA 23233.

MANUSCRIPT AND COMMUNICATION FOR PUBLICATION:
Editor, 3460 Mayland Ct, Unit 110, Henrico, VA 23233.

ADVERTISING COPY, insertion orders, contracts and related information: Business Manager, 3460 Mayland Ct, Unit 110, Henrico, VA 23233.

Message from the Editor

Dr. Richard F. Roadcap

Dr. William John Gies

Sometimes the greatest advances in science and education are achieved by outsiders, individuals with no connection to a certain field or discipline. Gregor Mendel, the father of modern genetics, was an Augustinian friar. Joseph Priestley, the discoverer of oxygen, was a Unitarian minister. Michael Faraday, whose discoveries led to the practical use of electricity, was an apprentice bookbinder who became a self-taught chemist and physicist. It's not surprising, then, that the professional status of dentists and the entire system of dental education in the United States are the legacy of an instructor in biological chemistry at a medical school.

William John Gies (1872-1956), born in Maryland and raised in Pennsylvania, graduated from Gettysburg College and later attended Yale University, where he was awarded a Ph.D. in 1897. After a brief period of study in Europe, he was appointed to teach biological chemistry at Columbia University's medical school. The era of modern dentistry began in 1909. Two New York City dentists, Doctors Howe and Merritt, approached Dr. Gies that year seeking his help in researching the origins of dental disease. Dr. Gies eagerly accepted their challenge, but soon found few resources in the literature and basic science to support him. At the same time, as a medical school instructor he noticed that physicians and other instructors ignored the oral cavity and its relationship to the health of the individual.

There were other problems: dentistry was considered a trade, not a profession; dental publications were proprietary, and editors were more interested in promoting products than publishing research; and dental education and practice had advanced little beyond the mechanics of prosthetic replacements. Faced with this overwhelming task, Dr. Gies spent most of the next three decades transforming dentistry into the modern profession in which we claim membership. He began by founding the Columbia University School of Dental and Oral Surgery in 1916 to promote basic research in dentistry and establish dental care as subspecialty of medicine. In 1919 he launched the *Journal of Dental Research*, and remained as editor until 1935. His call for an "army of dental researchers"[1] led to the founding of the International Association of Dental Research (IADR) in 1920.

Dr. Gies's landmark achievement, the most important development in dental education in the 20th century, was the 1926 publication of *Dental Education in the United States and Canada*.[2] Known simply as the Gies Report, it took five years of research, in which the author visited every dental school in the US and Canada. Funded by the Carnegie Foundation for the Advancement of Teaching, the report made five recommendations for dental education: higher standards for pre-doctoral candidates; an emphasis on basic science; greater correlation between clinical medicine and dentistry; more opportunities for specialization; and a commitment to ongoing research. There have been numerous studies of dental education published since then, but none has changed the course of a profession in a similar manner. The Gies Report turned a trade into a profession, removed conjecture and anecdote to make way for science, and replaced craftsmen, however skilled, with doctors of oral medicine.

Entry into any profession implies a certain set of behaviors, attitudes, and beliefs will be adopted. Perhaps William J. Gies, Ph.D., free of the restrictions and confines of early 20th century dentists, could explore paths that would change a venerable, but dated, craft into a modern profession. The next time a patient remarks that a new "white" filling (placed with a seventh-generation bonding agent) is comfortable, or greets us in the grocery aisle with "Hello, doctor!" we can give a measure of thanks to a chemistry professor who never attended dental school.

1 http://iuniv.tv/top/episode/eid/67491/pid/4100
2 http://www.adeagiesfoundation.org

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Message from the President

Dr. Roger Wood

I am excited and honored to be the next president of the VDA. I feel that I have been preparing for this office for many years. My career in dentistry began in the Air Force where I served as a dental assistant for four years. I entered MCV dental school after I was discharged from the service and continued on to Indiana University for my pediatric dental residency. In the years that followed, I was honored to be elected chair of the ADA Council on Dental Education and Licensure, President of the Virginia Board of Dentistry, and a member of the VDA task force that began the Missions of Mercy.

I am proud of the VDA. I am proud of the way VDA members rise to work together when we are treated unfairly by insurance companies or suffer a lightening strike that totally destroys our office building.

I'm proud of our passion for access to care as evident in the tireless dedication to the MOM project. The VDA is a stellar example of the power of unity and we demonstrate that every time we come together to achieve a goal. In hindsight, we can truly see the strength of our membership by its numbers. If we recall our presence at the General Assembly or at a MOM project we can easily visualize the mass amount of members involved in those successes. Every single member of the VDA contributes to our success through time, talent and membership dues.

Over the past few years, the goals and challenges before the VDA have increased. Our political fights seem to be multiplying. The need to shield our profession from the influences of managed care is of critical importance. The number of patients that need us to provide access to care for them continues to grow.

The demand on us to protect our profession and the patients it serves is clearly increasing – however, fewer dentists than ever are participating in organized dentistry. The slowly eroding membership is now reaching critical and finally, noticeable lows. Remarkably, while there are fewer members carrying the workload for more dentists, the job seems to still get done. This gives me pause to wonder if we - as members - are aware that we might be inadvertently sending a message to our non-members that they are not needed.

Since dental school, I have understood the importance of organized dentistry – as I believe most of my peers at that time understood it as well. I don't see that our young dentists share the same understanding. This problem is one that has been silent and could easily remain so. There are no burning buildings or full-page ads in the newspapers across the state placed by insurance companies to attract attention and draw action. The silent decline in membership poses a larger threat to the VDA than a lost building ever could.

In 2008, our market share was 70.9%, followed by 67.7% in both 2009 and 2010. This year it is predicted to be even lower. When we examine our number of non-members along with the number of non-renews we see that both categories are increasing. The record numbers we are experiencing are not in our favor. In the last three years we experienced our highest amount of non–renews to date, which amounted to 381 dentists that are no longer part of our organization. This problem extends beyond our state association as the ADA is tracking almost the same percentages nationally.

Another concerning membership statistic is the age of our members. We have 334 members aged 26-35 years old, but 898 of our members are aged 56 to 65 years old. The significance of noting the number of members in this upper age group is that at 65 years old their membership dues are automatically reduced by half. We will really start to feel this financial impact within the next few years. According to how we are currently predicting the number of new members, there will be a significant deficit in replacing those lost dollars.

There have been many attempts to explain the decrease in membership. Logical conclusions are fairly easy to surmise. For example, the younger members rely on the internet for information and connecting with their peers. Meetings don't hold the same importance to this generation. Face-to-face conversations and professional discussions often happen through social media and professional web-based groups such as Dental Town. In addition to generational shifts, we are now seeing more female dentists enter the profession. I can only imagine the demands placed on them as they start families while managing the duties of owning a practice.

We are all practicing at a time when the economy looks bleak. The younger dentists are facing financial challenges that rival our request for support through membership dues. I would expect non-renews to find it difficult to justify returning if they take a break from membership. After all, if they didn't find relevance in what their membership dollars provided then, what value proposition are we offering them now that is different?

We cannot define relevance for non-members. What is current, relevant and effective needs to be defined for us. What we can do is break their silence and give them a voice.

Nothing would make me happier than to be able to formulate a solution to the membership problem and implement it before my term is over. Unfortunately, this isn't feasible. If I deserted my practice and personal life for the next 365 days, I wouldn't be able to even come close to achieving this lofty goal. What needs to happen during the next year is research and development of a plan. This plan needs to be overlapped into the next Presidency. Creating a continuum of focus and effort on such a critical topic is necessary.

Fortunately, the structure of the VDA allows for action to be taken swiftly in the form of a task force. While our committees play a vital role in our growth as an organization, they pose many time restrictions. Time is not a luxury we can afford.

I will be forming a task force to address the membership issue immediately. While the goal will obviously be to increase membership, the initial focus of the membership task force will not be to put together a plan of action. We have attempted to conduct various recruitment events in the past and have not been successful. It is critical that we focus on uncovering what it is that will attract and retain members.

We need to survey all Virginia dentists to gauge their perception of the VDA. Perception is reality. We need to be open to changing how we are perceived. We need to create an action plan to recruit and retain members. However, it would be foolish to do so without collecting information from the very group of dentists we are trying to serve. We need to use internet based survey services for speed and efficiency of collecting data. We need to use current communication modes that are familiar to younger dentists such as Facebook. Communicating to our members through current technology should send a message though the communication method alone. That message is that we are willing to change and adapt. We can be current. We will be relevant.
As critical as technology is to this endeavor, it will not replace personal interaction between members and potential members. Members need to carry the message of the VDA and be ready to invite fellow dentists to join their own professional organization. We need to be tenacious in our efforts to increase the

size of the VDA as we know we have strength in numbers.
In tandem to the membership task force, I will appoint a second task force to begin to address another critical topic – Access to Care. This group will review the report by the Centers of Medicare and Medicaid Services (CMS) in which Virginia was selected as one of eight states identified as a best practice state. The report stated that these activities in Virginia have resulted in a 40% increase in utilization of children's dental services between 2005 and 2009, and a 67% increase in the number of children receiving dental services.

The CMS commended Virginia for a commitment from leadership to remove barriers to providers' participation in the Medicaid programs, establish fair reimbursement rates, and identify and eliminate unnecessary paperwork and prior authorizations. The task force would review the best practices of the seven other states and provide a list of additional proven methods that we can implement for improving access to care in Virginia.

The VDA cannot continue to practice as it has in the past. This is a serious time with change coming fast. We cannot stay where we are today. The time to re-establish the importance of the VDA is now. This includes promoting the mission of the VDA to the public.

Our patients need the VDA to protect the level of healthcare they deserve. We need their support as we oppose midlevel providers and the work of foundations like Kellogg and Pew that are trying to change the way dentistry is delivered. The public needs to know that dentists are a critical part of their healthcare. They need to see our commitment and concern for the health of our patients. They need to know how much we care and they can only measure that by how much they see that we do. We need to commend and follow the lead of the dentists in southwest Virginia that have created public awareness videos highlighting the dedication that VDA members have to providing access to care.
The message they are sending to their communities is to support the dental organization that cares for the public.

If nothing changes . . . nothing changes. If we continue using the same human and financial resources, communication methods and technology, we need to lower our expectations on what we can accomplish. I think we all agree that is not acceptable. The VDA has proven to be flexible and adaptable and I am confident we will continue to do so. And I appreciate your confidence in me in this important and exciting time. Thank you.

Letter to the Editor

Dental Emeritus = Volunteers

Marvin E Pizer, DDS, MS, MA (Ed.)

Almost every dental newsletter in our metropolitan area has headlines requesting dental volunteers for local indigent clinics as well as state-wide programs like M.O.M.

The young and middle aged doctors find it difficult to be available for volunteer clinics. With this present economy these dentists need to cover their financial obligations and have their appointments at the convenience of their patients.

There is however an available source of senior dentists who have retired from practice and surrendered their Virginal Dental Licenses. The doctors have hobbies, belong to civic organizations and even participate and attend sporting events. Most reside in an area where they have always lived and have time for extra-curricular activities. This resource of experienced dentists might willingly offer their professional services for charitable causes or cover temporarily a sick colleague's practice. The only factor preventing the professional services is the lack of a dental license. If this problem of dental licensure could be resolved, I feel the need for volunteer dentists could to a larger degree be solved. I am proposing that the Virginia Board of Dentistry establish an Emeritus status for retired qualified dentists.

The Board might consider these requirements for Dental Emeritus:

A. Practiced dentistry a minimum of 35 years in Virginia.

B. Were never involved in a disciplinary action.

C. Are in good health (perhaps confirmed by primary care physicians).

D. Require a minimum amount of continuing dental education.

E. Limit the number of hours of practice for the calendar year.

F. Do not accept a dentist who has not practiced for the past five years.

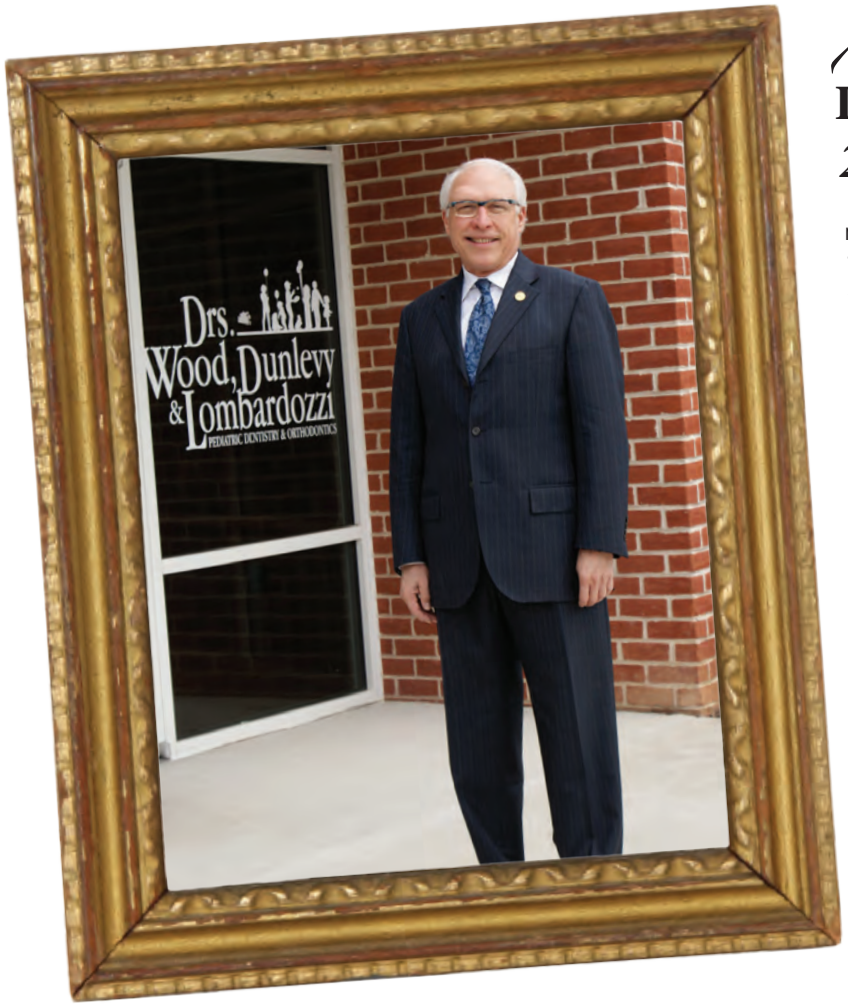
G. Accept honorably discharged military dentists who have practiced in Virginia 25 years.

Virginia Board of Dentistry - Please Consider Dental Emeritus!

An Interview with:

Dr. Roger Wood

2011-2012 VDA President



VDA Journal: What would you like to accomplish as VDA President?

Dr. Roger Wood: My goal is to implement systems for research and development of the membership issues and formulate a plan from the information we gather. While I will also be focusing on access to care and other issues, I strongly believe we need to address membership as a top priority.

Journal: Fewer dentists are joining organized dentistry nowadays. What answers do you have to this problem?

Dr. Wood: The problem is obviously the membership decrease, but we need to clarify the cause of the problem before we can offer an answer to it. I believe that the younger dentists are bombarded with information and choices that relate to their practice and position as small business owners – more so than those of us who have been in practice for many years. The message and significance of organized dentistry has been diluted or lost in a sea of constant information.

Without effective communication methods that call attention to organized dentistry we run a significant risk of fading out quietly.

We need a message of urgency, relevance and significance. We need to send out the message through every current and effective mode of communication we can access. First, we need to develop the plan to be effective in the delivery of our message.

Journal: In a tough economy, what would you say to a dentist on the verge of not joining (or dropping out)? Why should he or she write that check?

Dr. Wood: Organized dentistry exists to protect our profession and the patients it serves. Membership dollars contribute to political efforts against threats, provide access to care, and many more professional and patient related services. On a national level, it pays for ADA clinical research and national community care campaigns such as Give Kids a Smile. In addition, to the benefits to the profession, membership opens access to support for dentists as small business owners. Free quarterly industry reports are available from the ADA as well as practice management information. The ADA is a reliable resource for information about compliance and changes to federal regulations such as HIPAA, OSHA and FTC Red Flags Rule.

Without easy access to this type of necessary information, non-members have to work harder or pay a fee to get the same data. Unfortunately, a lot of membership benefits are not common knowledge.

Journal: What changes would you like to see in the VDA, not only during the year ahead, but also in the next five years?

Dr. Wood: Clearly, we are all in agreement that we would like to see an increase in our membership. We can't accomplish this without changing the perception of what the VDA does and can do. I think we need to look at changing our image and presence in the dental community.

The VDA needs to have a more prominent position in the eyes of Virginia dentists and our patients. I would like to see the VDA become an invaluable resource for Virginia dentists. The first place we turn for guidance in our practices. The news source we can rely on to deliver timely information on what poses threats and opportunities for us.

I would like to see us recognized as a valued resource for patients as well. Dentistry is an important part of overall health – a message all too slowly being delivered to the public. The VDA works tirelessly to provide access to care for all Virginians. That is demonstrated through donated dental services all the way to legislative actions that protect the patient's rights and relationship with dentists as health care providers. It's time that we broadcast this message to earn recognition for all the VDA does.

Journal: You're a pediatric dentist. How can we make sure specialists and general dentists work together to advance the profession?

Dr. Wood: I have never known of any issues that have prevented the two entities from working together. I do feel that specialists have a unique opportunity to work with their referral base and be an ambassador of organized dentistry to non-members. Specialists typically have a large number of professional relationships with general dentists. It would be advantageous to strengthen our relationships with our referring doctors through working together as VDA members outside of patient care.

Journal: What are some of the ways the VDA can improve communication with its members?

Dr. Wood: Methods of communication with members are going to be explored by the task force on membership. I see communication as the greatest opportunity for improvement we have as an organization. I don't believe we can continue to use the same communication methods and technology as we have in the past. That said, personal interaction with our members will remain as one of the most effective methods of communication.

Journal: Who are your mentors – your role models?

Dr. Wood: I really have a hard time answering this question as the list is exhaustive of those that have mentored me and those I consider role models. I run the risk of insulting someone by accidental omission.

I have so many people that have stepped up at the right times to help me with decisions and action plans. I have also had the privilege of observing our leaders guide our organization through difficult times. Our leaders are not always those holding office either. So many people have served as role models for me as they led by example. I am not positive they are even aware of their impact on me.

Journal: Finally – what would you like to be doing in five years?

Dr. Wood: I want to continue my service to organized dentistry. I have served in many different roles over my career with the local dental society, the VDA and the ADA and feel that I need to use that experience to benefit our profession in any way possible. I have served in many different capacities over the years and plan to continue to work in any way I am asked to serve.

Photos: (Courtesy of Dr. Wood) page 7 L-R Family Photo (Dr. Wood, his children and grandchild); Roger with his Mother on his birthday; Roger in high school; Dr. Wood honored as a Fellow of the American College of Dentists. Page 8 Roger all dressed up, Roger with his "boat", Roger age 7 rides a pony.

Trustee's Corner

Dr. Charles H. Norman, III - 16th District Trustee

Can We Justify New Dental Schools?

When I was considering potential topics for this column, I wanted to address a contemporary subject. I had just received the latest edition of the *ADA News*, and there was a rather lengthy piece on the opening of new dental schools. Even though the writers presented a thorough overview of the trends in dental education and the proliferation of new schools, they left many unanswered questions, many of which may become quite controversial. Being an editorial column, I thought this would be an ideal opportunity to address some of those questions.

Any discussion of this topic must begin with the basic question of "What is the primary function of dental schools?" Obviously, dental schools add to the knowledge base of our profession through research, they serve a valuable community service function, and they add a necessary component to the health sciences campuses of which they are a part. But, in my opinion, their primary role is to educate adequate numbers of dentists to meet the demand for dental services in our country. Graduates should be well prepared to treat all patient populations, have a robust clinical experience, have a thorough background in scientific theory and research, and an exposure to a curriculum that enhances critical thinking. If we accept that is the primary role of the dental schools, then decisions regarding increasing class size or starting new schools should be supported by overwhelming data showing unmet demand for dental services. We all recognize there is a segment of the population that has difficulty accessing care for any variety of reasons and we should continue to break down barriers that prevent the proper utilization of dental services. However, need does not necessarily translate into demand, and workforce studies continue to show that at our current graduation rates, the US will have an adequate dental workforce well into this century.

So, why are we seeing renewed interest in dental education after more than fifteen years of rather stable enrollment levels? The answer was clearly articulated in the *ADA News* report. When it comes to decisions about the opening of new schools (or increasing enrollments of others) there appears to be more emphasis placed on the ambitions of the sponsoring universities and the large number of qualified applicants, rather than demand for dental services. An evaluation of workforce needs should supersede the other two priorities. As a result of the increasing numbers of students enrolled, graduates may face tremendous educational debt and limited practice opportunities during an environment of economic stagnation.

The increasing cost of technology and a reduction in the demand for services has had a negative impact on dentists' net incomes consistently over the last three years. If this trend continues, dental schools may be faced with a period of dwindling applications. It is not a coincidence that the last time there were significant closures of dental schools, the mid '80s to the mid '90s, it was the same time that applicant pool was at a 25-year low. Historically, application trends are cyclical and there is reason to believe that will be the case in the future. When the applicant pool drops again, as it predictably will, how will the dental schools respond? Will they have the flexibility to cut enrollments or close their doors outright, or will they ignore market forces and maintain the status quo? We can only hope that our colleagues in dental education have thoroughly analyzed their business models and contingency plans, and will respond in a responsible manner. With up to twenty new schools projected to open over the next ten years, we could see these market corrections happening very quickly.

The Board of Trustees has spent considerable time this year discussing this issue. We invited the leaders of the American Dental Education Association to Chicago for an informal dialogue about the current state of dental education and particularly the opening of new schools. We had an opportunity to ask many of the same questions that I have discussed in this article so ADEA is aware of our concerns, and the Board is committed to working with the educational community so that the beat dental education system in the world can continue to thrive. The ADA will always play a vital role in dental education due to one of our core competencies, the development and evaluation of standards. Through the Council on Dental Education and Licensure and its relationship with CODA, the ADA has input in the development of criteria for accreditation and the appropriateness of curriculum. The effectiveness of that curriculum is evaluated through National Board testing administered by the Joint Commission. And finally, the licensing community provides the last evaluation of our educational system. All three steps of evaluation are within the scope of expertise of the Council, and ADA members have the opportunity for input at each level of the educational process.

We should embrace our role in this process as the premier association representing our profession, and we cannot shy away from having frank discussions about the future of dentistry. I think our students and members would expect no less.

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Management of an Altered Denture Foundation in an Edentulous Patient: A Case Report

By: Lakshya Kumar, M.D.S., Lecturer, Jitendra Rao M.D.S., Assistant Professor, Akanksha Yadav M.D.S.

ABSTRACT

This article describes a clinical approach to rehabilitating a completely edentulous patient with an abused denture foundation. The management of a "flabby" edentulous ridge is sometimes a challenging task for a prosthodontist. The successful rehabilitation relies upon accurately capturing the shape of the residual alveolar ridges and directing occlusal pressure on denture load-bearing areas. We used the impression compound tray for making an initial impression which was then trimmed away from the region of flabby tissue. Impression plaster was then applied over the window opening to capture the surface details of the residual ridge without distorting the displaceable tissues. The use of this technique helps in maintaining the contour and capturing the detail of the tissues, as well as accurately determining the extent of the muccobuccal denture extensions.

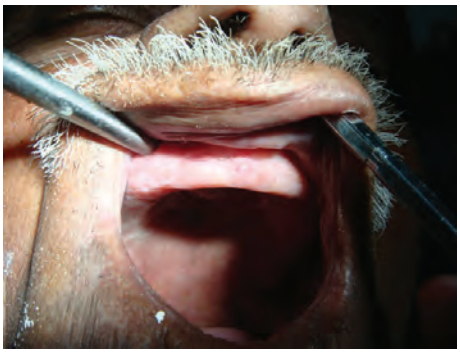

Figure 1- Flabby tissue

INTRODUCTION

Destructive changes in the hard and soft tissues of the jaws have been reported in patients with an occlusal scheme composed of a complete maxillary denture opposed by natural anterior teeth and a bilateral distal extension removable partial denture (1,2) Therefore, prosthodontic treatment is designed to provide posterior occlusal support and to minimize occlusal pressures in the anterior maxilla. The loose alveolar ridge tissue may also result from the denture abuse. Making a definitive impression of a compromised edentulous arch, especially when there is minimal bone height, unfavorable residual ridge morphology, and/or unfavorable muscle attachments is a challenging task (3). Making impressions is also difficult when the mucosa overlying the residual alveolar ridges is highly displaceable. Displacement of such residual ridge tissues during impressions is always a concern. Soft tissues that are displaced during impressions tend to return to their original form, and the final definitive prosthesis fabricated from the impression does not fit accurately on the recovered tissues, resulting in discomfort, loss of retention, stability, and gross occlusal disharmony of the dentures (4). In this article we are reporting a case of flabby alveolar ridge of the anterior maxilla, which was managed by an impression technique that involves use of a window custom tray and customized dental plaster as a recording medium.

CASE REPORT

A 70 year-old male patient reported to the Department Of Prosthodontics for fabrication of complete dentures. The patient was already wearing a set of complete dentures fabricated twenty years ago. The use of the prostheses resulted in loose, flabby tissue in the anterior maxilla and a resorbed mandibular ridge. The medical history of the patient was non significant.

TREATMENT PLAN

The treatment plan consists of:

1. Minimizing the risk of denture abuse.
2. Improving the condition of the denture bearing tissue.
3. Recording of the tissue in undistorted and proper form.
4. Suitable prosthodontic rehabilitation.
5. Preservation of tissues.

The patient was advised to immediately avoid the use of the faulty prostheses, as well as rest and massage of the abused tissue.

CLINICAL PROCEDURE IMPRESSION

STEP 1 - Maxillary and mandibular edentulous impressions were recorded in alginate (Zelgan 2002, Dentsply, India) and the cast were poured.

Figure 2 – Window prepared in secondary impression

STEP 2 - A custom tray was fabricated for a final impression of maxillary edentulous ridge. The sectional border moulding was performed.

Step 3 - The area of flabby tissue was marked by indelible pencil, and the mark was transferred to the tray. The area marked on the tray was cut with a Bard-Parker blade.

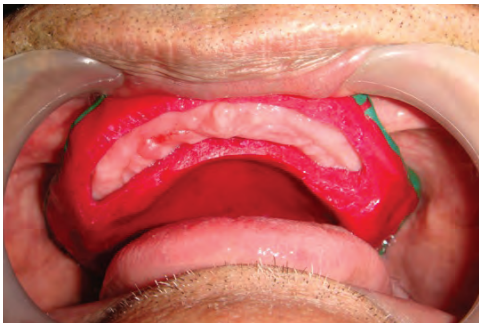

Figure 3 – Flabby tissue protruding out of the window

Step 4 - The final impression of the maxillary edentulous ridge is recorded in zinc oxide and eugenol impression paste.

