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VDA Virginia Dental Association Journal

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Virginia Dental Journal

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Due to the recent fire at the VDA Central Office we have relocated to a new temporary home. We will be sure to update you as we have more information.

Please make note of our new contact information.

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Dr. Terry Dickinson at the ADA Annual Meeting Orlando

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Message from the Editor

Dr. Richard F. Roadcap

About once a month a story in the lay press causes concern for the dental profession. Some of the controversies are long–running: mercury in dental amalgam, and water fluoridation are two examples. Even the bisphenol A controversy has been bandied about for almost a decade. The list of concerns reads like the periodic table: mercury (Hg) in amalgam and in the wastewater stream; lead (Pb) in offshore laboratory prostheses; zinc (Zn) in denture adhesive; and cadmium (Cd) in the toys we give to children. From thyroid collars on "Dr. Oz" to cone-beam computed tomography (CBCT) in the *New York Times* working dentists like us never get a break from the popular media.

Eruptions in the news media generally fall under one of three headings. Most involve clinical care and patient safety: dental amalgam, bisphenol A (alleged to be an endocrine disrupter), and fluoride, both in the public water supply and for professional use, are some examples. Environmental issues, while few in number, are well-known and contentious: mercury in the wastewater stream entering publicly-owned treatment works and disposal of sharps as regulated medical waste have gained public attention. Finally, there's a third category, less well-defined, but significant: public perception and esteem of the profession. Ethics and access-to-care are examples of subjects that frame many discussions and may dwarf all other concerns. It's easier to change the chemistry in sealants or install an amalgam separator than to convince the public we always place a priority on the interests of our patients.

News articles pertaining to the third category always seem to provoke the most vigorous debate. Fourteen years after *Reader's Digest* published William Ecenbarger's "How Honest Are Dentists?" the article is still mentioned by doctors as an example of press distortion and misrepresentation. *RD's* premise was simple: intrepid reporter goes behind the scenes, uncovers evidence of fraud and deception in trusted profession. Overlooked were two undercurrents. First, *Reader's Digest* at the time was a struggling enterprise (the publisher filed for bankruptcy in 2009) and needed to expand circulation. Second, dentistry was just one of a list of professions bushwhacked in print. The FBI and the auto repair industry were soon to follow. Mr. Ecenbarger used a well-worn journalistic device to make his case – state only the facts that support your conclusion, and withhold those that would refute it. For example, he assembled a foursome of "experts" to review his findings, but failed to disclose two had ties to the insurance industry. Predictably, the public greeted his report with a collective yawn. Our office had only one patient mention it. His take: "these things happen."

Some reports are baffling to most practitioners. The neurotoxic effects of zinc in denture adhesive and the discovery of lead in Chinese-made crowns were unknown to dentists until the findings surfaced in the press. Most of us give out, with a disclaimer, samples of adhesive and I've never questioned the origin of PFM crowns returned from a local laboratory. Our innocence didn't prevent these stories from going "viral" in the national media. Lisa Sanders, M.D. (technical advisor to the Fox network's House) devoted her monthly column "Diagnosis" in the *New York Times Magazine* to the tale of a middle-aged patient with poor-fitting dentures and a bewildering array of symptoms.[1] Except for greatly elevated levels of zinc, and depleted levels of copper her laboratory results were normal. (Guess what caused her disability.) ABC television's report on lab subterfuge – "made in the U.S.A." doesn't always mean that – has led to calls for legislation requiring dental labs to disclose the origin of their work.

Why are we such easy targets? Or are we receiving our "fair share of abuse"? As reported in these pages, the dental profession has been held in high esteem by the public for many years.[2] Our patients may not be losing as much sleep over this as we are. I suspect many of the reports have a lot to do with the character of the press in the 21st century, and not because any of any perceived deficiency or corruption. In an age of declining circulation for print media, and the ascendancy of online news, readers have shown tolerance for errors in reporting in exchange for immediacy. "Get it out" trumps "Get it right". Today's reporters often meet at the intersection of vanity and commerce, and the dental profession…well, we're good for a laugh now and then.