Figure 4 - Completed impression

Step 5 - After completing the final impression of the maxillary edentulous ridge the impression of flabby tissue was recorded by a modified dental plaster (three parts plaster, one part starch). The advantage of using this mixture of plaster and starch is that it has a long working time and can be easily separated from dental stone.

Step 6 – The tray was again placed in the mouth and the flabby tissue was coated with the modified dental plaster. This will record the tissue in undistorted form. The impression was retrieved and final cast was poured after beading and boxing of impression.

STEP 7 - The remaining complete denture fabrication was done in a conventional manner.

DISCUSSION

A "flabby" maxillary ridge usually results when the artificial prosthesis is opposed by natural teeth, or it may result due to inadequate occlusal contacts. Treatment options include a conventional denture, an implant-supported prosthesis, and a liquid supported denture5. Usually in these types of cases we have to provide a bilaterally balanced occlusal scheme and at each visit we check for deflective occlusal contacts and correct them for the longevity of the prosthesis.

The management of flabby tissue is most important in edentulous patients because it leads to unequal distribution of pressure on the denture bearing mucosa .The low-viscosity elastomeric impression material has shown some advantage because it

Continued on page 13

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Dr. Svirsky is a board certified oral and maxillofacial pathologist at Virginia Commonwealth University. In addition to teaching, he has a broad background in research and has numerous publications. He has a private practice of oral pathology and oral medicine in Richmond Virginia. Dr. Svirsky holds a Master's Degree in adult education. This lecture program will be presented in Dr. Svirsky's interactive, entertaining, and often risqué style. Dr. Svirsky makes oral pathology FUN!

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Continued from page 11

creates minimal pressure, produces accurate details, does not distort easily, and is easy to handle 6,7. In this article we described a method of recording flabby tissue by a modified impression plaster which can be made easily in the dental office. The method is quick, easy, and a satisfactory result is obtained. When considering conventional prosthodontics, there are a variety of impression techniques available to address the problems caused by the unsupported tissue during denture construction. However, there is a lack of scientific evidence for the use of any technique over another. Considerations for selection should include the location and extent of unsupported tissue.8

SUMMARY

The completely edentulous cases with altered denture tissue should be treated with caution. Consideration has been given for the choice of impression materials as well as the design of the impression tray to minimize the amount of pressure exerted on the displaceable regions of the residual ridges during the impression-making procedure. The impression technique presented here is quick and economic.

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PathologyPuzzler

with Dr. John Svirsky

A white female, 68 years old, was referred from a private practitioner to a local oral surgeon for evaluation and biopsy of a bothersome oral condition that has been present since October 2009. Multiple return visits to her dentist and physician resulted in no improvement. The affected area was the gingiva in the anterior region of the mandible and maxilla (figure 1). Her past medical history was reviewed and includes medical management of elevated cholesterol, high blood pressure and anxiety/depression. Her medications include Crestor®, Prozac®, Diovan®, Norvasc® and a low-dose aspirin.

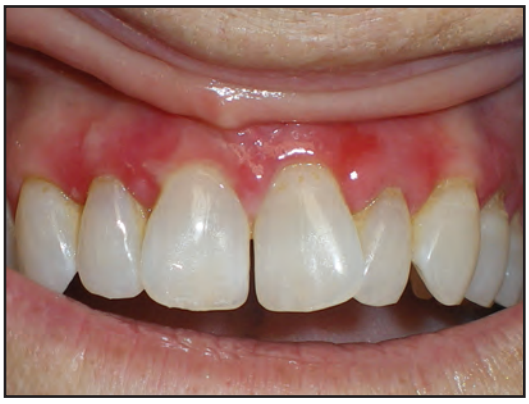

Figure 1

The clinical examination revealed a positive Nikolsky sign. The practitioner was able with light pressure to separate the epithelium from the underlying connective tissue (figures 2 & 3).

Which of the following conditions would be included in your differential diagnosis?

A. Aphthous stomatitis
B. Benign mucous membrane pemphigoid
C. Erosive lichen planus
D. Herpetic stomatitis
E. Pemphigus
F. Squamous cell carcinoma

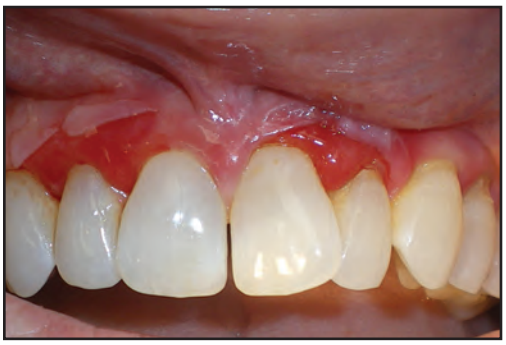

Figure 2

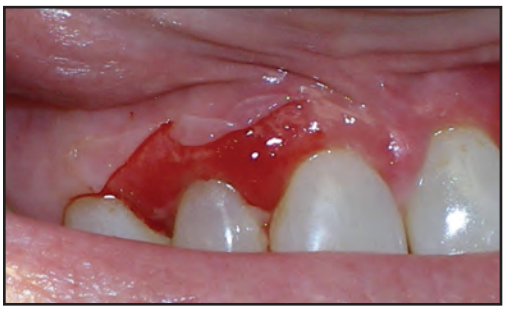

Figure 3

Continued on page 17

Oral Surgery Abstracts

Padilla, M; Clark, G; Merrill R. Topical Medications for Orofacial Neuropathic Pain: A Review. JADA 2000; 131 (2), 184-195

Many medications are given orally and intravenously for systemic effect. This is effective for many systemic problems like hypertension or diabetes. However, other problems may be localized to a system or a geographic area, thus a systemic approach to a targeted problem might be unwarranted and invite unnecessary side effects. This article discusses how local and topical medications can be used for treatment of neuropathic orofacial pain, a local condition.

The challenge for topical medicine is that it has to go through barriers to reach its target plane. The skin is resistant to penetration, so adhesives would need to be employed to increase the exposure time to the medicine. The oral mucosa has a less resistant barrier and allows 10 times more water permeability than the skin.

The most common neuropathic pain is related to the trigeminal nerve injuries like neuralgia, neuropathy, and neuromas. The mechanism is usually secondary to a crushing or cutting injury where the nerve sheath is damaged and a neuroma develops. This will eventually lead to chronic pain and subjective discomfort. Topical medication to this area has the advantage of rapid onset, low side effect, and higher safety with larger dosages. Topical anesthetics like lidocaine, benzocaine, and EMLA (eutectic mixture of local anesthetic) are also used frequently to maintain local numbness and reduce sensitivity. Capsaicin, an active ingredient for peppers, is also used for peripheral densitization. This encourages nociceptors to release substance P that causes local excitation and sensitization and central release of excitatory aminoacids through stimulation of C-fibers.

Topical NSAIDs (non-steroidal anti-inflammatory drugs) now frequently used for local joint pain have a place for orofacial pain. There has not been much research on the effectiveness of this approach versus a systemic approach. Ketamine, an NMDA receptor antagonist, has shown to be useful for neurogenic pain. There are adverse effects such as hallucinations and dysphoria. Also anticonvulsants that work through sodium channels help reduce primary peripheral nerve hyperexcitability.

There are many modes of delivery to a local target. A mucoadhesive is important to serve as a medium for drug delivery. Transdermal creams contain a pluronic mixture of lecithin and organogel which provides a hydrophilic medium for binding and delivering medication. Toothpastes can also be used as a medium for delivery. Chewing gum can allow a slow-release for medications. Another way to provide slow release is dissolvable tablets and lozenges. Adhesive cutaneous patches for creams and gels allow a protective barrier for local drugs.

Any future improvements in the delivery or drug choice to treat orofacial neuropathic pain will come from more research in pathophysiology and pharmacology of pain. Local delivery systems show the advantage of a targeted solution approach even with the disadvantage of inconvenient applications. Improvements in bioadhesive medication delivery will lead to better drug exposure and treatment time.

Nazir Ahmad, DDS, Resident, VCU Health System, Oral and Maxillofacial Surgery

Leung YY, and Cheung LK. Safety of coronectomy versus excision of wisdom teeth: A randomized controlled trial. Oral Surg Oral Med Oral Pathol Oral Radiol Endod 2009;108 (6): 821-827.

Damage to the inferior alveolar nerve (IAN) is a well known complication of mandibular third molar extraction with a rate ranging from 0.4% to 8.4%. An alternative procedure, coronectomy was first described in 1989, when symptomatic mandibular third molars, that had radiographic evidence to be with roots proximate to the IAN, treated with crown removal leaving the roots within bone. This study was aimed toward comparing the safety of coronectomy procedure versus conventional total tooth extraction in terms of postoperative complications, and more importantly the rate of neurosensory disturbances. The study was conducted between the years of 2006 to 2008, when 231 patients with 349 eligible wisdom teeth are randomly divided into two groups, a coronectomy group (171) and a conventional extraction group (178). The main eligibility criteria for a tooth to participate in the study was the root had to touch or overlap with the superior cortical line of the IAN on a radiograph. Additional radiographic criteria included darkening of the root, abrupt narrowing of the root, displacement of the IAN canal by the roots. Patients with other complicating factors such as being medically compromised with a condition that can predispose to infection were excluded from the study. The procedure was performed by exposing the crown with a conventional flap design, then removing the a crown with a fissure bur and trimming the roots to a level 3-4 mm below bone level. If roots became loose at any point during the procedure, they would need total extraction and it would be considered a failed coronectomy. No antibiotics were given after the procedure. Patients were followed up in one week and then 1,3,6,12 and 24 months, each time assessed for neurosensory deficit, pain, infection, dry socket, root exposure, root migration and need for re-operation. In terms of neurosensory deficit, one (0.65%) case developed a deficit in the coronectomy group that recovered after 12 months and nine (5.10%) cases in the extraction group developed a deficit, 6 of which recovered in 1 month and the other 3 never did. Assessing the pain level, in the coronectomy group 41.9% patients reported pain 1 week post op and 57.3% patients in the extraction group. As far as infection, the incidence of infection at 1 week post op was 5.8% in the coronectomy group and 6.7% in the control group. There were no dry sockets seen in the coronectomy group, but reported 5 cases in the extraction group. Calculating root migration, the authors found that roots migrate an average of 3.06 mm in 24 month period. The last assessment criteria was root exposure, where it was found to be in 2 cases. One case root coverage was observed spontaneously by soft tissue during the first month, the second remained exposed and became symptomatic, so it has been removed in the 9 month follow up. Of note, this removed root was sent for histological study and was found to contain vital pulp. At the end, the authors conclude by confirming that coronectomy is a safe procedure with significantly less risk of IAN damage. Coronectomy also has lower risk of the previously mentioned complications compared to conventional tooth extraction, except in infection rate, it was found to be the same in both groups.

Fahad Alsaad, DDS, Preliminary Intern, VCU Health System, Oral and Maxillofacial Surgery

Garner D, Dudgeon W, Scheett T, McDivitt E. The effects of mouthpiece use on gas exchange parameters during steady-state exercise in college-aged men and women. JADA 2011; 142 (9): 1041-1047

Athletes have worn mouthpieces during sports as protective devices against dental injuries and concussions. However, increased use of mouthpieces for performance enhancement is a recent trend in sport and exercise. Recent studies have reported lower lactate levels in participants who wore a mouthpiece compared with levels in those who did not wear a mouthpiece. The mechanism of this outcome is unclear. Thus, the purpose of this study was to explain the lower lactate levels observed with mouthpiece use during exercise by studying the oxygen/carbon dioxide differences with mouthpiece use.

The authors enrolled 16 participants (13 men and three women) ages 18 through 21. The men were physically active and had participated in university-mandated physical exercise, which consisted of a minimum of two cardiovascular and two resistance exercise sessions per week. The three women were college athletes, of whom two were on the track and field team and one was on the soccer team. All participants reported that they had refrained from physical exercise the day of testing and were free of injury or illness

Before testing, a dentist took impressions of each participant's lower teeth. Molds were then sent to a laboratory for fabrication of custom-fitted mouthpieces (Under Armour® Performance Mouthpiece). These mandibular arch mouthpieces have a wedge on the posterior teeth that creates a gap between the mandibular and maxillary dentition. Participants performed two 10-minute treadmill runs for each of the three treatment conditions assessed in this study: mouthpiece, no mouthpiece and nose breathing. Extensive measurements such as amount of oxygen used per

kilogram of weight and amount of carbon dioxide expired per minute were used to analyze gas exchange during exercise.

In this study, the authors measured a significant increase in voluntary oxygen used per kilogram of weight when participants wore the mouthpiece. They also measured an increase in voluntary carbon dioxide production. In short, better gas exchange was measured when athletes wore the mouthpiece than without it. Gas exchange was also improved with mouth breathing compared to nasal breathing.

One proposed a mechanism of improved gas exchange with the mouthpiece in place is the increased opening between the teeth created by the occlusal wedge mentioned earlier. In addition, this specific mouthpiece supposedly shifts the mandible down and into a more forward position. Other studies have reported that this type of mandibular shift results in increased airway openings. The improvements in gas exchange with mouthpiece use may explain the physiological outcomes of improved lactate levels during endurance running, as reported in previous studies. Specifically, improved CO_2 exhalation, as observed with mouthpiece use throughout treadmill protocol, leads to improved buffering of hydrogen ion levels, which, in turn, decreases lactate levels during endurance exercise.

Matthew N. Maxfield, DMD, Resident, VCU Health System, Oral and Maxillofacial Surgery

Rodriguez-Argueta OF, et. al. Postoperative Complications in Smoking Patients Treated with Implants: A Retrospective Study. Journal of Oral and Maxillofacial Surgery 2011; 69 (8): 2152-2157

There is a well documented association between smoking and an increase in postoperative complications in abdominal, orthopedic, oncologic and oral and maxillofacial surgery. Many physicians recommend smoking cessation prior to surgery but studies have found that a minimum of four weeks is required to reduce postoperative complications.

The relationship of smoking and dental implants has been extensively studied and there is a well documented association of smoking and an increase in implant failure. Smoking has also been shown to cause implant related complications including mucositis, peri-implantitis and infection. The goal of the present study was to investigate the effect of smoking on the risk of postoperative complications in patients receiving dental implants.

A retrospective study was conducted on patients who were treated at the Unit of Implantology, Universtiy of Barcelona Faculty of Dentistry. Inclusion criteria were a minimum six-month radiographic follow up and the placement of the final prosthesis. All patients receiving implants were prescribed a postoperative antibiotic, a non-steroidal anti-inflammatory drug (NSAID) and Peridex® mouth rinse. A total of 295 patients receiving 1,033 implants were enrolled in the study. There were a total of 209 complications. Overall, 82.8% of non smoking patients had no postoperative complications while only 74.8% of smoking patients had no complications. Smoking patients were found to have an increased incidence failure (loss of osseointegration), presence of mucositis, peri-implantitis and postoperative infection.
Postoperative complications associated with smoking and dental implants are believed to be related to a reduced ability to heal. The mechanism of reduced healing is due to vasoconstriction and decreased oxygen delivery to the tissues caused by toxins associated with smoking including nicotine, carbon monoxide and cyanide. Smoking also causes an inflammatory reaction and reduced fibroblast and collagen activity, which further prevent healing. While there have been several studies showing the link between smoking and implant failure, there has been little research into the effect of smoking on postoperative complications associated with implants. The current study not only showed an increased risk of implant failure but it also found that there was an increased risk of postoperative complications in smokers. Specifically smokers were found to have a higher incidence of mucositis, peri-implantitis and infection. The results of this study further show the importance in educating patients on the potential hazardous effects of smoking.

Dr. Daniel C. Braasch, Resident, VCU Health System, Oral and Maxillofacial Surgery

Sfondrini M, Gatti S, Scribante A. Effect of Blood Contamination on Shear Bond Strength of Orthodontic Brackets and Disinclusion Buttons. Brit J Oral and Maxillofacial Surgery 2011; 49 (5), 404-408.

Surgical exposure and orthodontically assisted eruption of impacted or ectopic teeth is a common procedure in comprehensive orthodontic care. The most commonly used method in current surgical practice is to bond orthodontic brackets or disinclusion buttons to the tooth's crown at the time of operation. Due to frequent surgical field contamination with blood and the technique sensitivity of composite resins, brackets and buttons may have to be rebonded due to premature failure from fluid contamination. Saliva and blood contamination adversely affects composite resin bonding due to wetting of the etched enamel, with resultant reduction in resin tag length and numbers. Previous studies show a reduction in bond strength with contamination, but no studies to date compare shear bond strength with contamination of conventional orthodontic brackets and disinclusion buttons.

Bovine teeth were used, as previous studies have shown that bovine and human enamel are comparable in physical properties, composition, bonding strengths, and have been found to be reliable substitutes for human enamel in bonding studies. Orthodontic stainless steel maxillary central incisor brackets and stainless steel orthodontic buttons were attached to 160 freshly extracted permanent bovine mandibular incisors with 3M Unitek 37% phosphoric acid, Ortho Solo® primer, Transbond XT® composite resin, and Ortholux XT® after being separated into the four test groups: dry, contamination with blood before priming, contamination with blood after priming, and contamination with blood both before and after priming. The teeth were contaminated with fresh human blood from the same female donor. Specimens were stressed in the occlusogingival direction with the Instron. The maximum load necessary to break the bond was recorded and ARI was used to assess the amount of adhesive remaining on the enamel surface after bond failure.

Results showed that both brackets and buttons had the highest bond strength on dry enamel with no significant difference between the two. All contaminated buttons had statistically similar decreased bond strengths from the control, and all contaminated brackets had statistically similar and the lowest bond strengths, compared to the control and contaminated buttons. The contaminated buttons had statistically significant higher bond strengths than the contaminated brackets. The contaminated buttons had a higher ARI score of 1, indicating less than half of the adhesive remaining, than the contaminated brackets, which had an ARI score of 0, indicating no adhesive remaining.

As with other studies, this study has corroborated the fact that blood contamination lowers composite resin bond strengths to enamel. The study also shows that the disinclusion buttons had significantly higher shear strength than the conventional brackets when contaminated with blood during the bonding process. The results show there is no statistically significant difference in the bond strength reduction with the time of blood contamination, for buttons or brackets. Other studies have found that a minimum bond strength requirement of 6-8 MPa is necessary for most clinical orthodontic needs. Contaminated brackets produced bond strengths around 2 MPa, which is far lower than the normal clinical requirements. Contaminated buttons produced bond strengths around 6 MPa, which are closer to the adequate bond strength values. This increase in bond strength in the contaminated buttons over the contaminated brackets may be due to appliance design or differences in retention of the mesh pads, but at this time the true reason remains unknown. Based on the results of this study, it was confirmed that contamination with blood decreases enamel bond strengths significantly, but more so with conventional orthodontic brackets than with disinclusion buttons.

Dr. Nicholas Kain, Resident, VCU Health System, Oral and Maxillofacial Surgery

Brandt R, et.al. The pulpal anesthetic efficacy of articaine versus lidocaine in dentistry: A meta-analysis. JADA 2011; 142(5): 493-504.

The US Food and Drug Administration approved articaine as a local anesthetic in the United States in April 2000. Since its introduction, articaine has become popular with clinicians because of the hope that it may provide increased efficacy. Multiple previous studies have attempted to compare articaine with a variety of other available anesthetic solutions, but published data do not support a clear superiority in terms of efficacy. The authors of this article evaluate published evidence from controlled clinical trials regarding the efficacy of articaine vs. lidocaine in providing successful pulpal anesthesia.

The authors prepared a protocol that included searching MEDLINE and Embase databases for controlled trials in which researchers directly compared articaine and lidocaine local anesthetic solutions in adult participants. Their inclusion criteria was comprised of studies that: evaluated the pulpal anesthetic effect of local anesthetic solutions of articaine comparatively with lidocaine, using volumes of at least 1.0mL per administration in combination with a vasoconstrictor; clinical trials that involved adult human participants; were published in a peer-reviewed journal in the period from January 1970 through December 2009; and provided original data generated by means of a comparative design. Based on this inclusion criteria, 13 studies were found that were considered randomized, controlled clinical trials in which researchers investigated pulpal anesthesia in adult participants. The authors also completed a subgroup analyses for both nerve infiltration and mandibular inferior alveolar nerve block anesthetic technique.

The results of this meta-analysis showed that articaine was 2.44 (95 percent confidence interval [CI], 1.59-3.76; p<.00001) times more likely to produce anesthetic success than lidocaine. With regards to infiltration anesthesia only, the odds ratio was found to be even higher, at 3.81 (95 percent CI, 2.71-5.36; P<.00001), in favor of articaine. With regards to mandibular blocks only, the weighted odds ratio was 1.61 (95 percent CI, 0.74-3.53); which they deemed to not be significantly different. This higher overall odds ratio of achieving anesthetic success with articaine indicates that there may be an advantage to using this local anesthetic.

The authors claim that results provide a high level of evidence in support of articaine having greater success than other anesthetic solutions when used for pulpal anesthesia in dental applications. However, they accurately warn that other literature supports there being an increased risk of paresthesia with inferior alveolar nerve blocks using articaine, and they therefore encourage further research in this area. The authors also mention the limitations in their review, including the lack of consistency of results across studies, the methodological heterogeneity of the trials included in this review (and variability of masking procedures), evaluation and definition of anesthetic success, sample size, experience of operator and preoperative pulpal status. They also offer advice on how to use electric pulp testing (EPT) results to define anesthetic success for future studies. In summary, this study showed that, in a clinical situation, articaine was more likely to produce anesthetic success than was lidocaine for achieving pulpal anesthesia when nerve infiltration was mode of administration being performed.

Dr. Ammar Sarraf, Resident, VCU Health System, Oral and Maxillofacial Surgery

Butura C, Galindo D, Jensen O. Mandibular All-On-Four Therapy Using Angled Implants: A Three-Year Clinical Study of 857 Implants in 219 Jaws Oral and Maxillofacial Surgery Clinics of North America 2011; 23 (2): 289-300.

Placing dental implants in the atrophic edentulous mandible is an interesting challenge to the surgeon. Branemark positioned implants between the mental nerves, to make use of the increased bone density in the symphyseal region. However, there is a limiting factor - symphyseal implant placement naturally prevents extension of the prosthesis posteriorly. Vertical implant placement requires the prosthesis to have cantilever lengths of 10 to 20 mm to provide adequate function and aesthetic outcome. This will ultimately result in increased compressive stress on the most distal implant when in function. Several studies have shown that the cantilever span should not exceed 7 mm in order to provide optimal stability.

Krekmanov and Aparicio showed that tilted implants did not exhibit advanced or extreme bone loss nor did they demonstrate significant bone stress when compared with cantilevers on vertically placed implants. Since then many researchers have validated the success of immediate loaded angulated implants in the edentulous mandible using the All-on-Four approach.
The question still remains - can the All-on-Four approach be used in the atrophic mandible and for immediate loading after multiple extractions? Although there is research that points to the success of placement of implants into immediate extraction sites, they were for single teeth and not for full arch restorations.

In this retrospective study a total of 857 implants were placed in 219 mandibles, of which 201 had more than three teeth present, 18 were fully edentulous, 7 had one to three teeth, 49 had four to six teeth, and 145 had over seven teeth. Dental extractions were completed then simultaneous implant placement, and immediate loading (within 2–3 hours post surgery) with fixed acrylic hybrid prosthesis. All surgeries were completed under monitored IV anesthesia and all patients were classified as either ASA class I and II patients

Pre and post operative radiographic analysis of bone was completed with Cone beam CT (CBCT) to classify the bone by pathology, arch shape, bone volume and U-shaped arches versus V-shaped arches. Also edentulous atrophic mandibles were analyzed with Hounsfield unit values in the CBCT software.

The authors describe three case studies all of which required extractions, or the patients have been edentulous for many years.
In case one, a 75 year-old male presented for extraction of all remaining teeth, debridement of hard and soft tissue, mandibular alveolar reduction of 5 mm, and placement of mandibular implants using the All-on-Four technique. Prior to surgery radiographic CBCT analysis revealed 70% to 90% bone loss on the remaining teeth without significant intrabony pathology and 14.5mm of anterior ridge available for implant placement. Posterior implants were placed angled at 30 degrees in the area of the second premolar and anterior sites at the canine-lateral incisor areas. The temporary prosthesis was stabilized in place using temporary cylinders. Four months later the temporary cylinders were removed and the final prosthesis was fabricated. Of particular note, is case report three of a 65 year-old female with a 45 year history of V shaped mandibular edentulism. Radiographically, at the mental foramen region she displayed a total mandibular height of 6.90mm on the right and 7.52 mm on the left. The symphysis displayed a height of 11.42 to 11.76 from right to left. Nobel- Biocare Speedy Groovy implants 4 x15 mm and the anterior 4 x 13 mm was used. In all three cases the one-year postsurgical radiographs showed adequate bone level at all implant sites regardless of axial or tilted positions.

This retrospective study of 857 implants resulted in only three failed implants - a success rate of 99.66%. The criterion for failure was defined as any implant demonstrating an inability to withstand 15 to 35 ncm of torque at the fourth month postoperatively. The three failed implants failed after 3 weeks and the authors believe they may have been due to intraosseous infections since those sites were all related to periapical pathologies prior to surgery.

The authors explain that the All-on-Four concept of implant placement can be effective. Survival of implants in the early stages of placement in the All-on-Four procedure can be done with a high degree of confidence for the mandible—putting into question the need for additional implants.

Osama Soliman, DMD, Resident, VCU Health Systems, Oral and Maxillofacial Surgery

Continued from page 13

PathologyPuzzler
with Dr. John Svirsky

Correct answers B & E and possibly C.

The best answers are benign mucous membrane pemphigoid and pemphigus vulgaris. Recurrent aphthous normally does not affect the gingiva. Herpes simplex does not have this clinical presentation and only lasts a week. Squamous cell carcinoma (SCCa) does not have a positive Nikolsky sign and clinically is elevated and irregular. SCCa is not normally in multiple areas. Lichen planus would normally show a lichenoid periphery with white stria adjacent to the erosive lesions.

Benign mucous membrane pemphigoid (BMMP) is an autoimmune disease in which auto antibodies are directed against the basement membrane. Women are more commonly affected than men with an average age of 50-60 years. Oral lesions are seen in most patients.

The oral lesions generally present as vesicles or bulla that rupture easily with minimal trauma. A typical complaint from a patient would be that they have abundant blood in their mouth following brushing. The differential diagnosis usually includes pemphigus and lichen planus.

Pemphigoid and pemphigus are differentiated based on the histological appearance with pemphigoid having subepithelial separation from the connective tissue (figures 4 & 5) and pemphigus having intraepithelial separation (figure 6). Pemphigoid, being subepithelial is usually thicker and will show vesicle and bulla formation. However pemphigus, showing intraepithelial separation, is thinner and usually presents intraorally with ragged erosions. BMMP rarely has skin lesions, but eye involvement is common. Patients diagnosed with BMMP should be evaluated by an ophthalmologist. Pemphigus patients, in addition to oral lesions ("first to show and the last to go"), have skin lesions that lead to serious consequences if not controlled.

Clinically patients will exhibit a positive Nikolsky sign. This sign is caused by rubbing or blowing air on unaffected mucosa and causing a separation of the epithelium. This is a classic finding in these two diseases. This is not a charactistic finding in lichen planus.

The oral lesions of pemphigoid are more of a discomfort, which at times may be painful, but much less so than pemphigus or erosive lichen planus (ELP). The lesions look worse than the pain the patient experiences.

If the patient does not complain of pain, they are followed. If painful the treatment varies. At times I have used all of the following: topical steroids, systemic steroids, dapsone (cannot be used if glucose-6-phosphate-dehydrogenase deficient), metronidazole, tetracycline with nicotinamide and palliative mouth rinses.

Clinically lichen planus would be unusual without white stria found in association with the erosions. Lichen planus can also have skin lesions which are purple, papular, pruritic and polygonal. Pemphigus skin lesions are typically erosions and can be formed easily by trauma.

This case was submitted by Dr. Craig Vigliante, an oral surgeon in Lansdowne, Virginia.

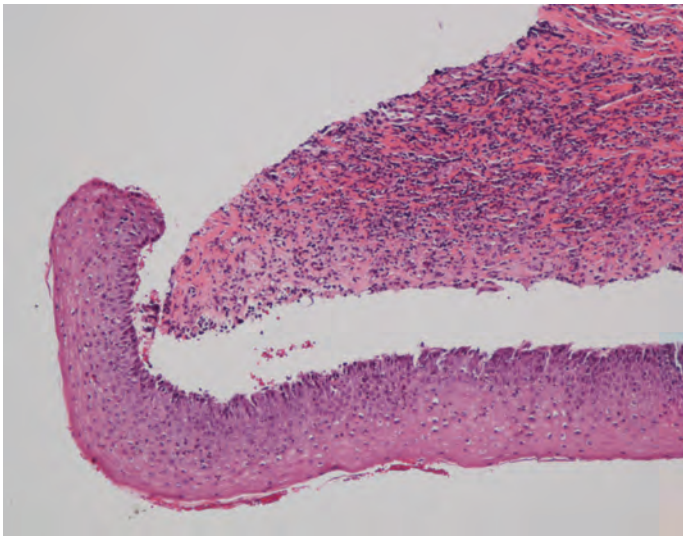

Figure 4

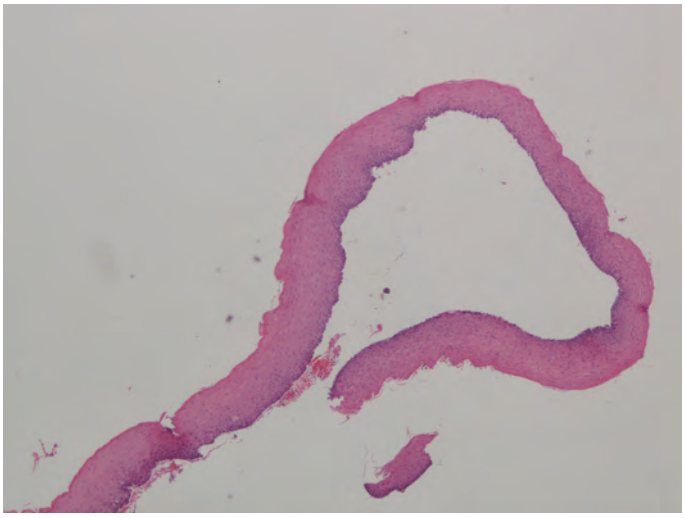

Figure 5

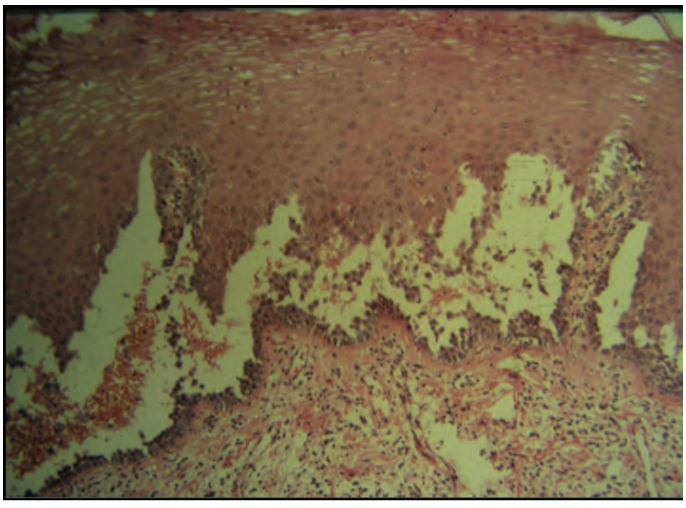

Figure 6

VDA's *Legislative Day on the Hill*: Mark Your Calendar for January 20, 2012!

Do you want to make a difference for your patients and your profession?
By attending the VDA Day on the Hill, you WILL make a difference. Participation in the political process is THE proven way to protect the dental profession and enhance the oral health of Virginia's citizens.

January, 20, 2012 is the most important day of the year for the VDA, so please mark your calendars.

This is the day for dentists, dental students, and other dental community members to come together and talk with General Assembly members about current issues affecting dentistry, and thank them for their support in past years. In order for the Virginia Dental Association to be successful in its legislative efforts, it is vital that each of you play an active role in the political process.

All VDA members and VCU dental students are invited to attend this important event. The day begins with a breakfast briefing at which participants learn about the important issues pending before the legislature. Members and students then enjoy the opportunity to participate as a large group, meeting with their respective Delegates and Senators at the General Assembly Building on Capitol Hill. Round-trip bus transportation is provided from the breakfast to the General Assembly Building that morning.

We encourage you to attend this special event and contribute your perspective on the issues of the day to our elected officials and policymakers. Registration will begin in November. Please contact Laura Givens at (804) 523-2185 or Givens@vadental.org if you are interested in attending.

VADPAC UPDATE

We would like to thank all VADPAC contributors! Because of your contributions, we are able to contribute to legislators to thank them for their support of YOUR profession and YOUR patients and to discuss with candidates the issues most important to dentists. The below chart illustrates the total contributions, broken down by components. Review this chart to see where your component stands.

Component	# of Members Contributing to Date	2011 VAD-PAC Goal	Amount Contributed to Date	Per Capita Contribution	Amount Needed to Reach Goal
1	171	$44,000	$42,510	$249	$1,490
2	115	$25,000	$27,944	$243	$0
3	51	$12,500	$12,600	$247	$0
4	234	$60,500	$65,291	$279	$0
5	113	$28,100	$27,485	$243	$615
6	89	$23,000	$26,368	$296	$0
7	106	$30,000	$26,600	$251	$3,400
8	482	$132,000	$129,374	$268	$2,626
TOTAL	**1,361**	**$355,100**	**$358,172**	**$260**	**$0**

Total Contributions: $358,172
Goal: $355,100

GOAL HAS BEEN REACHED!

If you have not yet contributed to VADPAC as a 2011 contributor, please contact Laura Givens at givens@vadental.org or 804-523-2185.

VADPAC Fundraisers- 2011

The VDA continues to ambitiously support campaigns for legislators and this year has been exceptionally successful. Two events were held in the spring and five have been held this summer. We still plan on hosting three more in the coming months prior to the 2011 elections in the Commonwealth. Nearly $70,000 has already been raised from these events. We encourage everyone to contribute and attend VADPAC Fundraisers as they are a wonderful opportunity to gather socially with your friends and colleagues and meet with legislators in an intimate setting. Below are several fundraisers we have held over this past summer……

Delegate Chris Jones Fundraiser in Suffolk

Dr. Brian and Lisa Midgette hosted a VDA fundraiser for Delegate Chris Jones at their home on June 9th. Delegate Jones represents the 76th district, which encompasses parts of the cities of Chesapeake and Suffolk. Dentists from his district and surrounding areas attended the event to show their support for Jones, a strong supporter in the General Assembly of dentistry and the interests of dental patients.

Senator Dick Saslaw in Annandale

The VDA hosted a fundraising event on June 21 in honor of Senator Dick Saslaw at the American Legion Hall in Annandale. Dr. Bruce Hutchison chaired the event. Saslaw, who has represented the 35th district for over 30 years, serves as Senate Majority Floor Leader and is Chairman of the Committee on Commerce and Labor. VDA members from his district, which includes parts of Alexandria and Fairfax and members from other parts of Northern Virginia attended the event.

Senator Tommy Norment Fundraiser in Williamsburg

Dr. Ray Lee hosted a fundraising event in honor of Senator Tommy Norment on Saturday evening, July 30, at his home in Williamsburg. Dr. Bill Bennett chaired the event. Senator Norment represents the 3rd district, which includes Gloucester County, James City County, New Kent County, part of Newport News City, Williamsburg City, and part of York County . As Minority Floor Leader, Senator Norment played a major role in Senate passage of last year's non-covered services legislation. VDA members from his district and members from other parts of the Peninsula and Tidewater attended the event.

Senator Edd Houck in Fredericksburg

Dr. Stan and Andi Dameron invited VDA members and friends to their home in Fredericksburg on August 2 to honor and thank Senator Edd Houck for his efforts supporting the practice of dentistry and the interests of dental patients in the Commonwealth. As Chair of the Committee on Education and Health and a Budget Conferee, Senator Houck has played important roles during his long legislative career to support dental Medicaid efforts, funding for the VCU School of Dentistry expansion and other legislation important to the oral health of all Virginians. Senator Houck represents the 17th district, which includes Culpeper County, part of Fredericksburg City, Louisa County, Madison County, Orange County, and part of Spotsylvania County.

Senator Philip Puckett in Abingdon

On August 4, the VDA hosted a fundraising event in honor of Senator Philip Puckett at the Glenroachie Country Club in Abingdon. The chairman of the event was Dr. Ronnie Brown. Attending were VDA members from Senator Puckett's district and surrounding areas. Senator Puckett's district includes
Bland County, Buchanan County, Dickenson County, part of Pulaski County, Russell County, Smyth County, Tazewell County, part of Wise County, part of Wythe County.

Additional 2011 Fundraisers

Other fundraisers this fall will be held in Bedford to honor and support Delegate Lacey Putney and in Richmond to recognize Delegate John O'Bannon. An event for House Speaker Bill Howell will be held in Fredericksburg.

VADPAC appreciates VDA member involvement in steering committees to make these fundraising events successful.

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Extraoral

By: Dr. Elizabeth M. Wilson

Thunder Dog-The true story of a blind man, his guide dog & the triumph of trust at Ground Zero

By: Michael Hingson with Susy Flory

ISBN- 13 9781400203048, $22.99
Thomas Nelson, Inc., 2011, Nashville

I wanted to remember September 11th, 2001 for the column this time. So, therefore, I was elated when I found *Thunder Dog*. The cover alone drew me over, as it displays a harnessed golden retriever next to a fireman. Then I read the subtitle and finally flipped to the back cover where I saw the words "Faith, Trust and Triumph". I was sold.

And yes, you will be too. Cat people as well, I'd wager.

Set amidst the attack on World Trade Center I, *Thunder Dog* is actually a very sweet and uplifting tale. Michael Hingson is our author. Mike, now about 50 years old, has been blind his whole life. His parents raised him to be independent and self-reliant. Eventually, he learned about guide dogs and so began his relationship with these animals.

This story in particular centers on Mike and Roselle, his golden retriever guide dog. They are a relatively new pair, having been brought together only ten months before. Roselle appears to be a serious worker when her harness is on, but your basic mischievous puppy once it comes off. Pretty endearing.

Mike describes his early morning of September 11th and his own activities as he arrives at work on the 78th floor of World Trade Center north tower. When the building is hit, the events unfold rapidly and several themes are explored. Teamwork is one, as Mike has to rely on Roselle. But Roselle also, relies on Mike. She can sense his emotions acutely and he must calibrate his feelings so Roselle may feel safe. They must trust each other.

There are 1,463 stairs awaiting Mike and Roselle. Once on the stairs, we again see teamwork. All those people, some badly burned, working together, not panicking, and helping each other down the stairs. I don't know, I can't imagine what was in the minds of all those people, but I find it amazing and uplifting to know how they responded. They moved quickly but not too fast. They made way for injured people. They made way for firemen going in the opposite direction. They even passed out water bottles up and down the stairs when they came upon a supply.

Much more is to happen to Mike and Roselle that day. They must navigate the buildings coming down, and somehow find a form of safety. I will tell you they manage to do it together.

You'll have to read the book, though, to find out why Mike thought of Roselle as Thunder Dog.

Excellent read and a fine tribute to everyone who was affected by September 11, 2001.

Community Based Dental Education & Service-Learning at VCU School of Dentistry

By: Kim T. Isringhausen, BSDH, RDH, MPH Assistant Professor, Director of Dental Hygiene & Community Based Education Programs

Increasing the use of community-based programs is an important trend in improving dental education to meet the needs of students and the public. In the recent Institute of Medicine (IOM) report (July 2011), Improving Access to Oral Health Care for Vulnerable and Underserved Populations, a recommendation was made for dental professional education programs to require all students to participate in community-based education rotations with opportunities to work with interprofessional teams. Virginia Commonwealth University School of Dentistry students are already visible in the community through participation in the school's community based education program which encompasses community service and service-learning.

Community service is donated service or activity that is performed by someone or a group of people for the benefit of the public or its institutions. The focus is on service and the beneficiary is the recipient of the service. Service-learning, like community service, seeks to make a valuable contribution to the community.

Unlike community service, service-learning is designed to promote the curricular goals of specified coursework through the application of academic learning in service settings. Structured reflection activities promote critical thinking and provide a means through which the relationship between service and academic coursework can be understood. In service-learning, the focus is on service and the learner with the beneficiary being the recipient and the provider of the service. Students, community partners, and the public all benefit from service-learning. Providing students with clinical experiences in community-based settings improves their comfort level in caring for vulnerable and underserved populations and fosters a sense of civic responsibility.

During the community education/service portion of the dental hygiene curriculum, students are required to participate in community-based health or oral health activities. The projects include, but are not limited to, participation in a community health fair, providing oral health care information and instruction to staff in nursing homes, providing oral health care service to nursing home residents, and developing oral health education lessons for pre-school children enrolled in Headstart programs. Students may choose the project most interesting to them and are encouraged to pursue development of an activity that meets the needs of the group they have chosen. Throughout the program, dental hygiene students are required to volunteer 35 hours of community service

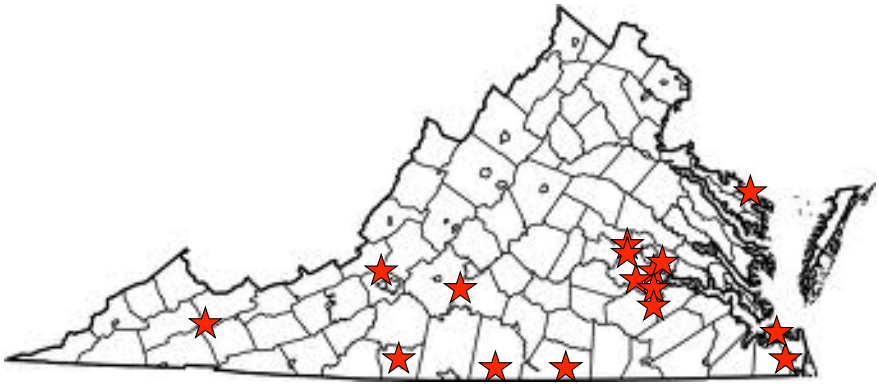
to helping meet the needs of a community. This year, dental hygiene student participation in outreach projects included but was not limited to: Salvation Army Dental Outreach, Give Kids a Smile Day, CARITAS Health Screening, and the VDHA Rappahannock Indian Care Project. The Salvation Army Dental Outreach program, organized and implemented by dental hygiene members of the Student Chapter of the American Dental Hygienists' Association, received the VCU Council for Community Engagement 2011 Currents of Change Award in Exemplary Partnerships with Teaching and Learning. In addition, the School of Dentistry received a Community Engagement Grant for its collaboration with the Department of Gerontology for the creation of a dental fair for Native Americans in Virginia.

Through community service, the School of Dentistry plays a significant role in the Virginia Dental Association's Missions of Mercy (MOM) projects. Dental and dental hygiene students from all class years, pre-dental students, faculty, and staff from the school typically comprise up to half of the volunteers at these service missions. The missions are two- to three-day events conducted in MASH-like settings in tents, open shelters, or large rooms in public buildings. Projects are conducted in identified, underserved areas of the state in response to need among underserved and uninsured patients. Wise and Grundy in the mountains of southwest Virginia, the rural Eastern Shore, and inner city Northern Virginia are visited every year. Newer sites include Emporia, Petersburg, Goochland, and Gloucester. In June, the School of Dentistry and the MOM project partnered with the Special Olympics, Special Smiles program where 114 patients received an estimated $34, 526 in free dental services. Recently, the project has included VCU pharmacy, medical and social work students who provide health care referral and follow-up for the dental patients. The Virginia MOMs see more patients at any two-day or three-day dental project than projects in any other states, due in large part to the participation of the VCU volunteers. To date, over 42,000 patients have been provided with more than $25 million worth of free dental care. Virginia's MOM projects have broken records for the largest dental outreach clinics ever conducted in the United States and have been used by other states as a model.

Reflective of the university's mission for health care that strives to preserve and restore health for all people, the Jamaica project provides dental services to the rural population of Trelawny Parish in Jamaica. In 2010, 18 students participated for three weeks. In all, the group performed over 4200 dental procedures totally in excess of 400,000.

Currently in the School of Dentistry, dental and dental hygiene students are enrolled in university-designated service-learning courses. To earn designation as a service-learning course, a course must meet specific exemplary practice standards. As a component of these exceptional courses, students help to meet community-identified needs through community service in assigned external clinics. The VCU School of Dentistry seeks to cultivate partnerships with clinics that will be diverse in the types of community-based settings and populations served by the clinical programs. Standardized protocols and rigid criteria are used for selection of our community-based clinical training sites and for selection of preceptors for students. Site selection is based foremost on the educational value of the experience and may include opportunity to work with special populations, including the socially and culturally disadvantaged, and to practice in alternative and non-traditional settings.

The service-learning program was built incrementally from its establishment in 2003-2004 as the preceptorship program. The program began with the development of three community-based sites, two of which were implemented; Northern Neck Fee Health Clinic in Kilmarnock and the Fee Clinic of Central Virginia in Lynchburg. Student placement in 2003-04 was 30.5% for senior dental students and 36.8 % for senior dental hygiene students. Since its inception, the program has experienced positive growth. To date, fourteen additional sites have been added to service making a total of sixteen community-based



16 Community Partners – diverse in community-based setting and population served by the clinical service-learning program

partnerships. Combined, fourth year dental and dental hygiene students now spend an average of 30 days per year working in public clinics throughout the Commonwealth. Each community partner is funded individually by a vast array of sources, including grants, foundations, donations and/or patient payment via insurance or self. All sites bear the burden of cost in hosting students for the provision of care to their underserved populations. The School of Dentistry receives no funding to support the development, implementation, and maintenance of substantial community-based education rotations. Further, the school is not budgeted by the state to be able to provide indigent care or to operate clinics that can provide free care.

In a 2006 article published in the Journal of the American Dental Association, Howard Bailit, D.D.S., and colleagues wrote, "The underserved population consists of 82 million people from low-income families. Only 27.8 percent of this population visits a dentist each year. The primary components of the safety net are dental clinics in community health centers, hospitals, public schools and dental schools. This system has the capacity to care for about 7 to 8 million people annually. The politically feasible options for expanding the system include increasing the number of community clinics and their efficiency, requiring dental school graduates to receive one year of residency training, and requiring senior dental students and residents to work 60 days in community clinics and practices. This could increase the capacity of the system to treat about 10 million people annually." Bailit et al acknowledge that even such an increase in capacity would fall far short of meeting the needs of the vast majority of underserved patients. He states further, "The majority of low-income patients would need to obtain care in private practices to reduce access disparities." Ensuring access to oral health is not solely the responsibility of dental schools; the responsibility must be shared by a multitude of stakeholders.

The vision for equal access to quality oral health care requires a multitude of actions by leaders at federal, state, local, and community levels in concert with oral health and other health care providers. The activities of the School of Dentistry's community based education program are part of this broader spectrum of strategies designed to eliminate oral health disparities, improve access to comprehensive, high-quality oral health care services, and increase the number of oral health care providers working in underserved patient populations.

Why Research in the Dental School is Important

By: David C. Sarrett, DMD, MS; Dean, Virginia Commonwealth University School of Dentistry

When I began to learn operative dentistry and dental materials in dental school, the enamel acid etch technique for bonding resin restorative materials to the tooth had recently become a standard technique. This was nearly twenty years after Dr. Michael Buonocore first described the use of phosphoric acid to increase adhesion of acrylic resins to enamel. Buonocore's research led first to dental sealants and later to bonded composite restorations. I was taught to coat all exposed dentin in the cavity preparation with a calcium hydroxide liner (Dycal®) prior to using the liquid etchant. In fact, the prevailing thought was that application of the acid etchant penetrated the dentin and caused pulpal damage. Post-operative sensitivity following composite restorations was often attributed to acid damage to the pulp. As students, the faculty warned us to never get etchant on the dentin. About fifteen years later, Dr. John Kanca first reported using phosphoric acid to condition dentin to create adhesion to dentin. Kanca was widely criticized by the "old guard" of operative dentistry. Eventually, Kanca's method was seen as a breakthrough for creating adhesion to dentin. As students today, you cannot even imagine performing a composite restoration without the use of an acid conditioner on dentin, either using a gel etchant or some type of self-etching system.

So what is my point? Well, my point is today we accept acid conditioning of dentin as absolutely necessary to achieve dentin bonding, which is exactly opposite of what my instructors taught me to do. What was thought to cause pulpal necrosis is now part of a scientifically proven treatment method. Seems odd! What are we teaching today that will eventually be shown to be scientifically wrong and replaced by new ideas? Why does this happen? It happens because research performed by people like Buonocore and Kanca questioned the accepted science and practice. Most of the basic science in the development of dental adhesives has taken place in dental schools and dental research institutes. Faculty who are engaged in research question what they do and teach. The act of questioning the science and practice they were taught is what moves the curriculum forward for today's students.

VCU School of Dentistry has a long history of faculty research. The school has received continuous funding from the National Institutes of Health (NIH) and other external agencies and foundations to carry out research for many years. Funding from the NIH is considered a benchmark for separating dental schools who are seriously engaged in research from those that are not. The research at VCU benefits our students because the faculty must stay up-to-date to perform research. For many individual students, being in a research dental school like VCU has provided them the opportunity to engage in research and question science and practice. One of Virginia's noted oral and maxillofacial surgeons, a Past-President of the American Dental Association, Dr. Ronald Tankersley is often heard saying, "To maintain our profession's credibility, our practices must be based upon sound science and critical thinking, not our personal needs and desires." Research and science is what separates dentistry and dental hygiene from being a trade.

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Editor's Note: Dr. Sarrett's article appeared previously in the Probe, the student newspaper of VCU School of Dentistry

VCU Oral & Facial Surgery: A Higher Purpose

By: Dr. Robert A. Strauss, Professor Director, Residency Training Program Dept of Oral and Facial Surgery
VCU School of Dentistry and MCV Hospitals

VCU Oral and Facial Surgery, like most of the other postgraduate programs at the school, participates in a variety of local and regional charitable and humanitarian programs. While the Missions of Mercy programs around the Commonwealth are perhaps the most visible of these efforts, our faculty and residents have volunteered with the American Cancer Society, the Virginia Dept of Health, the Veterans Administration Hospital, and many other national and international organizations to provide surgical services to those in need. In fact, the residents are encouraged to spend time on these mission trips and are provided time off, and when possible, funding (via our "residents fund) to do so. We consider it a responsibility of our specialty to "give back" to our global community, and both the faculty and the residents take that responsibility very seriously.

While almost all of our faculty and residents participate in some form of mission surgery both during and after their residency training, two of our residents deserve special mention as being representative of the kind of surgeon we hope to produce: ordinary surgeons who seek out the opportunity to use their talents in extraordinary ways. Our mission statement notes that we strive to train "superior oral and maxillofacial surgeons who are capable of practicing, the wide scope of the specialty in an ethical, compassionate and knowledgeable manner". While we think we do that well, we like to aim a little higher.

VCU Oral and Facial Surgery has a long history or producing extraordinary surgeons. In addition to the many fine clinicians that have graduated our program, many have gone on to become Residency Program Directors, Departmental Chairs, Deans, and Presidents of State and National Organizations (our own Dr. Ron Tankersley is, of course, the Immediate Past President of the ADA). However, even amongst that impressive group, Dr. Tim Bartholomew is perhaps the most remarkable graduate of our training program.

After completing residency, Tim knew he didn't want to enter private practice but was unsure of exactly what to do. He felt that he had a calling to be something more than just a good clinician who makes a nice income. After spending a year in an Orthognathic Surgery Fellowship he met two missionary general surgeons that had spent time in Africa. Their story inspired him and he decided that his Christian background meshed perfectly with his need to use his surgical knowledge for something other than monetary security. Convinced that his future was mission surgery in Africa, Tim spent the next two years in additional fellowships to improve his skills in cancer, reconstructive, and craniofacial surgery.

For the last 6 years, Tim and his wife Huyen (a family physician he met while in Cambodia at a CE course) have practiced in Niger, Gabon, Cameroon and Mali. The conditions they operate under are spartan at best, and primitive at worst—using flashlights for surgery when the power goes out (as it often does), reusing metal bone plates and screws donated by surgeons in the USA after their removal from patients, and since Huyen has O-negative blood, even providing their own blood emergently when needed by one of their patients. They often even have to provide their own general anesthesia since there are few anesthesia providers in rural Africa (luckily, our OMFS residency program is very heavily weighted in anesthesia training and our residents are quite comfortable providing intubated general anesthesia for cases like these. Tim has also taught anesthesia to Huyen who has become quite the anesthetist herself!).

Facing obscure diseases and conditions that American surgeons only read about in textbooks, such as massive grapefruit to cantaloupe-sized tumors

Figure 1

(Figures 1, 2a and b), advanced cancers, NOMA, and huge facial deformities and defects, Tim sees and treats things that requires him to innovate (he regularly has to become a "MacGyver" to re-create instruments, devices and equipment that we take for granted here). He has, on numerous occasions, even paid for patients to have surgery out of his own pocket—not a big deal until you understand that, since his graduation, at most he has earned about $800 per month for his service!

Every few months, Tim sends out a short

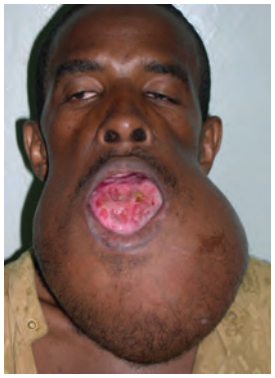


Figure 2A

Figure 2B

newsletter that describes some of his recent cases to his supporters (which can be financial or a part of his "brain trust"—a group of clinicians around the world who provide knowledge, supplies, or consults via email, pictures, or soon, video teleconferencing). He tells of his many successes—the child with Noma who has lost his nose and a part of his eye socket that Tim was able to reconstruct with bone and soft tissue grafts (Figure 3), a cancer patient that has done well after Tim removed the tumor and did bilateral radical neck dissections (there is no real hope for radiation or chemotherapy in this environment), excision of most of a patient's mandible for an ameloblastoma that he reconstructed with a "gently used" bone plate sent to him by an American surgeon, or has repaired a

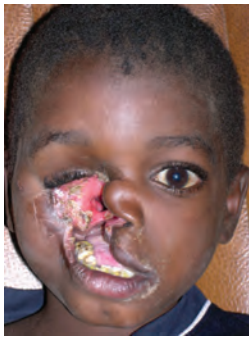


Figure 3A

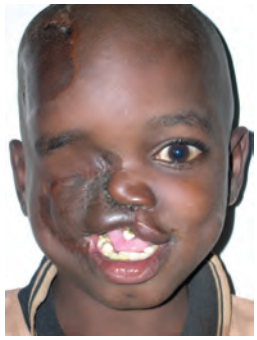


Figure 3B

severe facial cleft. The patients are usually very appreciative and the stories are amazing and heart-wrenching.

While all of his stories are heart-wrenching, some are equally heart-breaking. He recently told the story of 2 year-old twins, a boy and a girl, who both had cleft lips and palates. The boy was brought in for surgery and was well-dressed and clean. The girl was not brought in and when questioned, it was clear that the parents (like many families in Africa) did not feel it was worth spending any time

or money on a girl since she could not work and would never be pretty enough to marry. When Tim offered to operate on the girl for free, she was brought in, but in dirty and tattered clothing, starved for love and attention. It is often the case in Africa that a family with a deformed child will abandon the child altogether—figuring it is cheaper and easier to just make a new child than to fix this one!

Dr. Bartholomew needs that "brain trust", as he is often called upon to perform surgeries that tax even his extensive surgical experience. As he may be the only surgeon within hundreds of miles or more, he sometimes has to treat patients with conditions that require drastic or immediate action. When this happens, he contacts one of his consultants who will walk him through the diagnosis, management or surgery. This has included consultation with a neurosurgeon when presented with a large encephalocele in a baby (Figure 4), or a child who was badly burned as a baby and now had such extensive scarring and contracture of the neck and torso that he could move his arm because it was connected to his face. Consultation with another surgical specialist allowed him to perform the needed scar release surgery while consultation with a physical therapist allowed him to instruct the patient on appropriate exercises to maintain the result. (Figures 5a, b)

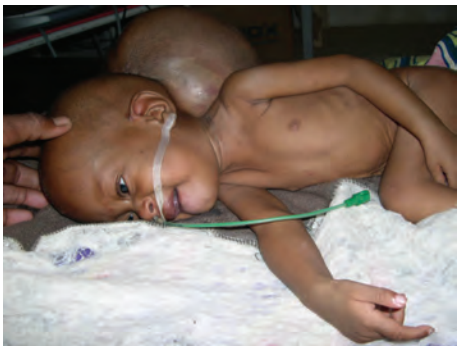


Figure 4

I remember well a case that Tim related to me and left me speechless. An older man with a cancer presented to "Likita Tim" (Dr. Tim). After multiple surgeries it was clear that the disease was too far advanced.

Figure 5B

Figure 5A

Over the course of his extended treatment, they had developed a strong bond. As a result, Tim and Huyen personally accompanied the patient, by stretcher, on a grueling 14-hour, 700 Km train ride to bring him back to his family and village. He desperately wanted to die in his village. Four days later he passed away. Tim described the terrible feelings of inadequacy that all surgeons feel when we are unable to cure a patient. Especially ones we like. Yet Tim said it best in his newsletter: "We try to help suffering people here with medicines or a scalpel and some die despite us doing what we think we should have. That's when you often wonder what you're doing here. We know we're not going to save the world, Africa or even Cameroon, but we know God can use us now and then to touch a life or save one. We have to remember for every patient we lose, there are hopefully many more people we help medically or surgically, make their lives better, and can form friendships with. We learn from our mistakes." For his selfless efforts, in 2010 Dr. Bartholomew was presented the American College of Oral and Maxillofacial Surgeons Humanitarian Award, the highest award given by that prestigious national organization and one of only 11 such awards in their 36 year history.

Not all humanitarian efforts require living in sub-Saharan Africa. Dr. Rob Doriot practices in Northern Virginia. He removes wisdom teeth, places dental implants, performs osteotomies and treats facial fractures just like most other OMSs. But, once a year, Rob "gives back". In 1990, as a 3rd year resident, Rob accompanied the well-known and venerable Richmond oral and maxillofacial surgeon, Dr. Phil Peters, on a trip to French New Guinea (that's at the tip of South America for the geographically-impaired) to treat kids with cleft lips and palates under the aegis of the International Hospital for Sick Children. It was a pilot program and it went so well that he and Dr. Peters repeated the trip the following year. In 1992, Rob (then an attending surgeon) led the trip himself accompanied by one of our senior residents. French New Guinea was a difficult and dangerous place, even for a missionary surgeon. In 1993, the opportunity came up to begin a new program in Honduras with a local Richmond organization, the Friends of Barnabas (FOB). FOB had a more elaborate infrastructure, including a full-time facility in Honduras and year-round medical staff and nurses who could care for surgical patients after the mission team left to insure continuity of care (a common problem with itinerant missions—they come, do surgery, and leave. Complications go untreated and often the patients are left in worse shape than before). Since that first year, Rob has annually led a team of nearly 15 oral and maxillofacial surgeons, OMS residents, anesthesiologists, floor and recovery room nurses, operating room technicians and interpreters (and now, he has even added art-therapists) on the OMS Cleft Lip Mission. Over the intervening years the team has included many residents who continue to go to Honduras with FOB or have joined or developed other mission teams of their own. Like any good leader, Rob knows that the key to really helping in the long term involves training more surgeons (both MCV surgeons and local surgeons in Honduras) to continue and expand the program.

I have had the opportunity to join Rob for the last 3 years on these trips and it has been an eye-opening experience. The opportunity to see a 6 month-old baby transition from failing to thrive due to the inability to suck on a bottle to become a smiling, happy baby from a 2-hour surgery is wondrous. Much like Africa, in rural Honduras many of these children are outcasts (although unlike Africa, the majority of the parents are fiercely protective and loving to their clefted and deformed children). In the 6 days there, Rob's team sees an average of 80 consults and performs between 30 and 40 surgeries. (Figures 6-8)

Figure 6A

Figure 6B

Although the team primarily performs cleft lip and palate surgery, occasionally the opportunity arises to change a life that we cannot pass up. One such example is a 20 year- old female who came to see us three years ago in the unlikely event we could help her. As a small girl she was badly burned and suffered severe scarring of her face and neck to the point that contracture had left her unable to lift her head, which was essentially attached to her neck

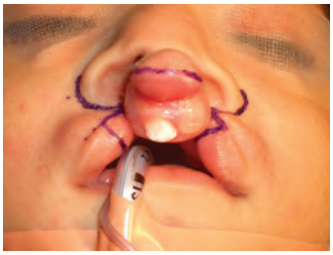


Figure 7A

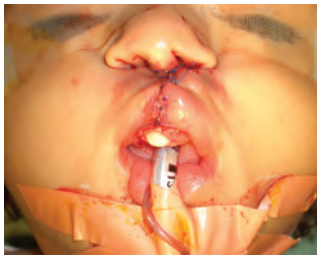


Figure 7A

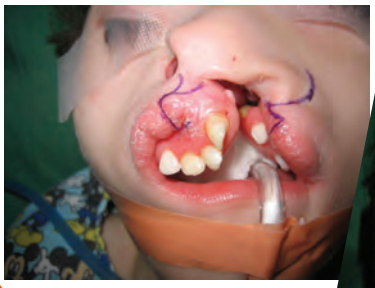


Figure 8A

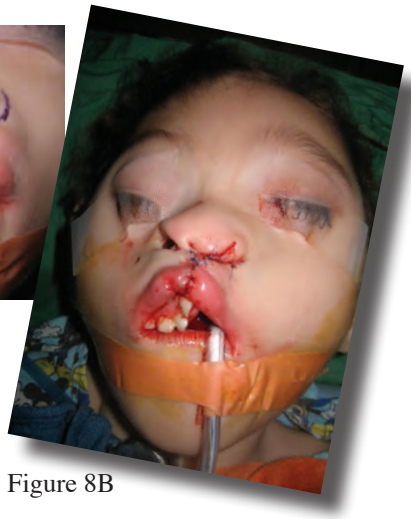


Figure 8B

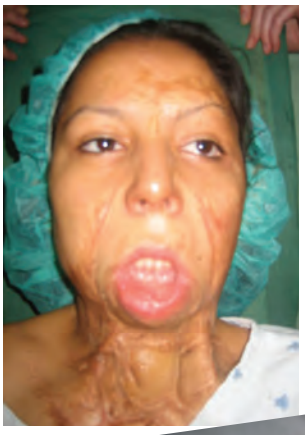


Figure 9A

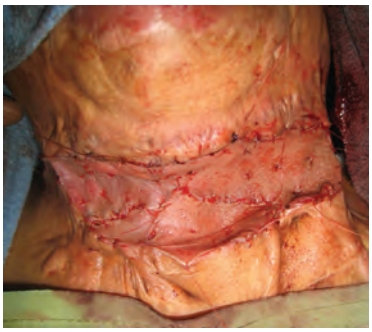


Figure 9B

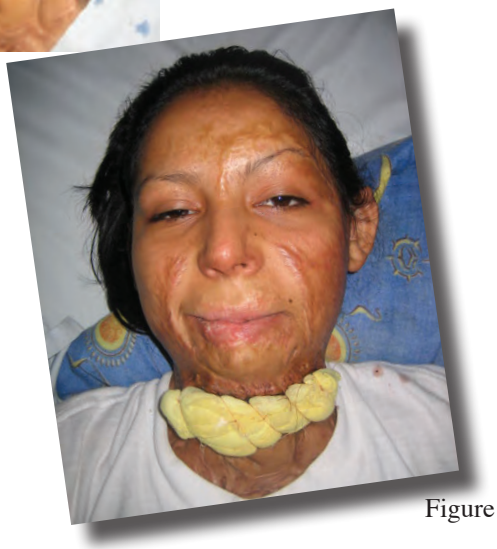


Figure 9C

and shoulder. When she presented, she was chronically sad and depressed. Because we didn't have the correct instruments to correct this problem, we told her to come back the next year and we would fix her up. I am sure she thought we would never remember her, but sure enough she came back the next year and we did indeed remember to bring all the needed items. We performed a wide scar release and, now that we had the right equipment, placed a large skin graft from her leg to her neck. As she was awakening in the recovery room and realized that, for the first time in nearly 15 years, she could lift her head, she began to sob. Then we all began to sob. But, soon the sobs turned to a smile (something she had actually been physically unable to do for those 15 years as her lower lip was also connected to her neck). Then we all began to smile. (Figure 9a-c). To this day, I can still see that smile, and it motivates me.

I would love to say that it is the VCU/MCVH OMS residency program that creates surgical leaders like Drs. Bartholomew and Doriot. But, realistically, it is not true and I know it. The program is but the conduit for exceptional people to focus their skills and desires. The real point is that it only takes one person—one person with a dream-- to fulfill the dreams of many others. As a program director, I go to work each day knowing that standing beside me in the operating room is perhaps another resident who will go on to become the next "Likita Tim" or Rob Doriot, someone who has the wisdom to have hopeful dreams, and the courage to believe enough in him or herself to trust that those dreams, with a little luck and a lot of hard work, can come true.

Legend of Figures

Figure: Large pendulous mass of right submandibular area. Masses such as this are usually benign and have been present for years.

Figure 2: A. Large ameloblastoma of mandible. B. After resection of the mandible and bone graft

Figure 3: A. NOMA of the right face with loss of nasal and orbital tissue. B. After debridement and repair by flap transposition and removal of the right eye.

Figure 4. Large encephalocele with extrusion of the brain and its covering tissues. This required Dr. Bartholomew to repair this and place of a shunt from the ventricles of the brain to the abdomen in consultation with a neurosurgeon in another country.

Figure 5: A. Severe scarring and contracture following a burn injury as a small child. B. Dr. Bartholomew and patient following scar release. Note the excellent range of motion of the arm.

Figure 6: A. Unilateral cleft lip. B. After repair

Figure 7: A. Bilateral cleft lip. B.After repair

Figure 8: A. Severe cleft lip and deformities. B. After initial repair. This will require several more surgeries for more complete repair.

Figure 9: A. Patient with severe burn scars causing inability to raise her head and depression of the lower lip. B. Split thickness skin graft from leg sewn into neck after scar release. C. Postoperative result showing the patient elevating head and her ability to gain lip closure now.

A Tale of Two Continents - My Experience at Orthodontics@VCU

By: Dr. Ahmad M. Hamdan

Background

The rivalry across the Atlantic has been present since the beginning of modern times. In particular, between the British with their "stiff upper lip" and the American "Yanks." Such rivalry and subsequent stereotyping has filtered into to the Arts and Sciences and, for the purpose of this article, into Dentistry and Orthodontics in particular. To put things into perspective, I think it fitting to give a brief outline of my background. I am a Jordanian national who was born in Lebanon. I received my dental degree from the University of Jordan in Amman, and, after being awarded a four-year joint scholarship from the British Council and the University of Jordan, I obtained a Masters in Dental Science (Orthodontics) and PhD from the University of Birmingham in the U.K. I also hold a Membership in Orthodontics from the Royal College of Surgeons of England. Most of my orthodontic career has been spent in Academia as Chair of the Department of Child Dental Health and Orthodontics at the University of Jordan and Lecturer in Orthodontics at the University of Birmingham, U.K. So in terms of my orthodontic background, it is British to the core.

It is for this reason that I sent an e-mail over a year ago to Professor Steven Lindauer, Chairman of the Deptartment of Orthodontics at VCU, asking if he would be kind enough to allow me to visit the Orthodontic Deptartment. The goals of this visit were twofold: to enrich my experience with the added knowledge of how orthodontic patients are treated in the U.S. and to establish a collaborative research project(s) with my colleagues at VCU. In addition, I was intrigued to see for myself if the myths of how U.S. orthodontists provided treatment for their patients were really true. I was very pleased that my request was positively received, and, after meeting with Professor Lindauer at the American Association of Orthodontists meeting in Boston two years ago and numerous e-mails flying back and forth across the Atlantic, the stage was set for my visit. It was really much more than I had anticipated. First of all I was able, with the help of Professor Lindauer, to obtain a "Restricted" license to practice at the Orthodontic Deptartment at VCU. This meant that I would be able to participate in all aspects of teaching and patient care. I would finally be able to see for myself what the "Yanks" were up to first hand and report back to the "Empire."

How are we alike?

There is no doubt in my mind that clinicians on either side of the Atlantic (and around the world) strive to provide the best possible care for their patients, and Orthodontics@VCU is a prime example of an institution that seeks excellence in everything it does. There is very little difference in the way we examine and assess orthodontic patients both clinically and radiographically. Our treatment goals of providing patients with ideal esthetics and function are the same. The orthodontic appliances we both use for treatment are similar, if not identical, and treatment procedures are based on the same mechanical principles. In addition, we both appreciate the limitations of orthodontic treatment alone in patients with severe skeletal and cranio-facial discrepancies.

How are we different?

After reading the above section, you may be thinking that there is not much left to be different. So how are we different? Well, we all start at the same point and strive to achieve the same end result; however, the difference is in how we get from A to B.

Our treatment planning philosophies differ: in the U.K., Residents are educated to start treatment planning with the lower arch where the teeth are in a zone of balance between the tongue on the inside and the lips and cheeks on the other, and then fit the upper arch around the lower. This means that tooth movement in the lower arch is largely restricted in the antero-posterior and transverse dimensions. And the lower arch form should be maintained (with few exceptions). Similarly, Residents at VCU are educated to start treatment planning with the lower arch; however, the restrictions on changing the lower arch form are much less rigid. The philosophy behind this method places more emphasis on facial esthetics.

What this all means is that proclination or bringing the lower incisors forward is more common in the U.S., whereas in the U.K. it is only restricted to those cases where it is believed that the incisors have been "held back." Examples of this are the presence of a digit sucking habit or a Class II division 2 malocclusion with a deep bite. Inevitably, the presence of all but mild crowding in the lower arch is likely to be resolved by extractions in the U.K. Maintaining the stability of the lower arch form provides justification for these extractions.

You can imagine my confusion when I first started attending treatment planning sessions, the lower arch form was no longer sacred! The question on everyone's mind now is: do orthodontists in the U.K. extract teeth more frequently than in the U.S.? In my opinion, and after spending eight months at VCU, the answer is no. Surprisingly, the treatment plans being presented around the room were very similar to mine. The reason for this was that we both would not consider pushing lower incisors that were already proclined further forward. In addition, even if the plan was to procline the lower incisors, you would have to procline your upper incisors too or else you may end up with a reverse overjet, and you really cannot do this if your upper incisors are already flared (proclined) because this would be unpleasing esthetically. The only exception would be a patient who had an increased overjet and lower incisors that were not already proclined. So it seems that our paths for getting from A to B are not that far apart after all.

Another difference was the more frequent use of removable orthodontic appliances as an adjunct to fixed appliances in the U.K. compared to the U.S. These are not functional appliances, rather acrylic plates with a variety of bite planes and active springs or screws used to assist and simplify orthodontic treatment.

How have I been influenced?

First and foremost I have had the pleasure of being acquainted with a distinguished group of fellow colleagues. I have experienced "southern hospitality" at its best, and the experience has exceeded all my expectations. Everyone I have met in the dental and orthodontic community in Virginia has been extremely friendly, courteous and helpful. Clinically, I have been able to experience different treatment philosophies and learn new ways of providing the best possible treatment for my patients. I have also seen some of the best treatment results.

Continued on page 28

WREBs: A Roadblock or a Detour for Today's Students?

By: Heather Brooks, VCU School of Dentistry, Class of 2012

The road to becoming a dentist is strewn with many obstacles, potholes, and bridges to cross: from educational excellence as an undergraduate and acceptance to dental school, to the initial exams and labs, and then, practicals and competencies. Each obstacle serves as a training session, propelling the student to excellence and preparing him or her for the championship game of dental school: the Clinical Licensure Board. While we may not receive a gold medal or championship ring, regional boards are the final event – the culmination of years of training, in which students become doctors, licensed to practice. Preparing for and taking any national examination can be stressful, but for those students at the VCU School of Dentistry who intend to take the Western Regional Examination Board (WREB) this year, the stress and difficulty of regional boards has been intensified.

For many years, a large number of students from Idaho and Utah, states that had no dental school, attended VCU School of Dentistry. For many out-of-state students who intend to go to their home state to practice, the WREB is the Clinical Licensure Board that they must pass. The WREB is accepted by fifteen states: Alaska, Arizona, California, Idaho, Kansas, Missouri, Montana, New Mexico, North Dakota, Oklahoma, Oregon, Texas, Utah, Washington and Wyoming. Alaska, Arizona, California and Oklahoma accept only the WREB. VCU has hosted the WREB for many years in order to aid the many out-of- state students who attend the dental school.

Last year the WREB executive committee expressed to VCU that the minimum number of examinees required to cover examination expenses had been set at thirty. Sadly, VCU's numbers did not measure up. VCU typically has declared WREB students in the low twenties, with the out of state component an unknown entity until weeks before the examination. Even with the examinees coming from other states, the total number of persons challenging the exam was never thirty or above. As the graduates of 2011 readied themselves for their impending clinical licensure boards, those taking the WREB were devastated by the announcement (with only five weeks' notice) that the exam would not be held at VCU. Students had to make a quick decision: would they take the Southern Regional Testing Agency (SRTA) exam and change their intended location of practice, or take on the added finances and logistics that come with practicing in their home state? Some students changed their intended path, others persevered.

For those students who decided to stay the course, they had the added difficulty of arranging travel to the examination site, acquiring materials and instruments, and the logistics of getting their patients to and from the location as well as providing lodging. Regional boards cost roughly $2500 to take the exam. The nearest WREB testing centers are in Boston and Kentucky, which will add geographic challenge to their preparation. The WREBs occur over three and a half days, in which students have both patient-based and mannequin-based sections. The WREB requires three patients, assuming one patient does not have the needed Class II lesion to be restored with amalgam, Class II/III lesion to be restored with composite, and supra/subgingival calculus that meet the requirements of the periodontics section. Not only would the student have to travel twelve or more hours, but also he or she would have to provide travel and lodging or compensation to each board patient. The student could choose not to bring patients along for the patient section and depend on the hosting school to arrange an adequate patient, a risky endeavor for such an important and expensive exam. Additionally, the host school may not allow instruments from another school and require that students pay a rental fee, which can be upwards of $500. The graduates of 2012 are being faced with a similar dilemma: earlier this year, the executive committee of the WREB announced that it would not host the exam at VCU this year.

Dr. Paul Wiley, faculty liaison to the regional boards for VCU spoke with the committee and encouraged them to reconsider, as there were 19 to 21 students in the class of 2012 that had announced their intentions of taking the WREB this coming spring. Despite his petition, the committee stood by their decision, which they felt would give students ample time to arrange to take the exam at another site. Thankfully, VCU still has every intention of having Mock Boards for those students who still wish to take the WREB. Unfortunately, a national board is an idea on the horizon that will not benefit students this year. While students may have added difficulties in arranging their big day, they will be just as well prepared as those taking SRTAs at their home school.

Continued from page 27

How might I have influenced others?

I would like to think that I have been able to portray a positive image of my Jordanian origin and to bring closer the thinking on both sides of the Atlantic (at least VCU and the University of Birmingham, U.K.). Clinically, I hope that I was able to add to the knowledge and experience of Residents and Faculty at VCU and share with them a few other ways of getting from A to B.

What I / we have achieved

All the goals I had initially set were fulfilled and many more. I was involved in the clinical teaching of orthodontic Residents and dental students and provided clinical support by screening new orthodontic patients. I was involved in multiple research projects, and we were able to publish three joint papers in The Angle Orthodontist, The American Journal of Orthodontics and Dentofacial Orthopedics and The Journal of the American Dental Association. The publications were entitled: 1) Perceptions of soft tissue laser use in orthodontics: A survey of orthodontists, periodontists and general dentists 2) The development of white spot lesions during orthodontic treatment: Perceptions of patients, parents, orthodontists and general dentists and 3) Management of white spot lesions during and after orthodontic treatment: A perspective of general dentists and orthodontists, respectively.

A final word of thanks

Finally, I would like to express my extreme gratitude to Professor Steven Lindauer for making my wish to visit VCU a reality and for all his professional and personal support, to Professor Bhavna Shroff for making all the necessary clinical arrangements to allow me to have the best possible clinical experience and for her kind personal support especially for my family, and to Dr Eser Tüfekçi for getting me involved in the clinical teaching of dental students and her personal support.

Virginia and VCU will always have a special place in my heart, and I hope to maintain the strong relationships formed here on my return to The University of Jordan for years to come.

Secretary-Treasurer's Report - Post Fire

Excerpts from Dr. Sherwin's Report to the 2011 House of Delegates

By: Dr. J. Ted Sherwin, VDA Secretary-Treasurer 2011

In July of 2010 our headquarters building was struck by lightning resulting in the total loss of the building. What I've learned over the last year is that it's neither the destruction nor the loss that defines us, it's the way we handle ourselves in the face of challenges that is the truest indicator of the strength of the Virginia Dental Association. Today, I will suggest to you that the VDA is stronger than ever. Based on our remarkable recovery, I saw the true strength of this Association. And based on this strength we clearly demonstrated that not only does this association have the ability to recover, but even thrive in the face of difficult challenges. Therefore I am optimistic, as we look forward, that the VDA can determine its own future even in the face of the most difficult obstacles.

I want to report to you today, that throughout this year of recovery I have seen time and time again our resiliency to rebound and rebuild. And though we have been extremely fortunate, many of us have come to realize that brick, mortar, and money, while important, are not what make this Association so special. It's the service and commitment of our volunteers and staff that make us extraordinary. This lies at the heart of our strength.

So with this picture I stood before you last year, knowing the hard road we had ahead and yet confident that your leaders would make every effort possible to recoup the financial loss to the Association. I am happy to report that we exceeded our expectations. With much better than expected insurance payments

and the purchase and relocation into a new building, our prospects are brighter than we could imagined last year. You can be proud of your Officers, Board of Directors and of course our incredible staff for what they have endured and accomplished.

You may wonder how the VDA became financially stronger while suffering the loss of our Headquarters building. I can attribute our strong financial position to four causes:

1. The steadfast support from our for-profit subsidiary, The Virginia Dental Service Corporation-the VDSC

2. The better than anticipated insurance reimbursement for our building loss. Keep in mind that we paid $525,000 for our old building and land. And that current property assessments put the value of the just the old building near $600,000 the day of the fire. We had no loan on the building. We have received $893,000 from insurance for the building. When we sell our land, our total return for building and land will be about $1.1 million. Considering the real estate market of late, I hope you will all agree that this is an excellent return on our investment.

3. The third reason for our strong projected reserves is two incredible years of net profit from our Annual Meeting. In the last two years we've averaged over $100,000 net from the AM which add to our liquid assets.

4. Fourth and just as important; our early and consistent tough financial constraints on spending.

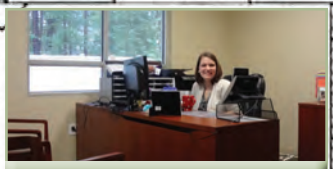
As you can see, we have some victories to celebrate this year and some concerns to challenge you, the 2011 VDA House of Delegates. It is up to you and our future leaders to sustain our successes and find new and bold approaches to keep our Association relevant in the future.

Tour the NEW Virginia Dental

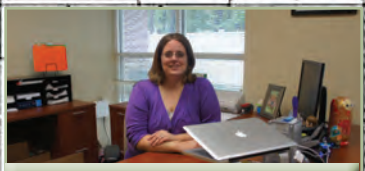
The Specs...

- **Address:** 3460 Mayland Court, Suite 110 Henrico, VA 23233
- **Main crossroads:** West Broad Street & Gaskins, off of Interstate 64
- **Many lodging and restaurant options.**

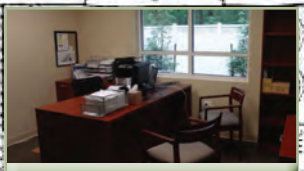
Kitchen/Break Area



Carter Lyons
Director of CE &
The Virginia Meeting



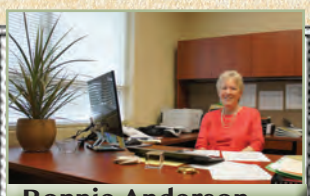
Shannon Jacobs
Director of Communications



Additional Office Space

Large Conference Room

Dr. Terry Dickinson
Executive Director



Bonnie Anderson
Director of Administrative Services

Coat Closet

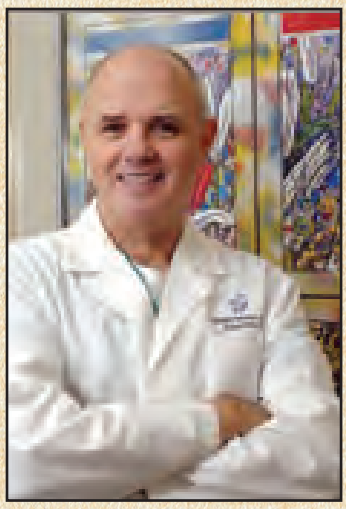
Entrance & Foyer

Association Central Office

- **Square Footage:** 6200 sq. feet
- **Offices:** 14 offices - all with windows
- **Restrooms**: 4
- **Conference Rooms:** 2
- **Storage:** 2-3
- **Workroom:** 1
- **Large Parking Areas**
- **Maximum Capacity:** 116

A Gift From Dr. Baxter Perkinson

New VDA Building outfitted with watercolors



"My thoughts were to put a variety of subjects, color, and sizes to bring interest to the new, wonderful space at the VDA. We dentists in the VDA should be proud of all that Terry and the VDA officers and leaders did to bring this project to fruition."

Dr. Perkinson

We Need YOUR Feedback...

The VDA is interest in receiving your feedback on our communication efforts. Please take a moment to give us your feedback on the questions below.

Mail completed surveys to: VDA Attn: Shannon Jacobs 3460 Mayland Ct, Ste 110 Henrico, VA 23233

or

Fax to 804-288-1880

This survey is also available online at http://survey.constantcontact.com/survey/a07e4vl7yulgsrmhe3n/start

1. Regarding the VDA Journal, do you...

☐ Read only the print copy that is mailed to you
☐ Read both the print and online versions
Other _____

2. The VDA Journal is now available online. Would you be willing to forgo the paper copy mailed to your home/office?

☐ Yes ☐ No

3. I would be interested in accessing VDA Publications with the following mobile options:

☐ Apple IPhone Apps ☐ Android Apps ☐ Mobile Website
☐ Not interested in mobile options

4. Do you keep copies of the VDA Journal for reference?

☐ Yes ☐ No

Why or why not?

_____

5. What VDA Journal feature do you read MOST often?

☐ Editorials and Commentary
☐ Scientific articles and abstracts
☐ University Connections
☐ Outreach and public service
☐ Membership News
Other _____

6. In your opinion, what Journal feature is LEAST important?

☐ Editorials and Commentary
☐ Scientific articles and abstracts
☐ University Connections
☐ Outreach and public service
☐ Membership News
☐ Volunteer Lists
Other _____

7. Do you make purchases based on advertisements in VDA publications?

☐ Yes ☐ No

Why or why not?

_____

8. What type of article would you like to see more often in VDA Publications?

☐ Peer-reviewed scientific
☐ Interviews
☐ Human Interest - dental related
☐ Human interest - non-dental related
☐ Legislative and advocacy
Other

9. In the past two years have you read the Etch online newsletter?

☐ Yes ☐ No

Why or why not?

_____

10. Please tell us what feature you like most about the Etch online newsletter?

☐ Ability to click on the links of many different articles on the web.
☐ Ability to click on advertisements and be taken to the companies' website.
☐ Financial features from Wayne Bullis
☐ Human interest articles
☐ Event and continuing education listings.
Other _____

11. The VDA is currently creating a new website. Please tell us what item is most useful on the current VDA website.

☐ Directory of Members
☐ Journal & Etch Archives
☐ CE/General Calendar
☐ Job Postings
☐ Endorsed Vendor Information (VDA Services)
Other _____

12. Do you recall receiving mass email communication from the VDA?

☐ Yes ☐ No

No, but I would like to. Here is my name and email address:

_____

13. Of the email communications you have received from the VDA, how would you rate there emails?
(1 - Strongly Disagree, 2 - Disagree, 3 - Neutral, 4 - Agree, 5 - Strongly Agree)

_____ Emails I have received are timely and contain good information.

_____ I can quickly determine that the email is from the VDA (a trusted source).

_____ I am able to click links within the email to obtain additional information.

14. Please indicate your age category (circle one):

18-24 25-30 31-40 40-50 50-60 60-65 65+

15. Other comments or opinions regarding these topics:

_____

_____

_____

Compared to our 100 years of experience, our competitors simply can't fill our shoes.

VDA SERVICES

It's hard to follow in Medical Protective's footsteps. No one else has over 100 years of proven experience defending malpractice claims. No other dental malpractice competitor's financial strength is ranked higher by independent rating agencies. And today, more than ever, the financial strength, integrity and powerful backing of Warren Buffett's Berkshire Hathaway is crucial to the quality of your dental malpractice protection.

Should you trust your career to the best or something less?

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a Berkshire Hathaway Company

Make Your Practice a Masterpiece

By: Dr. Tanya Brown and Ms. Laura Edwards

As 2011 draws to a close, it's a good time to take stock, turning an objective eye on your practice. Are you happy with how things are going? Are you attracting enough new patients for your practice to grow? Are you producing dentistry and collecting payments at the rate you should? If not, what can you plan on doing differently in 2012 so you meet or exceed your goals?

A healthy practice is one that attracts enough new patients to balance out patient attrition and keep the clinical team sufficiently busy. Take a look at your schedule. Are you happy with the number of patients you see each day? If not, now is the time to take a look at your marketing plan so you can enter 2012 with some momentum.

Start with internal marketing. Happy patients are your biggest asset. Cultivate ambassadors for your practice from within your patient base. Are they telling their friends and neighbors about your practice? Do they know that you are accepting new patients? Don't assume they know, be sure to tell them how much your office appreciates their referrals.

Then consider external marketing. Do new patients know how to find you when they are in need of a dentist? Phone book ads are no longer enough. Practices that lack a website or have an ineffective one will miss out on opportunities. Are you listed on Google Places? Does your practice have a Facebook page, Twitter page or Blog? Effective use of social media is a great way to let prospective patients get to know your practice.

Improving case acceptance is the path to improved profitability. Are you creating sufficient value in the mind of the patient for the dentistry you are proposing? Intra-oral pictures and other patient education tools are invaluable in helping the patient understand and accept the need for treatment. Practice the verbal skills used to discuss treatment and demonstrate the benefits. Make sure all the members of the team are using the same words. This is a perfect topic for a team meeting. You are having those regularly, right? Beyond the clinical, what about finances? If your patients have insurance, can you tell them what will be covered and how much? Real-time predeterminations and benefit verification can greatly improve your conversion rate by providing the coverage and financial details that the patient needs to say yes to treatment.

Cash flow is the lifeblood of the practice. Streamlining your insurance process is important to ensuring an uninterrupted flow of revenue. Take a look at your insurance denials. Denied claims cause unnecessary rework by your staff and greatly delay payment. Nearly two-thirds of claim denials are due to eligibility issues. You should verify benefits for each and every patient before every visit. Don't want to have your team tied up on the phone checking benefits? Automated solutions can streamline this process for you. What about patient payments? You should be collecting the patient portion at the time of service. If you aren't currently doing that, the beginning of a new year is the perfect time to change your office financial policy. Just be sure to inform your patients of the change and consider giving them a "grace period" if they are resistant.

These are just a few of the practice boosting strategies that will covered in the upcoming workshop Make your Practice a Masterpiece on Friday, December 2, 2011.

Workshop details:
Time: 8:00am – 3:00 pm

Place: Hilton Garden Inn, Virginia Beach Town Center

CE: 6 AGD Continuing Education credits under Practice Management (issued by Konikoff-Salzberg Periodontics)

Fee: $159 for the dentist or first attendee, $100 for additional team members

Register online at http://tinyurl.com/masterpiece-register ; call Melody Price at Konikoff-Salzberg Periodontics at 757-486-2796, or email info@center4perio.com.

Register NOW for the Emporia M.O.M. Project

Saturday, November 5, 2011

Greensville County High School

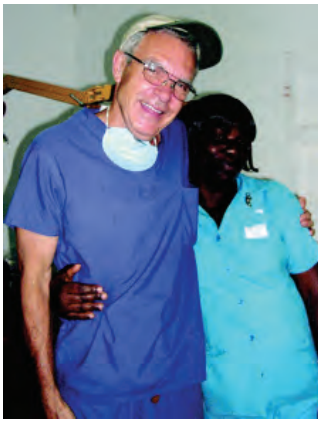
In a continued effort to decrease barriers to access to dental care, the Emporia Missions of Mercy returns Saturday, November 5, 2011 to the Greensville County High School gymnasium in Emporia, Virginia. Aimed at serving patients without dental insurance or without other access to oral health care, a wide range of patients from Brunswick, Sussex, Southampton, and Greensville Counties, the city of Emporia as well as other areas of Virginia and North Carolina will be treated for free. Hours on Saturday will be 8:00 a.m. to 5:00 p.m. Dr. Harold Neal and wife Jamie Neal, project organizers, say volunteers are also needed at 1:00 p.m., Friday, November 4, to screen patients prior to treatment on Saturday. Dentists, hygienists and assistants are encouraged to sign up as a large turnout is expected. This project is a partnership between the Southside Dental Society and the Virginia Dental Association, as well as a number of community partners.
More than 54 M.O.M. projects have been done over the past 12 years, treating nearly 42,000 patients with more than 25 million dollars in free dental care.

Lodging will be available for those staying overnight. A block of rooms has been reserved at the Hampton Inn in Emporia, at a rate of $79 per night. Please mention this event when making a reservation. For hotel accommodations, call (434) 634-9200. A dinner for volunteers is planned for Friday evening, and registration will be available online at www.vdaf.org. Questions concerning volunteer registration call (804)620-4032. Breakfast and lunch will be provided Saturday for all volunteers. An information packet will be mailed prior to the event.

Go to: http://www.vdaf.org/Emporia-MOM-Project for more information and to register

Christian Dental Society Inspires Smiles Worldwide

By: Dr. William T. Griffin



Dr. John Drescher & Friend

Reprinted with permission from *Dental Economics*

The Christian Dental Society has equipped and inspired Christian dentists to treat the needy for almost five decades. This organization gives American dentists, students, and auxiliaries the opportunity to serve in locations around the globe, including places where dental care is almost nonexistent.

The CDS traces its roots to 1962 when 12 interested dentists met in Miami, Fla., during the ADA convention. Dr. John McInnes, a dentist from Tucson, Ariz., became temporary chairman and the group named itself the Christian Dental Society.

The society opened its doors to Christian dentists of all denominations who were interested in working with foreign dental missions. CDS was formally organized in 1963 during the ADA convention in Atlantic City, N.J. The next year, the group was incorporated in Colorado as a nonprofit organization.

The primary purpose of the CDS is to publicize and facilitate dental mission trips for its members and others. To this end, CDS member services include inexpensive rental of equipment and instruments, information regarding upcoming trips around the world, and mentoring of dental students and new dentists in the exciting field of missionary dentistry. Fifty-two mission trips during the past year have included CDS equipment. Several hundred additional trips around the world involved members of the CDS.

While all of these trips provide much-needed services, conditions can vary greatly from one trip to another. Some mission trips use established clinics and have access to electricity and running water. Other trips to less-developed areas require dentists to carry their equipment and supplies on their backs from village to village. To meet the challenges of the latter, CDS has an inventory of efficient, lightweight, portable dental equipment. This includes chairs, headlights, handpieces, and sterilization systems.

In addition to its efforts to facilitate mission trip opportunities, the CDS hosts an annual conference for members and families. Past speakers at these conferences have included Jim and Naomi Rhode, Dr. Van Haywood, and Dr. Pascal Magne, as well as a host of experienced missionary dentists with some amazing stories to tell.

The following is an example of the type of work CDS does around the world.

Jammin' Jamaica

In 1979, while in college, Dr. Jim Carney was vacationing in Montego Bay, Jamaica. It was a most enjoyable trip, prompting him to want to return to the country.

But unwilling to merely enjoy all that Jamaica had to offer, he pondered, "What might I be able to do to help the wonderful people of Jamaica?"

A few years later, after completing dental school at the University of Iowa, he responded to an appeal from the Christian Dental Society to offer free dental services in Jamaica. Little did he know at the time just how involved he would eventually become.

Since that time, Dr. Carney, who practices in Lombard, Ill., has made more than 60 trips to Jamaica. He has also established seven dental clinics in various areas of Jamaica, enabling many others to share in this work. Approximately 70 to 80 dentists have accompanied Dr. Carney on these trips, many of whom subsequently returned to these clinics for additional trips.

In addition, about 160 dental students from schools such as Iowa, Temple, Pittsburgh, and Michigan have joined Dr. Carney on these trips. This has provided an excellent opportunity for the students to greatly expand their dental knowledge and experience by working with experienced doctors for patients who are most grateful for their services.

Dr. William Griffin standing, 3rd from left.

As Dr. Carney reflected on his many trips through the years, he commented, "I still love the people and feel energized each and every time I go."

Many of Dr. Carney's trips are a family affair, involving his wife, Sue, who is also a dentist, and their children, Kelly and Madeline, who have developed into most capable assistants. Dr. Carney describes this as "quality family time at its best."

The clinics that Dr. Carney has established have given other dentists the opportunity to treat the people of Jamaica without having to transport their own equipment. Dr. John Drescher, a veteran of 16 trips to Jamaica, is particularly grateful for Dr. Carney's clinics.

"They make it easier for me to go on missions to Jamaica," stated Dr. Drescher. "Things are more organized, and the clinics help us to establish a relationship with people in the community. The gratefulness of the patients we have treated has made me realize that we are really performing a much- needed service, and that we are appreciated and loved."

Hopefully the example above, focusing on the work of one of many ministries of the Christian Dental Society, gives a glimpse of the opportunities that exist to offer dental skills to the needy around the world. Members of the CDS share a strong desire to help the dentally underserved wherever they might be. But their incentive goes beyond humanitarian concerns. The care that is given is offered as a testimony to a loving God, who desires to show His love to people of every tribe and nation. Free dental care is offered to everyone possible, regardless of their religious beliefs. Those who receive treatment are also given an opportunity to learn about the inherent joy and peace that can be found through a personal relationship with Jesus Christ.

Dentists, hygienists, and assistants who desire more information regarding CDS membership and mission trip opportunities can visit the CDS Web site at www.christiandental.org. In addition, the home office may be reached at (563) 578-8887 or via e-mail at cdssent@netins.net.

Dr.WilliamT.Griffin has practiced dentistry in the Newport News, Va., area since 1983. According to Dr. Griffin, "Dentistry allows meto use myGod-given creativity to benefit others."He completed his doctor of dental surgery at the Medical College of Virginia. Reach him at williamgriffindds@gmail.com. Dental mission trip information may be found at www.dentalmissiontrips.com.

A family affair: Lysenkos Volunteer at Appalachian Clinic

By: Melissa Hale-Spencer

Reprinted with permission from
The Altamont (NY) Enterprise

Dr. Steven Lysenko handed a mirror to a woman who sat before him in a dental chair.

"She cried when she saw herself. She felt like she hadn't wanted to smile in so long," said Lysenko this week.

A long-time Voorheesville dentist, Lysenko had never seen this patient before yet she hugged him. The dental chair in which she sat was one of 70 set up in a tent on the fairgrounds in Wise, Va. in the Appalachian Mountain region of southwest Virginia.

"Music was blaring, people were talking," he said, describing the carnival-like atmosphere.

Lysenko, his wife, Laurie, and their two daughters were part of an army of volunteers working long hours for three days, from July 22 to 24, to provide medical care for people who needed it but couldn't afford it. The services — which, in addition to dentistry, included visual, audiological, and general medical care — were free.

Lysenko got interested in the project from his older daughter, Jennifer, a third-year dental student at Virginia Commonwealth University School of Dentistry. "She did this with some of her classmates last summer and found it very rewarding," he said.

Both the Lysenko girls are going to be dentists. "I guess I didn't complain enough about my work," quipped Dr. Lysenko. He hastened to add, "I love my practice, staff, and patients."

Lysenko, when he was his daughters' age, hadn't planned to be a dentist. He grew up in New Jersey and majored in biology at Alleghany College, then went on to Chapel Hill with the idea of earning a master's degree to become a professor. Halfway through, on the advice of a friend, he took the Dental Admission Test and did well. After graduating from the University of Medicine and Dentistry of New Jersey in 1983, he started practicing in Voorheesville.

"We've been very happy here," he said. His wife has been the school psychologist at Voorheesville for 28 years.

Jennifer graduated from Voorheesville in 2005 and Kristen in 2008. Both girls went to Cornell, where Kristen will start her senior year in the fall.
Her parents took her out to dinner this week to celebrate her good scores, like her father's, on the DATs.

All four of them piled into the family's car, packed with as much dental equipment as could fit, for the 14-hour ride to Virginia.

RAM and MOM

The three-day event was run by Remote Area Medical, known as RAM, in conjunction with the Virginia Dental Association. The association's website — www.vadental.org — says that one in five Virginians live in an underserved area — typically poor, rural communities. The working poor, the elderly, the disabled, or the uninsured "are often left without dental care to face extreme pain, discomfort, and embarrassment," the association says.

Consequently, the Virginia Dental Health Foundation launched the Mission of Mercy, known as MOM, where patients like those at the three-day clinic the Lysenkos were part of, are treated on a first-come, first-served basis.

The Lysenkos met RAM's founder, Stan Brock, who was on hand for the Virginia event.

"He's an interesting character," said Lysenko, who remembered Brock from his youth when he would watch Wild Kingdom on TV. "While Marlin Perkins was talking about the alligators or whatever, Stan Brock was the one who would jump off the horse and wrestle with the alligator or the anaconda," recalled Lysenko.

Brock is in his mid-seventies now, said Lysenko, adding, "He's in great shape." Brock's father was a British civil servant who was posted to the British colony of Guyana in South America. Stan Brock worked as a cowboy on the Dadanawa Ranch in Guyana in the 1950s.

"A half century ago," he writes in a "letter from the founder" on his RAM website — www.ramusa.org — "I was living in a part of the upper Amazon basin where health care was a 28-day march away on foot. I survived malaria, dengue fever, numerous wild animal attacks and various encounters with Longhorns and mustangs without the help of a doctor. Others were not so lucky and I buried a number of them.

"It occurred to me that designing an all-volunteer health and veterinary care program for such desolate places might make life easier for a whole lot of people," writes Brock.

"Extremely grateful"

A whole lot of people came to the July clinic in Wise. "We saw 1,200 people the first day," said Lysenko. "They came from miles around. Last year, people came from 12 different states. They came from as far as Florida and Texas. They traveled, some of them, for days to get there. They would camp in cars or pitch tents."

Lysenko himself tended to 12 to 15 patients a day. He and his family woke up in their hotel at 4:30 a.m. each of the three days to be at the fairgrounds by 5:30. They worked each day for 12 hours, from 6 a.m. to 6 p.m.
About 1,700 volunteers helped by doing everything from serving meals and caring for doctors' children to taking care of paperwork. Laurie Lysenko was one of the volunteers who did administrative work.

"There was no technical equipment and no staff; it was very primitive," said Lysenko. "I had what I could fit in my car." This included filling materials, hand tools, and a curing light to harden fillings.

"We saw all kinds of people," he said. Lysenko described a range from a pregnant 17-year-old with her upper front teeth missing to elderly people who had "broken-down teeth."

"Some people wanted to improve their teeth so they'd have a better chance of getting a job," he said.
Lysenko also said, "People were extremely grateful. They couldn't thank you enough."

While Jennifer Lysenko worked on rotations with her dental-school classmates, performing surgery, triage, and sterilization, Kristen spent the three days as her father's chair-side assistant.

"It was an eye-opener for her," said Dr. Lysenko. "I could explain a lot to her."
At the end of the grueling three days, Lysenko said, he was not tired. "No, every one was energized," he said. "We got much more out of it than the patients."

DELTA DENTAL'S Smart Smiles®

We're turning frowns upside down

Delta Dental's Smart Smiles® public outreach program reaches thousands of children and adults across Virginia every year. Through oral health research, education and access to care for the underserved, Smart Smiles helps support Delta Dental of Virginia's mission to improve the oral health of all Virginians.

DELTA DENTAL'S Smart Smiles® *In School*

Oral health education – through programs such as free, on-loan education kits to public schools, Radio Disney educational partnerships and support of oral health education exhibits in major area museums.

DELTA DENTAL'S Smart Smiles® *At the Dentist*

Access to oral health care – providing much needed oral health care and education to children who lack dental insurance or are eligible for Medicaid and FAMIS, through community partners such as Boys & Girls Clubs.

DELTA DENTAL'S Smart Smiles® *In the Community*

Community support – providing financial and volunteer support to charitable and philanthropic initiatives designed to improve oral health and enhance quality of life in communities throughout Virginia, including Mission of Mercy projects, Give Kids A Smile®, grants to Virginia's Free Clinics and support of Virginia's Dental and Medical schools.

Because everyone deserves a healthy smile

DELTA DENTAL®

800.533.4137 ext. 9
deltadentalva.com
(Community Outreach)

Another great effort by all in Wise!

Over 425 volunteers traveled from throughout Virginia and from 12 states (including WI, MI, IN, FL, KY, In, TN, NY, DC, MO and NC) to make this event possible. And, though patients were predominantly from Virginia, many others made the trip from a total of 15 states (as far away as Georgia, Florida, Ohio and Pennsylvania). 1,382 patients received dental care valued at $1.5 million during the 3 day project.

Treatment included:

1,963 fillings
3,575 extractions
331 cleanings and gross debridements
249 fluoride varnishes
33 root canals/pulpotomies
52 complete denture sets
17 complete dentures
20 partials
1,264 panorex/bite-wings/PAs

From 2000-2011, the 12 missions to Wise have provided 14,979 patients with over $11 million in free dental care.

We wish to thank each and every volunteer for sharing your time, talent and treasure. You ARE "making a difference."

Through 54 completed MOM projects 42,586 patients have received dental care valued at $24.9 million!!

Our Weekend in Wise County, Virginia

By: David Rothkopf, DDS; Washington, DC

Last year, I read an article in the *Washington Post* about the efforts of Remote Area Medical (RAM) and the Missions of Mercy (MOM) in Wise County, Virginia, and wanted to become involved. When I told my 28-year old daughter, Emily, she was excited to help as my assistant. We knew that many of the people in this part of the country had little access to dental care, and that there would be many people in need of our services.

So we registered for the event on July 22-24, 2011, and were amazed to see how many people were lined up, waiting overnight in their cars, hoping to be seen by a dentist. While we saw a few people that had good dental health and needed simple restorations, most of the people we treated were in very poor dental health. We tried to do as much as possible on each patient with the restorative options available, but many needed more advanced procedures. We saw one young woman who was my daughter's age and already needed a full denture.

Emily and I engaged in a conversation with everyone we treated. We wanted to get to know them as human beings—not just teeth that needed fixing. We asked the people about their jobs and their families, if they had health insurance, and how the current economy had impacted them. No one had health insurance, and many were disabled. One man said that his workweek had been reduced from 40 to 39 hours, and he had lost his eligibility for medical/dental benefits.

We truly cared about every person that we treated and were saddened that these good, decent Americans had no access to health care, which is a basic human need. We are committed to doing as much for the people of this region as we can, and will continue to be part of future RAM/MOM events.

THANK YOU!

A BIG THANK YOU TO ALL THE 2011 Wise & Special Olympics M.O.M. Project VOLUNTEERS!

Carol Abbott
Dr. Mike Abbott
Cheryl Abernathy
Ashley Abesamis
Molly Adler
Dr. Nazir Ahmad
Chelsea Aiken
Dr. Anna Aldworth
Nada Al-khafaji
Priscilla Allen
Ray Allen
Dr. Steve Alouf
Dr. Edward Amos
Robert Amos
Delilah Anders
Dr. John Andre
Ben Archer
Saleh Ashkanani
Dr. Katerina Ashland
Donna Ayers
Tina Bailey
Sam Bakuri
Dr. Mark Ball
Tyler Ball
Matt Banghart
Charlotte Barnes
Melissa Barnette
Regena Barthelemy
Allison Bartlett
Rachel Baylin
Christina Becco
Ashley Beck
Holly Beck
Brittany Belcher
Win Bell
Tina Benner
Luann Bennett
LuAnn Bennett
Kenneth Bernstein
Dr. Sanjay Bhagchandani
Colleen Bickers
Dr. DJ Bickers
Dr. Bob Bigelow
Dr. William Bigelow
Justin Billings
Lauren Billings
Taylor Blake
Caitlin Blankenship
Kyle Blankenship
Pam Blankenship
Scott Blankenship
Dr. Bill Blaylock
Emily Bodsford
Emilie Bonovitch
Beth Bortz
Devon Bortz
Tracey Bourassa
Emily Bowen
Lewis Bowles
Heather Brooks
Karen Brooks
Jeannie Brown
Joe Brown
Joe Brown
Joseph Brown
Dr. Ronnie Brown
Vicky Burnette
Orlantha Cain
Terry Cain
Jamie Campbell
Melissa Carpenter
Peggy Carwile
Judith Cash
Dr. Dana Chamberlain
Stephanie Chambers
Michael Chandler
Houman Chegini
Miriam Chung
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Special Olympics

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Rawan Alfadly
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Rebecca Almond
Manahel Alqadeeb
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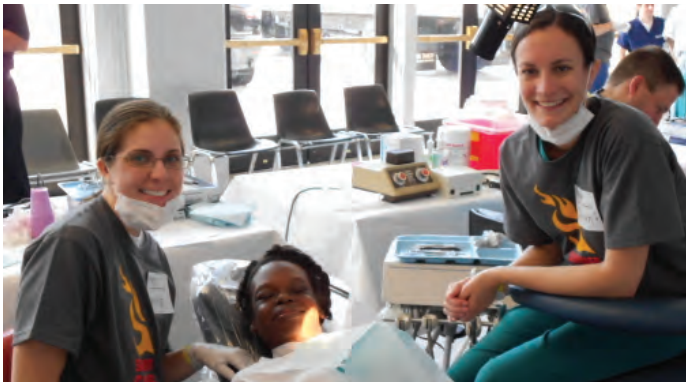
Dr. Keith Wunsch
Dr. Patty Wunsch

Special Olympics, Special Smiles in Virginia

By: Dr. Matthew Cooke



The first Special Olympics Special Smiles program took place at the Massachusetts Special Olympics Summer Games in Boston. The program was the inspiration of Dr. Steven Perlman, a Massachusetts pediatric dentist, who is now the global clinical director of Special Smiles. In 1997, Special Olympics Inc. adopted the Special Smiles project as the official dental health program of the Healthy Atheletes Initiative.

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The 2001 Virginia Summer Games held on June 9, 2001 hosted the first official Special Smiles program for the Virginia Games. Twenty-four dentists, hygienists, dental students, and hygiene students came out to the University of Richmond's Robins Center to provide dental screenings to over 325 athletes. Oral hygiene instruction was a must for anyone who passed through the booth and any athlete who played a contact sport received a custom-made mouth guard; over 200 mouth guards were fabricated. In addition, each athlete received a report card detailing their oral health status, a Colgate toothbrush, toothpaste, and a Puffkin toy.

The program reflected a joint venture between Virginia Dentists, Delta Sigma Delta International Dental Fraternity, the Virginia Commonwealth University, School of Dentistry, and Special Olympics Incorporated.

In 2011, Special Smiles partnered with the Virginia Dental Association's Missions of Mercy (MOM) Project to provide a full range of services to the athletes. Virginia is the first state ever to offer comprehensive care to Special Olympics Athletes at a state game, making Virginia a leader in providing oral health care to persons with developmental disorders.

On June 11, 2011 at the Special Olympics of Virginia's Summer Games 114 patients were seen in the volunteer MOM clinic (83 adults and 31 children). The services totaled $34,526.00 and included:

Many thanks to all 100 plus volunteers who made our first Special Smiles/Missions of Mercy a huge success with a special thank you going to the Virginia Dental Association and their foundation. Special Smiles also appreciates the contributions from our corporate sponsors, Colgate of North America, Patterson Dental Supply Co., Sonicare, State Farm Insurance, and the Grottoes of North America.

It was evident from seeing the smiles on the athletes' faces that they appreciate all that we did. In the words of a Special Olympics volunteer, "I will never be the same again, what an amazing experience!" This is an incredible opportunity to serve a special population, who may otherwise not have access to oral health care. The Virginia Chapter of Special Smiles is continually seeking volunteers to help with its program. If you are interested please contact Dr. Matthew Cooke, Clinical Coordinator for the Virginia Special Smiles Program at mrcooke@vcu.edu or mrc99@pitt.edu.

Outreach

Awards & Recognition

Ms. Jocelyn Lance
Ms. Lance was awarded Honorary Membership in the American Dental Association at the ADA Annual Session in Las Vegas. She served previously as President of the Alliance of the ADA.

Dr. Ronald Tankersley
Dr. Tankersley was honored as a VCU Alumni Star on Friday, October 21, 2011. Eleven alumni representing schools within the university were honored.

Dental Direct Reimbursement & Assignment - *Providing Quality Dental Benefits to Virginia Employers & Value to Dentists for Over 15 Years*

By: Elise Rupinski, Director of Marketing & Programs, VDA

DENTAL DIRECT
www.VADentalDirect.com

The Virginia Dental Association (VDA) started its promotion of Direct Reimbursement (DR) Dental Plans in 1995 as an alternative to traditional insured dental plans. The simple concept of a dollar-based, fee-for-service dental plan was presented to Virginia employers as a new way to provide their employees with a quality dental benefit. With no networks to join and no fee schedules to agree to, the concept is one that preserves the dentist-patient relationship and keeps treatment decisions between the patient and the practitioner. In 1996, the VDA was chosen as a pilot state for the American Dental Association's (ADA) national Direct Reimbursement Promotional Campaign. As part of the ADA's program, DR plans were advertised nationally and promoted to employers across the country. At the height of the ADA's promotion, nearly 1.5million Americans were covered by DR plans.

Since the start of the program in 1995, the VDA has put considerable time and energy into the DR program and has seen modest results from those efforts. While the blockbuster success for the DR program has been elusive, there are thousands of Virginians that have enjoyed using their DR dental benefit over these past 15 years. Additionally, dental offices in Virginia have been able to receive up to $1.5million/year in non-discounted fees from patients covered under a DR style plan. Not only have DR dental benefits provided benefits to patients and to dental offices, but they have also helped employers save money while still providing their employees with a quality dental benefit that is both easy to use and easy to understand. Overall, DR plans have been a win-win-win in the Commonwealth for employers, employees and dentists.

Since 1995, a lot of things have changed with the DR program and its promotion. The ADA has ceased its national campaign and no longer provides support for the states in their DR programs. Also, through careful evaluation, the VDA's DR Committee has chosen to significantly reduce its budget for promotional activities in response to the diminishing results from those activities. But despite these changes, DR plans still continue to provide value to patients, dental offices and employers in Virginia. And while the VDA is no longer doing a large-scale promotional campaign, there are still resources available to dental offices that want to help in the promotion of DR and for employers interested in the plan. Additionally, the TPA (Third Party Administrator) that we have been working with since 1996 continues to provide support to current and potential clients interested in implementing a DR plan. So despite these changes, DR is still alive in Virginia.

Several clients have been with DR since the beginning in Virginia and they are still finding that their DR plan is a great fit for their firm. And there are dentists across Virginia that have seen more fee-for-service patients in their offices through DR dental plans. If your office knows of any companies that might be looking for an alternative dental benefit, please direct them to the VDA's comprehensive Dental Direct Reimbursement and Assignment website: www.vadental-direct.com. You will also find information on the site for your office to learn more about DR and to request resources for your office.

An Interview with:
Dr. Carole Pratt

Editor's Note: Dr. Carole Pratt, who practiced in Pulaski County, was recently awarded a fellowship by the Robert Wood Johnson Foundation. She was interviewed at the 2011 Missions of Mercy Project in Wise.

VDA *Journal*: Congratulations on your selection as a Robert Wood Johnson Foundation Health Policy Fellow! What led you to apply for this well-known national program?

Dr. Carole Pratt: It's something I've always wanted to do; I've always admired the Robert Wood Johnson Foundation and its Health Policy Fellows program - which provides the nation's most comprehensive fellowship experience at the nexus of health science, policy and politics in Washington, D.C. My volunteer work has been in the area of oral health, obviously, with a further focus on economic development and job creation in communities. In 2009, I was awarded a Fellowship with the National Rural Health Association, and this opportunity with the Robert Wood Johnson Foundation seems the logical next step.

Journal: What will be your assignment(s) during the twelve months beginning in September?

Dr. Pratt: From the program overview, "Beginning in September with an intensive three-and-a-half-month orientation arranged by the IOM (Institute of Medicine), fellows meet with key executive branch officials responsible for health policy and programs, members of Congress and their staff, and leaders of health and health policy interest groups. Fellows also participate in seminars on health economics, major federal health and health research programs, the congressional budget process, current priority issues in federal health policy and the process of federal decision-making…In November, fellows join the American Political Science Association Congressional Fellowship Program to expand their knowledge and awareness of Congress and the political process. Fellowship working assignments begin in January. During these assignments, fellows are full-time contributing participants in the policy process with members of Congress."

Fellows typically will
- help develop legislative proposals;
-arrange hearings;
-meet with constituents (I consider my constituents to be "we the people")
-brief legislators for committee sessions and floor debates; and
-staff House-Senate conference

Journal: What would you like to accomplish during your Fellowship?

Dr. Pratt: The responsibilities mentioned before are all goals that I hope to accomplish. My one personal goal is to have the four other Fellows, along with Robert Wood Johnson Health Policy Fellows staff, (perhaps twelve people altogether) attend the Virginia Dental Association MOM (Mission of Mercy) clinic at Wise in July 2012.

Journal: There have been over 200 RWJF Fellows, but only twelve have been dentists. How can the dental profession offer a unique perspective on the health policy process?

Dr. Pratt: Many organizations are worried about dental disease, its implications for the general health of the patient, access to dental care, and the consequent economic impact on patients, providers of clinical services, and society. The dental profession offers the unique perspective of being "expert witnesses" to these issues. Heretofore, much of health policy in the United States has spoken very little to oral health concerns, and now is an important time for our profession to be at the table. There's a real danger of someone else speaking for us.

Journal: What have you been doing to prepare for your Fellowship since your selection?

Dr. Pratt: In April, the FedEx truck came to my driveway with a big box of books and I have been reading ever since. My required reading list is as follows:

Governing Health: The Politics of Health Policy
Health Care Policy and Politics A to Z
Leadership on the Line
Policy Paradox: The Art of Political Decision Making
Public Health Law: Power, Duty, Restraint
The Art and Politics of Science
The Federal Budget
The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care (this book is hard to put down – a compelling read)
The Heart of Power: Health and Politics in the Oval Office

I have also been reading abstracts of various Institute of Medicine reports to get an overview of their work.

For anyone interested in an engaging, objective comparison of health care in the United States with other developed countries, I recommend *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care*, by T.R. Reid.

The Fellows and staff have had several conference calls to prepare us for the move to Washington, and there is a regular email thread among us to share frustrations about said reading list!

Journal: You've practiced many years in a rural community. What changes in rural health (both policy and outcomes) have you seen since you began practice?

Dr. Pratt: I practiced in a county of 35,000 for 32 years. During that time, many of the region's counties actually posted a decline in life expectancy, one of the key measures of population health. Among others, contributing factors include obesity and associated disease, the plateau of smoking cessation, and loss of health insurance due to unemployment.

Over 62 million Americans call rural communities home, and on average these people are older, sicker, and less well insured than their urban and suburban counterparts. Pressing issues include, among many others, an aging population, use of hospital emergency rooms for non-emergency care, concerns for payment for needed services, distances to access specialty care, and vanishing numbers of primary care physicians, dentists, and health care providers at every level. An additional problem that is more pronounced in rural Virginia communities is that of prescription drug abuse with an unintended drug overdose rate 2.5 to 6 times that statewide. These problems don't seem to be lessening with time, and resources are shrinking.

On a positive note, there were few dental specialists in our area when I began practice and patients often had to travel an hour or more for appointments. We are fortunate now to have excellent dental specialists in every discipline within reasonable driving distance. Dental care may be getting better while other measures of health care decline.

Journal: How can the dental profession join other professions to improve health care in rural areas?

Dr. Pratt: Keeping oral health in the larger health policy discussion is part of the role of our profession. Dentists know the importance of dental health and the impact of dental disease, and it is our responsibility to be sure that message doesn't get lost or overshadowed. We have to constantly be at the table.

Journal: What role do you foresee for organized dentistry (i.e., the ADA, VDA) in setting health care policies? What should we be doing that we're not?

Dr. Pratt: The ADA and VDA are responsible for being the voices for oral health in the overall health care policy discussion at the national and state levels. Advocacy and legislative involvement has always been critical, and will be even more so going forward into an age of more need and less resources. Our profession is brilliant at disease prevention, and that strategy can be extremely effective in the future health of the United States, where a huge proportion of chronic disease is preventable. We need to expand our vision of what we do at every level, not just providing dental care.

Journal: What advice what you give to dental students considering practice in a rural area?

Dr. Pratt: The quality of life in a rural setting is second to none. Relationships with patients can span generations, and close contact with other health care professionals is the norm. Practice in a rural area offers many opportunities for community and professional involvement. Study clubs and component societies are smaller and leadership roles are available for dentists who are interested. Local boards of hospitals, banks, the Chamber of Commerce, and other organizations are happy to have the expertise of dentists who want to serve. The jobs a dentist creates in a small community are stable with higher than average pay, and are very important to the local economy. Any dentist who wants to practice in a rural area is expected to participate in the life of the community.

Journal: Finally, best wishes for your tenure as a RWJ Fellow. What would you like to do after September 2012?

Dr. Pratt: I'm not sure where this will lead, but it is expected that once the Fellowship is ended, I will take a position in which I will further develop skill in health policy leadership. To quote our fellows' manual "Once the Washington experience is complete, fellows become part of a nationwide alumni network and typically return to Washington each year to attend the IOM's (Institute of Medicine) annual meeting and be briefed on issues and trends in health and health care policy."

Dental Ethics – Advertising - what are your standards?

By: Dr. Daniel E. Grabeel, Ethics and Judicial Affairs Committee

Ethics, the discipline dealing with what is good and bad and with moral duty and obligation---the principles of conduct governing an individual or a group, as defined by Webster.

Are our standards lower today than in the past? Is dentistry changing? Is this good or bad? Who loses and who wins, dentist or patient? Think about that. Why are a large number of articles today slanted toward how you can increase your income, if you do as they say?

When I graduated from dental school our dean, Dr. Harry Lyons, told me how to be successful: go to the location that makes you happy, establish an office well-equipped and affiliate with the church of your choice and treat your patients as you would like to be treated (doing the best dentistry you are capable of doing). He said you will be successful. That was back then, will that work today?

Why has dentist moved down the list of people (professional) most trusted? Is advertising right or wrong? You say everyone is doing it, just look at your phone book now as opposed to 10-20 years ago. I hear the public needs to be informed as to what I do. I agree with that, but is "we cater to cowards" informative? We, the members of the VDA Ethics Committee, have the responsibility to inform and enforce as the definition says, the principles of conduct governing an individual, you the dentist or a group like the VDA and ADA.

The ADA sets the standards by which we are governed. It is your and my responsibility to know and follow these standards. As a committee member it is my responsibility to help all members of the VDA get this information and as a group enforce if necessary.

I have provided below the Virginia Board of Dentistry's "Advertising: Are You In Compliance?" for your information.

Virginia Board of Dentistry
Advertising: Are You In Compliance?
Pursuant to 18 VAC 60-20-180 (F) Advertising.

The following shall constitute false, deceptive or misleading advertising within the meaning of §54.1-2706(7) of the Code of Virginia:

1. Publishing an advertisement which contains a material misrepresentation or omission of facts;

2. Publishing an advertisement which contains a representation or implication that is likely to cause an ordinarily prudent person to misunderstand or be deceived, or that fails to contain reasonable warnings or disclaimers necessary to make a representation or implication not deceptive;

3. Publishing an advertisement which fails to include the information and disclaimers required by this section;

4. Publishing an advertisement which a claim of professional superiority, claims to be a specialist, or uses any of the terms to designate a dental specialty unless he is entitled to such specialty designation under the guidelines or requirements for specialties approved by the American Dental Association (Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists, October, 1995), or such guidelines or requirements as subsequently amended and approved by the dental disciplinary board, or other such organization recognized by the board; and

5. A dentist not currently entitled to such specialty designation shall not represent that his practice is limited to providing services in a specialty area without clearly disclosing in the representation that he is a general dentist. A specialist who represents services in areas other than his specialty is considered to be practicing general dentistry.

We only want to inform, so help us help you by staying within the guidelines and let us hear from you. Send your comments to us through the VDA by letter, email or fax. This will help us to better understand your thoughts and we might not agree but we can work together to make dentistry back up the list of trusted people and we most definitely will respect your thoughts. Help me by responding to the questions I ask at the beginning of this article, if you choose. Thank you and may God bless the ADA, VDA and all dentists.

Editor's Note: Readers may contact Dr. Grabeel by e-mail, dgrabeel@aol.com

Mentor Program Holds First Session - Students paired wtih dentists

By: Kirk Norbo, DMD, VDA President-Elect

The VDA/VCU mentorship group held its first formal meeting at the dental school on Saturday, August 20th. The main lecture room in the Perkinson building was filled to capacity with over 135 attendees. There were nearly 80 VCU second year dental students, 10 pediatric dental residents, 40 VDA mentors and several VCU pediatric faculty in attendance.

Dr. Marvin Berman, a pediatric dentist from Chicago, was the guest speaker. Dr. Berman discussed the management of difficult pedodontic patients while interjecting his various philosophies of dental practice into the presentation. The lecture was informative, entertaining and well-received by the audience.

During the lunch hour, Dean Rebecca Pousson, Dr. Fred Certosimo and I outlined the curriculum and expectations for the mentorship program. This joint VDA/VCU venture is now a part of the VCU practice management curriculum and student participation is mandatory. This added structure to the program will help to encourage mentor/student contacts while creating a self-perpetuating environment.

A special thanks to Leslie Pinkston for her dedication and efforts organizing the meeting.

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Dental Therapists - The International Dental Therapist: History & Current Status

By: Jay W. Friedman, DDS, MPH

Author / Jay W. Friedman, DDS, MPH, is a dental consultant and writer living in Los Angeles, Calif.

Abstract - Dental therapists provide preventive, restorative and minor surgical treatment, mostly for children in government-sponsored health programs, in more than 53 countries. Their quality of care and acceptance by the public and dental profession has been well-documented. Since 2005, they have been effectively serving native Alaskans in remote communities. Not only do dental therapists provide basic dental care to underserved populations, they enable associated dentists to practice at a higher level of proficiency and efficiency.

Since their initial deployment in 2005, dental therapists have been providing basic dental care—prophylaxis, sealants, fillings, stainless-steel crowns, pulpotomies, and simple extractions with local anesthesia—to the native Alaskan population in rural communities.[1,2] In May 2009, Minnesota authorized the training of dental therapists to provide oral health care in underserved areas in the state.[3] And in November of this same year, the Connecticut Dental Association's House of Delegates voted to endorse a pilot project for a two-year training program for dental therapists to work in a public setting.[4] In what appears to be a developing trend, a number of dental associations, including the California Dental Association, are reviewing the potential dental therapists have to address the problem of access to care in the United States.

Until recently, many dentists and dental hygienists in the United States were unaware that dental therapists are utilized in at least 53 countries throughout the world.[5] Many dentists question the need for dental therapists or reject the concept as a threat to their profession and their livelihood. A review of the development and acceptance of dental therapists in other countries can be helpful in understanding the positive benefit that the adoption of dental therapists in the United States can have for the profession and society.

Origins - The development of dental therapists began in New Zealand with recognition of the high rejection rate for military service of its young men and women during World War I due to severe, rampant dental disease. With only 100 dentists for a population of 1.2 million, a ratio of 1:12,000, the impossibility of bringing dental care to so many people without the introduction of a new auxiliary was recognized. The first training school for dental nurses, specifically for children's dental care, was established in 1920 by the New Zealand Department of Health. Until recently, employment of all dental nurses, now called dental therapists, was restricted to a school dental service, with assignment to small clinics located on public school grounds, supervised by Department of Health dentists. Dental nurses provided care to children, including preschoolers, only to age 12, after which adolescents aged 13 to16 received care from private practicing dentists paid for by the government. Participation in the program was voluntary, requiring parental permission. By the 1970s, more than 60 percent of preschoolers and 95 percent of schoolchildren were enrolled in the program, with permanent tooth loss virtually eliminated, long before the advent of water fluoridation.[6]

Expansion - Other countries faced with similar widespread dental disease and a shortage of dentists soon adopted the New Zealand dental nurse model. Initially their dental nurses/therapists, were trained in New Zealand. Many countries now have their own training schools.

It is not only "underdeveloped" nations that utilize dental nurses. With respect to provision of oral health care to their entire populations, most nations are underdeveloped. Thus, countries similar to the United States such as Australia, Canada, and Great Britain have well-established dental therapist programs that are widely accepted by the public.

Counting only those trained on the New Zealand model, there are more than 14,000 dental therapists presently deployed worldwide.[5] However, China has an estimated 25,000 "assistant dentists" who are very similar to dental therapists in training. They practice independently in rural areas.

Supervision and Quality of Care - The quality of care provided by dental therapists has been thoroughly investigated. Beginning in the 1950s and to the present, these studies have shown that dental therapists maintain technical standards equivalent to dentists.[7-17] Important aspects of their training are an understanding of their limitations, their parameters of care, and their need to work in close association and consultation with dentists. Countries that permit dental therapists to practice independently usually require consultative collaboration with a supervising dentist.

From a public health perspective, few countries have achieved, much less exceeded, the success of New Zealand where virtually all children are enrolled in the school dental program. Malaysia is one of these countries where 96 percent of elementary and 67 percent of secondary school children are seen by school dental nurses, as they are still called there.[18] As in New Zealand, the dental nurses also provide care for preschool children brought to the school clinics by their parents. It is likely that other countries with an expanding dental therapist workforce will achieve these high utilization rates, which are the sine qua non of a successful oral health care program.

Current Trends - New Zealand - More than 95 percent of children under age 13 and 56 percent of preschoolers continue to receive preventive and curative oral health care by dental therapists in the School Dental Service and there is virtually no untreated dental caries by the end of the school year. This extraordinary achievement is accomplished by providing service directly on the school grounds in either fixed dental facilities or mobile units. Because many schools, particularly those in remote rural communities do not need a full-time dental therapist on-site, and rather than replace aging onsite clinics and equipment, the trend is toward greater utilization of mobile units and community health ("hub") centers that promote a team approach to health care.[19]

Adolescents aged 13 to18 are eligible for care from private practitioners paid by the Government Adolescent Oral Health Services at no cost to the patient. But only about 54 percent of adolescents access private dentists, significantly fewer than when services are provided directly at school.

As a consequence of the reduction in caries from water fluoridation, the number of dental therapists declined from 1,350 in the 1970s to about 660 today. By 1999, the three regional schools were closed as training of dental therapists was transferred to the University of Otago School of Dentistry in Dunedin. Three years later, a second dental therapist program was begun at the Auckland University of Technology. By 2007, each school had merged the dental therapist and dental hygiene programs into one three-year program, with a bachelor of oral health degree. After graduation, registration is required to designate the area of practice, which may be in only one discipline or both. Those credentialed in general dental therapy practice are allowed to treat patients to age 18. Oral health therapists could qualify to treat adults with additional training, but thus far no courses are available for this purpose. There are no treatment age limits if credentialed in general dental hygiene practice.[19]

As a point of historical interest, dental hygienists were employed by the military as early as 1974, but training of dental hygienists for the general public did not begin until 1994 due to opposition of the dental profession, which had long since accepted dental therapists. There are presently fewer than 250 dental hygienists in New Zealand, but they are rapidly gaining in numbers and acceptance by dentists, particularly with the development of the combined dental hygiene/therapist program.

Since 2003, oral health therapists are permitted to work in the private sector where they may be employed by dentists to care for their adolescent patients.[20,21] However, the majority continue to provide dental therapy in the School Dental

Service. Dental therapists may also own their own practice, with the requirement of a supervisory contract with a dentist, but few if any have done so. In a 2008 survey, almost 60 percent of dentists in private practice said they would be willing to employ a dual-trained therapist/hygienist.[22]

With the increase in population and the decline of the existing workforce due to retirement, a shortage of dental therapists is anticipated in the future. But from the standpoint of the newly emerging oral health therapists, the future in New Zealand is positive.

Australia - From the time of its inception in 1966 until 2000, dental therapists in Australia were generally restricted to practice only in the School Dental Services, where the large majority of dental care for children is still provided in fixed and mobile dental clinics. As of 2003, 87 percent of all dental therapists were employed at least part time in the schools.[23]

In one state, Western Australia, dental therapists have always worked in private practices as well as public service; since 1983 they have been able to treat adults as prescribed by dentists. Although required to have some dental hygiene skills, they do not qualify nor can they register as hygienists, since their dental hygiene training is limited to a six-week to 12-week course. Dental therapists in the public sector are restricted to children and adolescents up to age 18. They do not require diagnostic prescription by dentists. All but one state, New South Wales, have now eliminated employment restrictions so that many more dental therapists work, at least part time, in private dental offices and in community and hospital clinics where they are also permitted to treat adults.[24]

Originally designed as two-year certificate or diploma programs in nonuniversity dental therapy schools restricted to females, a number of universities now offer a three-year "oral health therapist" program that combines traditional dental therapy and dental hygiene, as in New Zealand. The oral health therapists will trend more toward private practice where their periodontal therapy skills have more applicability. The number of dental therapists working in private practice has doubled since 2003. However, most continue to work in both the public and private sector, many part time. "Part-time work is reflective of the majority female workforce and equates with other similar health disciplines including dental hygiene and nursing."[25]

How this will affect the School Dental Services and oral health care for children remains to be seen, but it is likely that many, if not most, dental therapists will continue, at least part time, in the School Dental Service.

Great Britain - The first dental therapist school was opened in the United Kingdom in 1959, patterned after the New Zealand model. There are now 17 schools that provide dual qualification in dental therapy and dental hygiene, with approximately 240 therapists/hygienists graduating each year. The diploma courses for both dental hygiene and dental therapy are 27 months in length, compared to three years to obtain a BSc degree in oral health sciences. One school provides for dental hygienists to qualify as dental therapists by completing a three-day a week, 36-week course.[26]

The trend toward dual qualification was stimulated by a shortage of dental therapist positions in governmental and hospital services; whereas, there were more job opportunities for dental hygienists who had long been employed in private general dental practices. Thus, many unemployed dental therapists acquired additional training as dental hygienists, which eventually led to the dual training programs. In 2002, the governing General Dental Council granted permission for dental therapists to work in private dental practice. However, many dual-trained dental therapists still work as dental hygienists, although there is increasing recognition and utilization of their combined skills, particularly since more dentists are now trained alongside dental therapists in the same university programs.

Though accustomed to dental hygienists, the public is generally unaware of the role of dental therapists, which makes it difficult to obtain consent to their care. Even after the qualifications of dental therapists was explained in recent surveys, only 61 percent of adults would accept treatment from them. On the other hand, a recent survey reported that those patients receiving care from dental therapists expressed a higher degree of satisfaction than patients treated by dentists.[27] For dental therapists to be more widely accepted as oral health care providers in private practice, the public needs to be better informed and reassured of their qualifications and competence.[28-30]

There has been a remarkable shift in employment, with 50 percent of dental therapists now in private dental practices, compared to none six years ago. Slightly more than half work part time, averaging about 25 hours a week.[31] Nearly two-thirds work in multiple locations and are paid an hourly rate or a monthly salary and one-third are self-employed.[32] They treat both children and adults. It is estimated that therapists have the potential to provide the treatment in 35 percent of dental visits and 43 percent of clinical time.[33] Wherever they practice, a written treatment plan must first be developed by a registered dentist, after which they can implement treatment independently, based on their own judgment of priorities and techniques. The treatment plan may be very detailed, or just state "restore."[34] Many therapists are concerned that dentists do not fully appreciate their clinical skills, that they are not being fully utilized, and that more patients could be referred to them.[35] However, their employment by dentists is still limited because the National Health Service, under which most dental care is provided, does not yet pay for treatment by dental therapists in private practice. The NHS contract is being revised and it is hoped that treatment by dental therapists in all settings will soon be covered.[30]

Fiji - The Republic of Fiji was established in 1970 after being granted independence by Great Britain. It extends over 322 islands in the South West Pacific, east of Australia and north of New Zealand. Only a third of the islands are occupied by its population of a little more than 900,000.

In 1998, the Fiji School of Medicine, Department of Oral Health, established a "multientry, multiexit" career "Dental Ladder."[36] This modular approach to dental education takes full advantage of work experience. In most other countries, including the United States, many dental assistants become dental hygienists and a few dental hygienists go on to become dentists, but there is virtually no credit allowed for previous experience or training, particularly for hygienists. The Fiji program allows full credit so that it requires only a second year of training after the first year of introductory dental assisting courses to be certified as a dental hygienist; a third year leads to a diploma in dental therapy; two additional years, for a total of five, qualifies for a bachelor of dental surgery (BDS), the equivalent of a DDS/DMD in the United States.

Fiji's career Dental Ladder is not limited to its territorial sovereignty. Since its beginning 11 years ago, 16 dental therapists from other areas stepped up the ladder to become dentists: American Samoa (2); Kirbati (2); Nepal (1); Papua New Guinea (4); Samoa (1); Solomon Islands (4); Tonga (1); and Vanuatu (1). In addition, 14 dental hygienists have advanced to become dental therapists.[37]

At present, there are approximately 100 dentists, for a dentist/population ratio of 1:9000; and more than 70 dental therapists. Entry up the ladder is determined by the needs and availability of funds as assessed by the Ministry of Health. There is only one oral surgeon, so general dentists are trained not only to extract teeth, but also to reduce and wire mandibular fractures. In addition to preventive and restorative services, dental therapists perform extractions on both adults and children, which, unfortunately, is a much needed service particularly in the outer island villages that are unlikely to have more than an annual visit by a dentist.[36]

Canada - From a high of 365 in 1990, there are presently 280-300 dental therapists serving in governmental, nongovernmental, territorial, and aboriginal organizations. Of these, 128 (or 45 percent) are in private practice; 105 in the province of Saskatchewan.[38]

The Saskatchewan Dental Health Plan was remarkably successful. By the mid-1980s, with a staff of 400, including about 26 dentists and 150 dental therapists and their assistants, more than 80 percent of school children received annual examinations, preventive and restorative treatment in school and community clinics. Yet, by 1992, after years of declining financial support, the school program was eliminated. Oral health care for school children is now completely in the hands of the private dental sector with a sharp decline in utilization and consequent increase in untreated dental disease.[5]
Despite the negative impact of conservative governments, fiscal restraints and

professional opposition, the dental therapists have survived in many parts of Canada, particularly in Saskatchewan, Manitoba, and the Northwest Territories. Indeed, dental therapists in Saskatchewan, who number more than 200, are unique in that they are a self-regulating profession, licensed by the Saskatchewan Dental Therapists Association.[39] Nonetheless, they are required to have a formal referral or consulting relationship with a dentist, whether as an employee in a governmental organization, a community health center, or a private practice. That they have been so well incorporated in the private sector by dentists, as well as continuing to serve in the public sector, should allay concerns that they are competitors with dentists rather than colleagues on the dental team.

The Netherlands - Although specific to the Netherlands, the following quotation summarizes the impetus for change in the character and delivery of oral health care, "A number of factors, including rising expectations for the quality of life in modern society, the related need for medical care and an increase in the volume of knowledge available, have produced pressures for more knowledgeable and skilful health professionals, including dental hygienists. Dental awareness in the general population has grown. Patients have become more assertive and, with increased possibilities to obtain information (e.g., Internet), demand different kind of treatments. They are also more oriented toward preventive health care, including preventive oral health care. The aging population is increasingly retaining teeth and needs more, and often more complex, care than the previous elderly generation who were often edentulous."[40]

Beginning in 2002, the Netherlands began a major transformation of its dental profession. There are no longer dental therapists and dental hygienists, but rather a combination of the two that retains the name "dental hygienist." The "new-style dental hygienist" provides the basic preventive and periodontal services of the traditional dental hygienist, plus the basic restorative treatment and noncomplex extractions of the dental therapist. The university training has been increased from three to four years, culminating in a bachelor's degree.[40]

Competing with the dental hygienist is the "prevention assistant," a trained dental assistant who receives further training in an eight-day course developed by the Dutch Dental Association. Employed by dentists, prevention assistants do prophylaxis including supragingival scaling and fluoride applications. Because they are paid less, many dentists prefer them to dental hygienists. Nonetheless, most dental hygienists, approximately 1,500 (or 65 percent), are traditional hygienists in association with or employees of private dentists. About 800 (or 35 percent) work as private entrepreneurs.[41]

In consideration of changing demographics, particularly the aging of the population, the "new-style dentists" are to be the oral physicians of the future, with their training increased from five years to six. Ideally, their practice will be devoted more toward the medically compromised and elderly populations that require greater knowledge, skills, and experience, while the new-style dental hygienists provide routine oral health care for the younger, healthier population.

It should be noted that although the Dutch dental profession opposed this transformation, it was enabled by the support of other professional organizations, educational institutions, consumer organizations, and the health insurance industry. There are as yet too few new-style practitioners to assess their impact on dentistry and the acceptance by the public.

Summary - Advocates of dental therapists believe their addition to the oral health workforce in the United States will enhance the profession. Not only do dental therapists provide necessary care to underserved populations, they have the potential to enable dentists to practice at a higher level of proficiency and efficiency. Far from being a novelty, this brief review of the long history of dental therapists and their current status in five representative countries demonstrates their remarkable contribution to the oral health of their recipient populations and ultimate acceptance by private dental practitioners and their representative associations.

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Virginia Dental Association
Governance Meeting

September 16-18, 2011
Fredericksburg, VA

Board of Directors - Actions in Brief
September 16, 2011

The following is reported as information only:

September 16, 2011 Meeting

1. Approved: The VDSC's Right of First Refusal on the purchase of the property (lot) located at 7525 Staples Mill Rd.

2. Approved: A motion that members of the Board read *Race for Relevance* (by Harrison Coerver and Mary Byers) before the November Board meeting and be prepared to discuss its contents as they apply to the VDA.

September 18, 2011 Meeting

1. Approved: The following appointments for 2011-2012.

    1. Parliamentarian – Dr. David C. Anderson
    2. Journal Editor: - Dr. Richard F. Roadcap
    3. Executive Director – Dr. Terry D. Dickinson
    4. Legal Counsel – David Lionberger, ESQ. and Scott Johnson, Esq.

3. Approved: The following members of the VDSC Board of Directors for 2011-2012:
VDSC Board of Directors: Lanny R. Levenson, President; Leslie S. Webb, Jr., Vice President; Rodney J. Klima, Secretary/Treasurer; Fred A. Coots, Jr.; Frank C. Crist, Jr.; Wallace L. Huff; Bruce R. Hutchison; Jeffrey Levin; Robert A. Levine; Stephen S. Radcliffe; Gus C. Vlahos; Edward J. Weisberg; Andrew J. Zimmer; Kirk Norbo, liaison; Roger E. Wood, liaison, Steven G. Forte, advisory; Harvey H. Shiflet III, advisory.

Minutes of the 142nd Annual Business Meeting
Saturday, September 17, 2011, 2:00pm
Fredericksburg Hospitality House Hotel and Conference Center, Fredericksburg, VA

1. President Michael A. Abbott called the meeting to order.

2. The flag pledge was recited.

3. The following deceased members were remembered:
Component 1: John I. Bowman, Leon Hecht, William H. Higinbotham, Jr., William C. March. Component 2: Jeffrey W. Bass, Ulpian G. Bradenham. Component 3: John D. Rice. Component 4: Dewey Bell, George Crist, Carl Flanary, Major D. Gayle, Jr., Randal King, David G. Shannon, Julian P. Todd, Jr., Component 6: Milton W. Brockmeyer. Component 7: Emerson Cornett Gambill, Sr., Howard B. Watkins, Ivan V. Yonce, Jr. Component 8: William F. Freidank, Jeffrey M. Massey, Kenneth S. McAtee, Albert G. Paulsen, Robert E. Schell, Douglas C. Wendt, Thomas J. Winkler.

4. Recognition was given to:

A. 2011 VDA Fellows Inductees:
Component 1: Anthony R. Peluso. Component 2: William G. Harper. Component 4: Kit T. Sullivan. Component 7: Alan J. Bream. Component 8: Peter K. Cocolis, Jr., Edwin Lee.

B. Recipients of Life Member Certificates in 2011:
Component 1: Stephen Goldstein, Michael Hechtkopf, J. E. Lewis, Louis C. Peron, Leslie I Richmond, Ivan R. Schiff, Martin L. Walton III, Charles R. Wright. Component 2: Gisela K. Fashing, Barry L. Green, Jesse A. Hobbs, Joseph A. Lombard, Jack A. Mrazik, Alfred P. Moore. Component 3: William F. Callery, James M. Keeton, Jr., Harvey Thompson. Component 4: Anne C. Adams, Frank L. Angus, William H. Angus; William C. Betzhold, Daniel R. Leahy, Donald G. Levitin, Harry A. Raddin, Jr., William J. Redwine, Thomas C. Waldrop, Richard H. Wood. Component 5: Charles E. Ayers, David E. Bittel, David E. Black, James R. Evans, David C. Jones, William W. Martin, Edward M. O'Keefe, Robert L. Plapp, Charles Ramsberger, James W. Shearer, H. M. Sparger, Marvin E. Thews, Jr., Guy W. Walton, Jr. Component 6: Daniel E. Thompson. Component 7: Dandridge B. Allen, Robert M. Driscoll, Jr., Danny B. Neese, Andrew B. Martof, William J. Viglione. Component 8: Edward J. Bernhart, George M. Casey, Mary A. Choby, Frank A. Delatour, Jr., John P. DeMorro, Jr., David M. DeViese, Richard F. Donohue, Marshall E. Flax, John A. Good, Stuart L. Graves, Michael T. Hardin, Barry Herbst, Stephen J. Mayo, Joseph A. McConaghy, David I. McGibbons, Michael Polifko, Richard O. Rice, Harold L. Shapiro, Dale P. Shewmaker, Martin D. Siegel, James A. Snyder, Richard K. Stern, Thomas S. Striano, Rouben Yedigarian, James G. Zaletel,
Paul N. Zimmet.

C. Recipients of 50 Year Certificates in 2011:
Component I: Samuel S. Bisese, Samuel V. Russo, Jerome W. Schonfeld, Oscar W. Self, Jr. Component 2: William T. Green, Marvin I. Kaplan, George R. Knox, Rene D. Koun, Jr., Francis W. Sheild, Harry Simpson, Jr. Component 3: John W. Lynn, Ronald I. Stallings. Component 4: Marshall C. England, Jr., John A. Kontopanos, Jr., Joseph H. Morgan, Patrick T. Quisenberry, Donald E. Wheless. Component 5: Fred B. Caffey, George H. Snead, Jr., Joseph K. St Clair, Jr., Gordon R. Woody, Jr.. Component 6: Ellis T. Taylor. Component 8: Gary R. Arbuckle, Stanton K. Calhoun, Arnold Hecht, Rafel F. Madan, Barry McNair, Albert S. Roslyn, Robert P. Sabatini, Stanley M. Stoller, Ramon A. Woodall III.

D. Recipients of 60 Year Certificates in 2011:
Component I: Gerald J. Babbitt, Ernest N. Duvall, Jr., Thomas W. Peterson. Component 2: Irving V. Behm. Component 3: William B. Russell. Component 4:
Daniel M. Laskin, Lewis T. Rogers. Component 5: William A. Coleman, John H. Cundiff, Malcom B. Lacy, Jr., William G. Martin. Component 6: Kemper McCloud, Jr. Component 7: Virgil H. Marshall. Component 8: Thomas W. Armstrong, Marvin E. Pizer, Elizabeth S. Powell.

5. Bruce Hutchison, VADPAC Chair, gave a committee update and announced the following VADPAC awards:

Category A – Small Component Membership
Percentage of members who contributed to VADPAC (50%)
Component 6
Percentage of Commonwealth Club Members (38%)
Component 6

Category B – Large Component Membership
Percentage of members who contributed to VADPAC (42%)
Component 1
Percentage of Commonwealth Club Members (30%)
Component 1

The Governor's and Apollonia Club members were recognized.

6. Ralph L. Howell, Past President, announced the following election results:

President-Elect – Kirk M. Norbo
Secretary/Treasurer – Steven G. Forte
ADA Delegates – Alonzo M. Bell, Bruce R. Hutchison, Kirk M. Norbo, Roger E. Wood. (All will serve three year terms.)
ADA Alternate Delegates – Michael A. Abbott, Vince Dougherty, Paul Olenyn, Ted Sherwin. (All will serve two year terms.)

7. The out-going component presidents were recognized.

8. Michael Abbott installed the newly elected VDA officers, ADA delegation members and component presidents.

9. Michael Abbott presented in-coming president, Roger E. Wood, with the president's pin.

10. Roger Wood presented Michael Abbott with the past president's pin, the VDA Torch Bearer Award and the ADA Constituent President's Plaque.

11. The meeting was adjourned.

40th HOUSE OF DELEGATES - ACTIONS IN BRIEF
SEPTEMBER 17-18, 2011

1. Adopted: The following VDA Policy: Anyone wishing to use the VDA logo will need to contact the VDA and sign the following agreement.

VDA Logo Usage Policy
The logo of the Virginia Dental Association (VDA) represents an important element of our Association's identity. Members in good standing may use the logo to identify themselves as members of the VDA. Use of the VDA logo by members demonstrates pride in Association membership and helps to identify the VDA to patients and the public.

The Virginia Dental Association will license use of its logo to any member who agrees to and satisfies the terms of the License Agreement set forth below. PLEASE READ THE AGREEMENT CAREFULLY. If you agree to its terms, please indicate your acceptance by signing where indicated at the end of the Agreement.

Agreement for Licensing Of VDA Logo to Members
In consideration for a limited license from the Virginia Dental Association ("VDA") to use its logo in accordance with the terms and conditions set forth below, I hereby agree as follows: I recognize that the attached logo is the sole and exclusive property of the VDA. By using the VDA logo, I acquire no rights in that logo other than as set forth in this license.

I will use the VDA logo only as long as I remain a member in good standing of the VDA. I will not make any use of the logo without clearly and conspicuously

indicating a category of my membership in VDA, e.g. Active Member, Associate Member. I will immediately cease using the logo if I cease being a member of the Association, and I will immediately make the appropriate modification in my use of the logo if my membership category changes.

I recognize that the VDA may revoke my license to use the logo at any time and for any reason. I hereby waive any and all rights that I may have to contest revocation by the VDA of my right to use the VDA logo.

I will not revise or alter the VDA logo as set forth below in any way. I will always use the logo as it currently appears, except in terms of color and size. I may use the logo only on my stationery, business cards, in telephone directory listings, and on my website. The logo may not appear on any educational advertising or marketing materials. This includes any correspondence on letterhead related to such events.

Notwithstanding the foregoing, I may not use the VDA logo in any manner that, in the sole discretion of the VDA, discredits the VDA; is false or misleading;violates the rights of others; or violates any law, regulation or other public policy. I will not make any claim that states or implies endorsement, approval, sponsorship, or certification of me or my practice by the VDA. I will immediately cease using the VDA logo if I am convicted of a felony; am found to have a substance abuse problem; have my dental or Controlled Substances Act license revoked, suspended, or restricted; or have disciplinary proceedings instituted against me by the VDA, any licensure authority, or similar institution.

If requested by the VDA, I shall give the VDA samples of my use of the VDA logo. I agree to forfeit any and all right to use the logo if the VDA, in its sole discretion, determines that my use of the logo is not in strict accordance with the terms and conditions of this license.

I agree that use of this logo does not imply, or suggest in any way, endorsement by the VDA. I will direct any questions concerning the use of the VDA logo or the terms and conditions of this license to the VDA Membership Director at (804) 288 5750.

Read and agreed to: _____
Signature

_____
Print Name

2. Referred back to the Board of Directors for further study:

VDA ANTITRUST COMPLIANCE POLICY

It shall be the policy of the Virginia Dental Association to be in strict compliance with all federal and state antitrust laws, rules and regulations. To ensure the VDA and its members comply with antitrust laws, the following principles will be observed:

• The Association or any committee, section, chapter or activity of the Association shall not be used for the purpose of bringing about or attempting to bring about any understanding or agreement, written or oral, formal or informal, expressed or implied, among two or more members or other competitors with regard to prices or terms and conditions of contracts for services or products. Therefore, discussions and exchanges of information about such topics will not be permitted at Association or component meetings or other activities.

• There will be no discussions discouraging or withholding patronage or services from, or encouraging exclusive dealing with: i.) any supplier or purchaser or group of suppliers or purchasers of products or services; ii.) any actual or potential competitor or group of actual potential competitors; or iii.) any private or governmental entity.

• Any discussions of prices/fees or price/fee levels are prohibited. In addition, no discussion is permitted of 1) cost of operations, supplies, labor or services; 2) allowance for discounts; 3) terms of sale including credit arrangements; and, 4) profit margins and mark ups. These limitations are not intended to extend to discussions of methods of operations, maintenance, and similar matters in which cost or efficiency is merely incidental.

• There will be no discussions about allocating or dividing geographic or service markets or customers. There will be no discussions about restricting, limiting, prohibiting or Sanctioning advertising or solicitation that is not false, misleading, deceptive or directly competitive with Association products or services.

• There will be no discussions about discouraging entry into or competition in any segment of the marketplace.

• There will be no discussions about whether the practices of any member, actual or potential competitor or other person are unethical or anti-competitive, unless the discussions or complaints follow the prescribed due process provisions of the Association's bylaws.

• Certain activities of the Association and its members are deemed protected from antitrust laws under the First Amendment right to petition government. The antitrust exemption for these activities, referred to as the Noerr-Pennington Doctrine, protects ethical and proper actions or discussions by members designed to influence: 1) legislation at the national, state or local level; 2) regulatory or policy-making activities (as opposed to commercial activities) or a governmental body; or, 3) decisions of judicial bodies. However, the exemption does not protect actions constituting a "sham" to cover anti-competitive conduct.

• Speakers at committees, educational meetings or other business meetings of the Association shall be informed that they must comply with the Association's antitrust policy in the preparation and the presentation of their remarks. Meetings will follow a written agenda approved in advance by the Association or its legal counsel.

• Meetings will follow a written agenda. Minutes will be prepared after the meeting to provide a concise summary of important matters discussed and actions taken or conclusions reached.

At informal discussions at the site of any VDA or component meeting, all participants are expected to observe the same standards of personal conduct as are required of the Association in its compliance.

It is the policy of the VDA that a copy of this Antitrust Compliance Policy be given to each officer, trustee, and committee member annually.

I have read and understand the VDA Antitrust Compliance Policy.

_____
Signature

3. Adopted: The 2011 revision of the House of Delegates Manual of Standing Rules for the Annual Session (Replaces the document last revised in 2006.)

4. Adopted: Bylaws amendment making the Bylaws consistent with The House of Delegates Manual of Standing Rules for the Annual Session regarding the appointment of Reference Committee chairs.

Article III, Section 5.A
Section 5. Reference Committees:

A. The Reference Committees of the House of Delegates shall consist of five voting members of the House of Delegates appointed by the President of the Association. Reference Committee chairs also shall be appointed by the President. The number of Reference Committees shall be determined by the Board of Directors. Reference Committees shall meet at designated times following the first meeting of the House of Delegates to consider reports and resolutions of committees. Reference Committee hearings are open only to members of the Virginia Dental Association and invited guests. All members of the Association shall be permitted to speak. Invited guests may be permitted to speak only at the pleasure of the Committee.

5. Adopted: Bylaws amendment making the Bylaws consistent with The House of Delegates Manual of Standing Rules for the Annual Session regarding the appointment of Reference Committee chairs.

Article IV, Section 4.A-c
c. Appoint all chairs and members of the Reference Committees of the House of Delegates.

6. Approved: The Proposed VCU Legislative Bill relating to the licensure of dental school faculty. The Bill will be submitted to the 2012 General Assembly.

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2709, 54.1-2711.1, 54.1-2712, 54.1-2713, 54.1-2714, and 54.1-2725 of the Code of Virginia are amended and reenacted as follows:

§ 54.1-2709. License; application; qualifications; examinations.

A. No person shall practice dentistry unless he possesses a current valid license from the Board of Dentistry.

B. An application for such license shall be made to the Board in writing and shall be accompanied by satisfactory proof that the applicant (i) is of good moral character; (ii) is a graduate of an accredited dental school or college, or dental department of a university or college; (iii) has passed ~~Part I and Part II~~ all parts of the examination given by the Joint Commission on National Dental Examinations; (iv) has successfully completed a clinical examination acceptable to the Board; and (v) has met other qualifications as determined in regulations promulgated by the Board.

C. The Board may grant a license to practice dentistry to an applicant licensed to practice in another jurisdiction if he (i) meets the requirements of subsection B; (ii) holds a current, unrestricted license to practice dentistry in another jurisdiction in the United States and is certified to be in good standing by each jurisdiction in which he currently holds or has held a license; (iii) has not committed any act that would constitute grounds for denial as set forth in § 54.1-2706; and (iv) has been in continuous clinical practice for five out of the six years immediately preceding application for licensure pursuant to this section. Active patient care in the dental corps of the United States Armed Forces, volunteer practice in a public health clinic, or practice in an intern or residency program may be accepted by the Board to satisfy this requirement.

D. The Board shall provide for an inactive license for those dentists who hold a current, unrestricted dental license in the Commonwealth at the time of application for an inactive license and who do not wish to practice in Virginia. The Board shall promulgate such regulations as may be necessary to carry out the provisions of this section, including requirements for remedial education to activate a license.

E. The Board shall promulgate regulations requiring continuing education for any dental license renewal or reinstatement. The Board may grant extensions or exemptions from these continuing education requirements.

§ 54.1-2711.1. Temporary licenses to persons enrolled in advanced dental education programs; Board regulations.

A. Upon recommendation by the dean of the school of dentistry or the program director, the Board may issue a temporary annual license to practice dentistry to persons enrolled in advanced dental education programs, serving as dental interns, residents or post-doctoral certificate or degree candidates in hospitals or schools of dentistry that maintain dental intern, residency or post-doctoral programs accredited by the Commission on Dental Accreditation of the American Dental Association~~. No such license shall be issued to a dental intern or resident or post-doctoral certificate or degree candidate who has not completed successfully the academic education required for admission to examination given by the Board~~. Such license shall expire upon the holder's graduation, withdrawal or termination from the relevant program.
B. Such temporary license shall be for patient care activities associated only with the educational program and that take place only within educational facilities owned or operated by, or affiliated with, the dental school or program. The license holder shall not be permitted to practice dentistry in other offices or clinics.

C. The Board may prescribe such regulations not in conflict with existing law and require such reports from any hospital or the school of dentistry operating an accredited advanced dental education program in the Commonwealth as may be necessary to carry out the provisions of this section.

§ 54.1-2712. Permissible practices.

The following activities shall be permissible:

1. Dental assistants or dental hygienists aiding or assisting licensed dentists, or dental assistants aiding or assisting dental hygienists under the general supervision of a dentist in accordance with regulations promulgated pursuant to § 54.1-2729.01;

2. The performance of mechanical work on inanimate objects only, for licensed dentists, by any person employed in or operating a dental laboratory;

3. Dental students who are enrolled in accredited D.D.S. or D.M.D. degree programs performing dental operations, under the direction of competent instructors (i) within a dental school or college, dental department of a university or college, or other dental facility within a university or college that is accredited by an accrediting agency recognized by the United States Department of Education; (ii) in a dental clinic operated by a nonprofit organization providing indigent care; (iii) in governmental or indigent care clinics in which the student is assigned to practice during his final academic year rotations; (iv) in a private dental office for a limited time during the student's final academic year when under the direct tutorial supervision of a licensed dentist holding appointment on the dental faculty of the school in which the student is enrolled; or (v) practicing dental hygiene in a private dental office under the direct supervision of a licensed dentist holding appointment on the dental faculty of the school in which the student is enrolled;

4. A licensed dentist from another state or country appearing as a clinician for demonstrating technical procedures before a dental society or organization, convention, or dental college, or performing his duties in connection with a specific case on which he may have been called to the Commonwealth~~; and~~

5. Dental hygiene students enrolled in an accredited dental hygiene program performing dental hygiene practices as a requisite of the program, under the direction of competent instructors, as defined by regulations of the Board of Dentistry, (i) within a dental hygiene program in a dental school or college, or department thereof, or other dental facility within a university or college that is accredited by an accrediting agency recognized by the United States Department of Education; (ii) in a dental clinic operated by a nonprofit organization providing indigent care; (iii) in a governmental or indigent care clinic in which the student is assigned to practice during his final academic year rotations; or (iv) in a private dental office for a limited time during the student's final academic year when under the direct supervision of a licensed dentist or licensed dental hygienist holding appointment on the dental faculty of the school in which the student is enrolled; and
6. A graduate of an accredited dental program or a graduate of an accredited dental hygiene program, engaging in clinical practice under the supervision of a licensed faculty member, only while participating in a continuing education course offered by a dental or dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association.

§ 54.1-2713. Faculty licenses to teach dentistry; renewals.

A. Upon payment of the prescribed fee and provided no grounds exist to deny licensure pursuant to § 54.1-2706, the Board ~~shall~~ may grant, without examination, a faculty license to teach dentistry in a dental program accredited by the Commission on Dental Accreditation of the American Dental Association to any applicant who ~~(i) is~~ meets any of the following qualifications:

1. Is a graduate of a dental school or college or the dental department of a college or university, ~~approved by the Board of Dentistry; (ii) has a D.D.S. or D.M.D. degree and is otherwise qualified; (iii) is not~~ has a current, unrestricted license to practice dentistry in at least one other United States jurisdiction, and has never been licensed to practice dentistry in the Commonwealth; ~~(iv) has not failed an examination for a license to practice dentistry in Virginia; and (v) has a license to practice dentistry in at least one other state~~ or

2. Is a graduate of a dental school or college or the dental department of a college or university, has completed an advanced dental education program accredited by the Commission on Dental Accreditation of the American Dental Association, and has never been licensed to practice dentistry in the Commonwealth.

~~The applicant shall also be certified to be on the faculty of an accredited program that teaches dentistry.~~

B. The dean or program director of the accredited dental program shall provide to the Board verification that the applicant is being hired by the program, and shall include an assessment of the applicant's clinical competency and clinical experience that qualifies the applicant for a faculty license.

C. The holder of such a license shall be entitled to perform all operations ~~which~~ that a person licensed to practice dentistry would be entitled to perform ~~but only for the express purpose of teaching~~ and that are part of their faculty duties. This includes all patient care activities associated with teaching, research, and the delivery of patient care and that take place only within educational facilities owned or operated by, or affiliated with, the dental school or program. A license holder who is educationally qualified for a specialty board certification shall only practice in the specialty in which he is qualified. This license does not ~~entitle~~ permit the holder to practice dentistry ~~intramurally or privately or to receive fees for service~~ in other offices or clinics.

D. Any license issued under this section shall expire on the June 30 of the second year after its issuance or shall terminate when the licensee leaves employment at the accredited dental program. Such license may be renewed annually thereafter as long as the accredited program certifies to the licensee's continuing employment.

§ 54.1-2714. Restricted licenses for a temporary appointment to teach dentistry for foreign dentists.

A. The Board may grant, without examination, a restricted license for a temporary appointment to teach dentistry at a dental school in this Commonwealth to any person who:

1. Is a resident of a foreign country;

2. Is licensed to practice dentistry in a foreign country;

3. Holds a faculty appointment in a dental school in a foreign country;

4. Is a graduate of a foreign dental school or college or the dental department of a foreign college or university;

5. Is not licensed to practice dentistry in Virginia;

6. Has not failed an examination for a license to practice dentistry in this Commonwealth;

7. Has received a temporary appointment to the faculty of a dental school in this Commonwealth to teach dentistry;

8. Is, in the opinion of the Board qualified to teach dentistry; and

9. Submits a completed application, the supporting documents the Board deems necessary to determine his qualifications, and the prescribed fee.

B. A restricted license shall entitle the licensee to perform all operations which a person licensed to practice dentistry may perform but only for the purpose of teaching. No person granted a restricted license shall practice dentistry intramurally or privately or receive fees for his services.

C. A restricted license granted pursuant to this section shall expire twelve months from the date of issuance and ~~may not be renewed or reissued~~ may be renewed for one 12 month period.

§ 54.1-2725. Faculty licenses to teach dental hygiene; renewals.

A. Upon payment of the prescribed fee, the Board shall grant, without examination, a license to teach dental hygiene to any applicant who (i) is a graduate of a dental hygiene school or college or the dental hygiene department of a college or university ~~approved by the Board of Dentistry~~ accredited by the Commission of Dental Accreditation of the American Dental Association; (ii) has a B.S., B.A., A.B., or M.S. degree and is otherwise qualified; (iii) is not licensed to practice dental hygiene; and (~~iv) has not failed an examination for a license to practice dental hygiene in this Commonwealth~~; and (v) has a license to practice dental hygiene in at least one other ~~state~~ United States jurisdiction. ~~The applicant shall be certified to be on the faculty of an approved institution that teaches dentistry or dental hygiene~~.

B. The dean or program director of the accredited dental hygiene program shall provide to the Board verification that the applicant is being hired by the program, and shall include an assessment of the applicant's clinical competency and clinical experience that qualifies the applicant for a faculty license.

C. The holder of such a license shall be entitled to perform all operations ~~which~~ that a person licensed to practice dental hygiene would be entitled to perform ~~but only for the express purpose of teaching~~ and that are a part of his faculty duties. This includes all patient care activities associated with teaching, research, and the delivery of patient care and that take place only within educational facilities owned or operated by, or affiliated with, the dental school or program. This license does not entitle the holder to practice dental hygiene ~~intramurally or privately or to receive fees for services~~ in other offices or clinics.

D. Any license issued under this section shall expire on ~~the second~~ June 30 of the second year after its issuance ~~but may be renewed~~ or shall terminate when the licensee ceases employment at the accredited dental program. Such license may be renewed annually thereafter as long as the accredited program certifies to the licensee's continuing employment.

2. That § 54.1-2714.1 of the Code of Virginia is repealed.

~~§ 54.1-2714.1. Faculty licenses to practice dentistry for full-time faculty members. Pursuant to regulations promulgated by the Board, the Board may grant a faculty license to practice dentistry to full-time faculty members of schools of dentistry in the Commonwealth.~~

7. Approved: The proposed Virginia Dental Laboratory Safety Act.

VIRGINIA DENTAL LABORATORY SAFETY ACT

Whereas, this General Assembly finds that the health, safety and welfare of the citizens of this Commonwealth are promoted by the establishment of registration and disclosure procedures for the dental laboratory industry, it is hereby resolved that the following shall be enacted:

SECTION I. Purpose

1.1 The purpose of this Act is to promote the health, safety and welfare of the citizens of this Commonwealth by requiring that all dental laboratories conducting business in this Commonwealth register with the Board of Dentistry in order to engage in the manufacture and repair of dental prosthetic appliances as hereinafter provided, and further; to disclose to the prescribing dentist the material content and any contraindications for purposes of ensuring the health and safety of the patient as well as the point of origin and location(s) of manufacture of the prescribed restoration.

SECTION II. Definitions

2.1 Dental Laboratory: A commercial dental laboratory is any individual or business entity including but not limited to a corporation, partnership or sole-proprietor engaged in the manufacture or repair of dental prosthetic appliances on the prescription of and
for a licensed dentist or the work authorization of another commercial dental laboratory.

2.2 Licensed Dentist: shall mean any person duly licensed to practice dentistry under any statute of this Commonwealth or practitioners licensed in other states.

2.3 Prescription: shall mean a written instrument executed by a licensed dentist and directed to a registered dental laboratory authorizing the manufacture or repair of a dental prosthetic appliance for such licensed dentist. A prescription may be handwritten and may be faxed or sent electronically using an electronic signature.

2.4 Work Order: shall mean a written instrument executed by a registered dental laboratory authorized by prescription by which such dental laboratory subcontracts all or part of the fabrication or repair of a dental prosthetic appliance authorized by prescription to another registered dental laboratory. A work order may be

handwritten and may be faxed or sent electronically using an electronic signature.

SECTION III. Registration and Disclosure
3.1 Upon the effective date of this Act, all dental laboratories with offices or facilities located with the Commonwealth of Virginia and all dental laboratories operating, doing business or intending to operate or do business within the Commonwealth of Virginia shall be required to register with the Board of Dentistry. The registration shall be valid for a two-year period; the Virginia Board of Dentistry shall set a reasonable registration fee.

3.2 In order to comply with this Act, a dental laboratory shall practice infectious disease control as required by OSHA.

3.3 A dental laboratory wherever located shall be considered as operating or doing business in this Commonwealth if its work product is prepared pursuant to a prescription originating from within this Commonwealth.

3.4 A dental laboratory shall disclose to the dentist the material content used in prescribed restorations with any contraindications for purposes of ensuring the health and safety of the patient. The dental laboratory shall provide the dentist with the FDA product registration number of the material, to be included in the patient's record.

3.5 A dental laboratory shall disclose to the dentist the point of origin and location(s) of manufacture of the prescribed restoration, whether partially or entirely manufactured by a foreign dental laboratory or any domestic ancillary dental laboratory.

3.6 Dental technician(s) employed, and under the direct supervision of a practicing dentist in the Commonwealth of Virginia, in office lab, or those acting in support of an educational setting, or involved in charity or non-profit work shall be exempt from registration. If these technicians conduct business with outside providers then they too will be required to register.

SECTION IV. Prescription/Work Order Required

4.1 No dental laboratory shall perform any manufacture or repair of dental prosthetic appliances for a licensed dentist without a valid prescription from the licensed dentist or a valid work order from a registered dental laboratory authorized by prescription.

SECTION V. Use of Non-Registered Dental Laboratory Prohibited

5.1 It shall be prohibited for any dentist licensed in this Commonwealth to knowingly have a dental prosthetic appliance manufactured in or by a dental laboratory, in the Commonwealth or otherwise that does not meet the regulatory requirements of this Commonwealth.

SECTION VI. Non-Compliance Dental Laboratory Prohibited
6.1 Dental laboratories are required to comply with the registration and disclosure requirements of this act. Non-compliant laboratories will be subject to disciplinary action by the Board of Dentistry.

SECTION VII. Effective Date

This Act shall become effective July 1, 2012.

Adopted: The current remote supervision of hygienists employed by the Virginia Department of Health be expanded to all Virginia Health Districts and the VDA continue to look for innovative solutions that will directly impact the access to care issue. (VDA Policy)

Adopted: As part of the solution to improve access to care the House of Delegates recommends that the Board of Directors create a legislative initiative to increase funding for the Division of Dental Health for more public health dentists. This initiative should encourage placement of dentists in the public health districts of Southside, Cumberland Plateau and Lenowisko, as well as other areas of need. The initiative should be included in the 2012 VDA legislative agenda and the Board should report back to the House of Delegates in 2012 on the progress of the initiative.

Adopted: A dues increase of $11.00.

Defeated: A special assessment of $20 per member per year for the next five years to restore the reserve to the goal of 50%. The assessment will be reduced, if possible, and be eliminated totally once the 50% mark is achieved.

12. Adopted: The 2012 proposed budget.

13. Approved: The 2011 VDA Life Members: Component 1: Stephen Goldstein, Michael Hechtkopf, J. E. Lewis, Louis C. Peron, Leslie I Richmond, Ivan R. Schiff, Martin L. Walton III, Charles R. Wright. Component 2: Gisela K. Fashing, Barry L. Green, Jesse A. Hobbs, Joseph A. Lombard, Jack A. Mrazik, Alfred P. Moore. Component 3: William F. Callery, James M. Keeton, Jr., Harvey Thompson. Component 4: Anne C. Adams, Frank L. Angus, William H. Angus; William C. Betzhold, Daniel R. Leahy, Donald G. Levitin, Harry A. Raddin, Jr., William J. Redwine, Thomas C. Waldrop, Richard H. Wood. Component 5: Charles E. Ayers, David E. Bittel, David E. Black, James R. Evans, David C. Jones, William W. Martin, Edward M. O'Keefe, Robert L. Plapp, Charles Ramsberger, James W. Shearer, H. M. Sparger, Marvin E. Thews, Jr., Guy W. Walton, Jr. Component 6: Daniel E. Thompson. Component 7: Dandridge B. Allen, Robert M. Driscoll, Jr., Danny B. Neese, Andrew B. Martof, William J. Viglione. Component 8: Edward J. Bernhart, George M. Casey, Mary A. Choby, Frank A. Delatour, Jr., John P. DeMorro, Jr., David M. DeViese, Richard F. Donohue, Marshall E. Flax, John A. Good, Stuart L. Graves, Michael T. Hardin, Barry Herbst, Stephen J. Mayo, Joseph A. McConaghy, David I. McGibbons, Michael Polifko, Richard O. Rice, Harold L. Shapiro, Dale P. Shewmaker, Martin D. Siegel, James A. Snyder, Richard K. Stern, Thomas S. Striano, Rouben Yedigarian, James G. Zaletel, Paul N. Zimmet

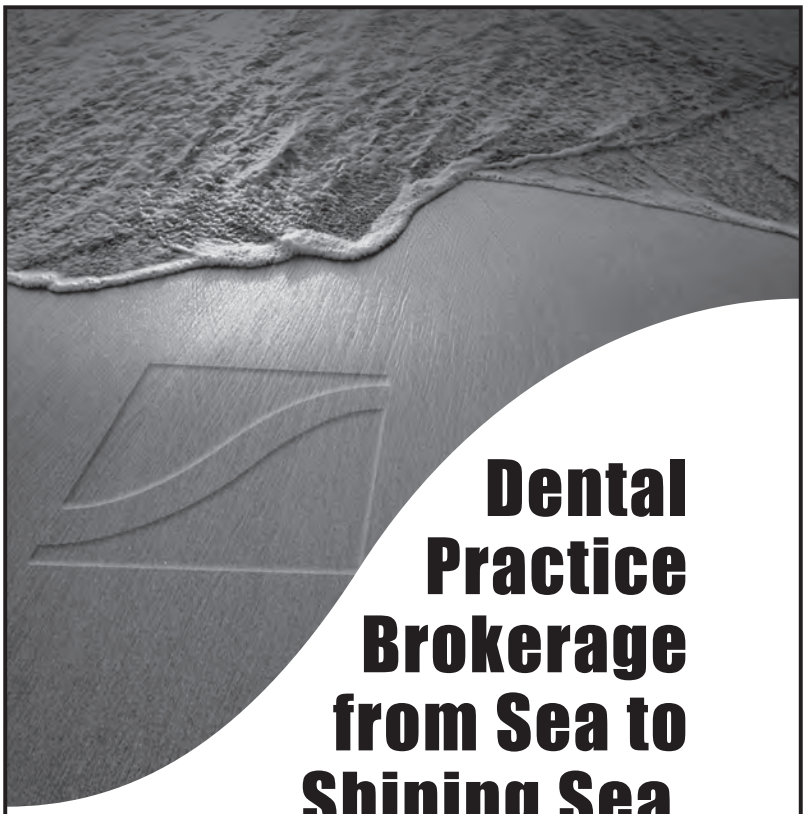
14. Approved: Robbie Schureman for Honorary Membership in the Virginia Dental Association.

Reported as information only:

1. The following were elected to serve on the VDA Board of Directors (three year terms):

Samuel W. Galstan	Component 3
David E. Black	Component 5
Neil J. Small	Component 8

2. Charles E. Gaskins III was elected Speaker of the House.



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Welcome New Members!

September 2011

Tidewater Dental Association

Dr. Francisco Aviles graduated from San Carlos de Guatemala University in 2004. He completed his AEGD in 2009 from CAGS. Dr. Aviles is practicing in Virginia Beach.

Dr. Christine Cerar graduated from the University Of Pittsburgh School Of Dental Medicine in 2001. She completed her AEGD in 2003, from Ft. Campbell, KY, and received her Certificate in Endodontics in 2008 from Ft. Bragg, NC. Dr. Cerar is practicing in Virginia Beach, with General Booth Endodontics.

Dr. James Lee graduated from VCU School of Dentistry in 2009. He received his AEGD Certificate in 2010 from the University of Florida. Dr. Lee is practicing in Norfolk with Konikoff Family Dentistry.

Dr. Scott Sachs graduated from VCU School of Dentistry in 2008. In 2008-2009 he completed his GPR from St. Barnabas Hospital. In 2011 he received his Certificate in Pediatrics from NYU. Dr. Sachs is practicing in Chesapeake with LWSS Family Dentistry.

Dr. Jacob Saxton graduated from VCU School of Dentistry in 2009. Dr. Saxon is practicing in Virginia Beach.

Peninsula Dental Association

Dr. Francisco Carlos graduated from the University Of Connecticut School Of Dental Medicine in 2007. He received his Certificate in Periodontics in 2010 from VCU. Dr. Carlos is practicing at Langley AFB Dental Clinic.

Dr. Helen Fiscella graduated from VCU School of Dentistry in 2002. Dr. Fiscella is practicing in Williamsburg.

Dr. John Morgan graduated from VCU School of Dentistry in 2005. He then received his Certificate in Oral Maxillofacial Surgery from Detroit Medical Center in 2011. Dr. Morgan is practicing with Oyster Point Oral and Facial Surgery in Newport News.

Dr. Sayward Duggan graduated from VCU School of Dentistry in 2006. She completed her GPR from UVA in 2008, where she received her Certificate in Periodontics. Dr. Duggan is practicing in Yorktown.

Richmond Dental Society

Dr. Jin Choi Graduated from VCU School of Dentistry in 2011. Dr. Choi is practicing with Dr. Walter Saxon in Dillwyn.

Dr. David Christianson graduated from VCU School of Dentistry in 2008. He attended Oregon Health and Science University where he received his Certificate in Endodontics in 2011. Dr. Christianson is practicing in Fredericksburg, with Dr. Pagan.

Dr. Sarah Gerber graduated from VCU School of Dentistry in 2010. Dr. Gerber is practicing with Drs. Oley and Quilez in Richmond.

Dr. Elizabeth Lee graduated from VCU School of Dentistry in 1990. Dr. Lee is practicing in Richmond.

Dr. Dean De Luke graduated from Columbia University in 1978. He completed his Oral Maxillofacial Surgery Residency in 1982 from Long Island Jewish Medical Center. Dr. DeLuke is now at the VCU Department of Oral and Maxillofacial Surgery in Richmond.

Dr. Athra Khalaf graduated from VCU School Dentistry in 2011. Dr. Khalaf is practicing in the Richmond area.

Dr. Feisal Osman graduated from MCV in 1992 . Dr. Osman is practicing in Richmond.

Dr. William Octave graduated from the University of Pittsburgh in 1975. Dr. Octave is a new faculty member at VCU School of Dentistry.

Dr. Thomas Vahdani graduated from the University of S. CA in 2003. Dr. Vahdani is a new faculty member at VCU School of Dentistry and has joined the faculty practice as well.

Piedmont Dental Society

Dr. Loren Cook graduated from Medical University of South Carolina in 2009. She is practicing with Dr. Lawrence Kyle in Blacksburg.

Dr. Matthew Estes graduated from VCU School of Dentistry in 2011. Dr. Cook is practicing in Lynchburg.

Dr Hui Yang graduated from NYU in 2011. Dr. Yang is practicing in Roanoke.

Southwest VA Dental Association

Dr. Brittney Ellis graduated from VCU School of Dentistry in 2011. Dr. Ellis is practicing in Abingdon with Dr. Scott Miller.

Shenandoah Valley Dental Association

Dr. Brian Fangman graduated from the Ohio State University in 2007. He received his OMFS Certificate in 2011 from NY Nassau University Medical Center in 2011. Dr. Fangman is practicing with Dr. M. Todd Brandt in Fishersville.

Dr. Ricardo Solis graduated from VCU School of Dentistry in 2003. Dr. Solis completed his GPR in 2004. Dr. Solis is practicing in Charlottesville.

Dr. Austin Westover graduated from VCU School of Dentistry in 2011. Dr. Westover is practicing with Dr. John Neumann in Winchester.

Dr. Mitra Westover graduated from VCU School of Dentistry in 2011. Dr. Westover is practicing with Dr. John Neumann in Winchester.

Northern VA Dental Society

Dr. Edison Abril graduated from Saint Louis University in 2011, where he received his Certificate in Periodontics. Dr. Abril will be practicing in the Northern VA area.

Dr. Angela Austin graduated from the University of Pennsylvania in 2004. She received her Certificate in Pediatric Dentistry in 2006 from Children's National Medical Center. Dr. Austin is practicing in Alexandria.

Dr. Jana Boyd graduated from LSU in 2001. Dr. Boyd is practicing in Suffolk, with Dr. Ralph Howell.

Dr. Brigid Buck graduated from University of Texas Health Science Center in 2011. Dr. Buck is practicing in Arlington with Dr. David Cote.

Dr. Giovanni Caballero-Acuna graduated from the University of San Martin de Porres in 2001. She received her AEGD in 2010 from Howard University. Dr. Caballero-Acuna is practicing in Alexandria.

Dr. Jerry Cheng graduated from the University Illinois at Chicago in 2011. Dr. Cheng is practicing in Alexandria.

Dr. Ray Cho graduated from VCU School of Dentistry in 2010. He received his AEGD Certificate in 2011 from the University of Florida. Dr. Cho is practicing in Arlington.

Dr. Nadia Church graduated from VCU School of Dentistry in 2006. She received her AEGD from VAMC Martinsburg in 2007. Dr. Church is working with Neibauer Dental Care in Gainesville.

Dr. Carola De La Cruz graduated from Howard University in 2008. She received her Certificate in Pediatric Dentistry in 2010 from the University of Medicine and Dentistry of New Jersey. Dr. De La Cruz is practicing in Arlington, with Arlington Pediatric Dentistry.

Dr. Karina Vera-Lopez graduated from the University of Michigan School Of Dentistry in 2011. She is practicing in Alexandria.

Dr. Minoo Akhavan Malayen graduated from NYU in 2011. She is now practicing in the Northern VA area.

Dr. Wanda Goldhush graduated from VCU School of Dentistry in 1988. She completed her AEGD in 1989. Dr. Goldhush is practicing in Alexandria.

Dr. Jolanta Griffiths graduated from the University of Connecticut in 2010. She completed her AEGD in 2011 at Jackson Memorial. Dr. Griffiths is practicing in McLean with Dr. Ramin Razavi.

Dr. David Groy graduated from Temple University in 1979. He completed his GPR in 1980. Dr. Groy is practicing in Leesburg.

Dr. Andrew Hinkle graduated from the University of Maryland Dental School in 2011. Dr. Hinkle is practicing with Dr. R. Alan Hinkle in McLean.

Dr. Steven Johnson graduated from University of Colorado in 2010. He received his GPR in 2011 from East Carolina University. Dr. Johnson is practicing in Leesburg with Loudon Dental Smiles.

Dr. Eunghwan Kim comes to us from Nebraska. He graduated from Seoul National University in Seoul, Korea, in 1994. Dr. Kim received AEGD in 2002 from the University of Maryland. Dr. Kim is practicing in Fairfax.

Dr. Jyothi Koneru graduated from NYU in 2003. She is now practicing in Chantilly.

Dr. Audrey Mairano graduated from VCU School of Dentistry in 2010. Dr. Maiurano is practicing in Fairfax.

Dr. Diego Morales graduated from the University of Maryland in 2004. He is practicing in Manassas with Ackerman and Associates.

Dr. Tamesha Morris graduated from VCU School of Dentistry in 2003. Dr. Morris is practicing with Dental Serenity in Dumfries.

Dr. Amir Naimi graduated from VCU School of Dentistry in 2004. He completed his Certificate in OMFS in 2008. Dr. Naimi is practicing in Burke with Graves, Patterson, Yaghmai.

Dr. Anthony Papinsick graduated from the University of PA in 2011. He is practicing in Arlington, at Arlington Center for Dentistry.

Dr. Kelly Peaks graduated from the University of TN in 2009. Dr. Peaks is practicing in Alexandria.

Dr. Rabia Rafiq graduated from NYUCD in 2007. She is practicing at the Reston Center for Dentistry.

Dr. Margo Robinson graduated from Howard University in 2003. She received her AEGD from VCU in 2004. Dr. Robinson is practicing in Manassas.

Dr. Milan Simanek graduated from VCU School of Dentistry in 2011. Dr. Simanek is practicing with Charles D. Kirksey and Associates in Fairfax.

Dr. Norman Trahos graduated from VCU School of Dentistry in 2006. Dr. Trahos is practicing in Alexandria with Del Ray Smiles.

Dr. My Kim Tran graduated from VCU School of Dentistry in 2008. She received her Certificate in Pediatrics in 2010 from NYUCD. Dr. Tran is practicing in Gainesville, with Gainesville Pediatric Dentistry.

Dr. Thoai-Lan Tran graduated from VCU School of Dentistry in 2008. Dr. Tran received his Certificate in Orthodontics in 2010. Dr. Tran is practicing in Fairfax.

Dr. Gavin Uchida graduated from the U. California San Francisco in 2005. He received his Certificate in Pediatrics from the University of Texas in 2007. Dr. Uchida is practicing in Fairfax.

Dr. Pedram Yaghmai graduated from VCU School of Dentistry in 2004. She completed her Certificate in OMFS. Dr. Yaghmai is now practicing in Burke with the Northern VA Oral, Maxillofacial and Implant Surgery Associates.

In Memory of...

Name	Component	City	Date
Dr. Dewey H. Bell	4	Gloucester	August 20, 2011
Dr. John I Bowman	1	Virginia Beach	June 20, 2011
Dr. Ulpian G Bradenham	2	Williamsburg	February 18, 2011
Dr. William F. Freidank	8	Nokesville	July 4, 2011
Dr. Major D Gayle, Jr.	4	Fredericksburg	December 31, 2009
Dr. Randal W. King	4	Midlothian	June 26, 2011
Dr. William C March	1	Suffolk	June 18, 2011
Dr. Jeffrey M. Massey	8	Bentonville	October 11, 2010

The Southside Dental Society and the Virginia Dental Association present

Occlusion for the Aesthetic Restorative Practice

John Cranham, DDS

Friday, November 18, 2011
Country Club of Petersburg
1250 Flank Road
Petersburg, VA 23805

Registration: 8:00 am - 8:30 am
Program: 8:30 am - 4 pm
Lunch will be served from 12-1pm
6.5 Credit Hours

Registration Fees Per Person
(Includes Continental breakfast and lunch)

SDS members	**$75**
Other VDA members	**$125**
VDA Auxillary and Staff	**$50**
Non-VDA members	**$250**

Please contact Dr. Mike Webb with questions Phone: (804) 539-3794 Email: angelwing86@verizon.net

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Academy of General Dentistry
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Send registration to: Dr. Michael Webb - 10409 Midlothian Turnpike, Richmond, VA 23235

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1. Publication Title	2. Publication Number	3. Filing Date
Virginia Dental Journal	0066-0300	September 16, 2011
4. Issue Frequency: Quarterly (Jan Mar April June Jul Sep Oct Dec)	5. Number of Issues Published Annually: 4	6. Annual Subscription Price: $12

7. Complete Mailing Address of Known Office of Publication (Not printer) (Street, city, county, state, and ZIP+4®): 3460 Mayland Court, Suite 110, Richmond, Va 23233 — Contact Person: Terry D. Dickinson — Telephone (Include area code): 804-288-5750

8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not printer): 3460 Mayland Court, Suite 110, Richmond, Va 23233

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor (Do not leave blank)

Publisher (Name and complete mailing address): Virginia Dental Association — 3460 Mayland Court, Suite 110, Richmond, Va 23233

Editor (Name and complete mailing address): Dr. Richard F. Roadcap — 3460 Mayland Court, Suite 110, Richmond, Va 23233

Managing Editor (Name and complete mailing address): Dr. Terry D. Dickinson — 3460 Mayland Court, Suite 110, Richmond, VA 23233

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13. Publication Title: Virginia Dental Journal	14. Issue Date for Circulation Data Below: Jul, Aug, Sep	
15. Extent and Nature of Circulation: Dental Periodical	Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies (Net press run)	4100	4100
b. Paid Circulation (By Mail and Outside the Mail) (1) Mailed Outside-County Paid Subscriptions Stated on PS Form 3541 (Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	3011	2841
(2) Mailed In-County Paid Subscriptions Stated on PS Form 3541 (Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	208	187
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c. Total Paid Distribution (Sum of 15b (1), (2), (3), and (4))	3219	3028
d. Free or Nominal Rate Distribution (By Mail and Outside the Mail) (1) Free or Nominal Rate Outside-County Copies included on PS Form 3541	394	617
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(3) Free or Nominal Rate Copies Mailed at Other Classes Through the USPS (e.g. First-Class Mail)	105	76
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e. Total Free or Nominal Rate Distribution (Sum of 15d (1), (2), (3) and (4))	831	1005
f. Total Distribution (Sum of 15c and 15e)	4050	4033
g. Copies not Distributed (See Instructions to Publishers #4 (page #3))	50	67
h. Total (Sum of 15f and g)	4100	4100
i. Percent Paid (15c divided by 15f times 100)	79%	75%

16. Publication of Statement of Ownership
☑ If the publication is a general publication, publication of this statement is required. Will be printed in the Oct Nov Dec issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Executive Director, Business Manager — Date: September 16, 2011

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