Practitioners today are busy – too busy to deal with the latest outburst on network news. But they don't have to. Organized dentistry has already prepared a response so we don't have to be confronted by patients clutching a newspaper and demanding an answer. Not only is the ADA's response prompt, but also measured – even no response may be the best answer. When an interview on National Public Radio with Dan Ariely, Ph. D. (a behavioral economist at Duke University) veered off course, with Dr. Ariely stating dentists misread x-rays to make more money, the ADA was swift and forceful in its response. Our patients' trust and respect were at stake. NPR's ombudsman later issued a we-were-wrong-but-we-won't-apologize statement, admitting the interviewer failed to ask the professor to substantiate his claim.[3] I once reported to the ADA an article posted by another profession, an anti-fluoride polemic masquerading as science, and was told they were familiar with the article and the author and were considering a response. No reply was made, and the report gained no traction in the press. Each member is backed by the association's policy, science, and finesse in dealing with the fourth estate. Policy statements covering every subject from amalgam waste to tooth whitening are posted on their website. We can focus on patient care, and not worry over the monthly dustup in the media.

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1 Lisa Sanders, "Fear of Falling", *New York Times Magazine*; September 6, 2009

2 Chambers, D. Gallup on Trust. Virginia Dent J 2010: 87(1): 9

3 http://www.ada.org/news/5042.aspx

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Message from the President

Dr. Michael Abbott

I am pleased to inform you, that after an wide-ranging search of the real estate market in the Richmond area, we have just signed a contract to purchase a 'shell' building (new construction) just off Gaskins Road and I-64 on Mayland Court. This is a medical office park and so our new neighbors will be physician practices. It is located just off Mayland Drive on the east side of Gaskins (very close to the state dental board building) and has a hotel (SpringHill Suites) located within walking distance and has a number of restaurants a short drive away. Those who like to shop will find Short Pump Town Center a short distance down Broad Street.

The VDA House of Delegates gave the Building Committee (established by the Board of Directors) its support and authority to pursue the search for a new building and/or the rebuilding of the old building. Realizing that the future space needs for the VDA were greater than what the old building would provide, we ended up making the decision to purchase new construction. After considering a number of other choices and locations, it was the feeling of the group that, for our immediate and future needs, this building would serve the VDA well into the future. Having a shell building allows us to design and build something that will fit our specific needs. Terry and staff are quite pleased with this choice and opportunity to build for our future requirements.

The space is 1200 square feet larger than the Staples Mill building and allows us that growth space that the VDA requires. Incidentally, there are more than adequate parking spaces available. We will be allowed to park our VDA truck on site which allows us an efficient process for loading, etc., for the MOM Projects and we will have the additional storage space needed for files and supplies. The projected move date will be April 1st and hopefully that will occur as planned. We feel we have done our due diligence and feel certain that you will agree with our choice.

If you missed the VDA Leadership conference, on November 12th and 13th, you need to talk to those that were present. The take home message from the conference is one of ownership. Who do you want to own your VDA and your Profession? If you think that it needs to be us, then each of you will need to take ownership and responsibility of that statement. There are many outside forces that would like to take control of our professions and change it into a trade which they can control, not you or I.

We are at the proverbial fork in the road – take the 'left' road with business as usual and onto a future that is filled with despair for those that follow us. Take the' right' road and be willing to get out of your chairs and be a more active participant in taking an ownership position in making certain that we leave a strong association, profession and legacy for those who follow us. We (the leadership) cannot do it alone, you must make that investment if you want to travel the 'right' road. The world has become far too complex and unpredictable for business as usual. Into this new world filled with uncertainty and confusion we must travel, not in the ways of the past, but with new strategies and new battle plans. We are in the fight of our lives and for the future of our profession. In my opinion, I see one road - the 'right' road. It will not be easy or without a personal cost of time, energy and commitment, but it is our only choice if we care for this great profession we call dentistry. I urge you to be part of this-we can win standing together. Please make the right choice with me as we face this crucial time in our profession. I can't do it, the Board of Directors can't do it, the component presidents and others within your components can't do it, our Executive Director and his staff can't do it, it is up to you – separately and collectively to make sure that we leave a profession behind for those who follow us. Please make that commitment for our future.

Cherryl Bates Dickinson

August 14, 1947 - January 2, 2011

'Thank you to all of our VDA friends for all the support and love you have shown Cherryl and I during our time together in Virginia. Thank you all for the love you have shown me during this most difficult time in my life. Cherryl was my inspiration and was the most amazing person I have ever known. She rests gently in the arms of God and the stars shine brighter because of her presence.'

Terry D. Dickinson, DDS

Increasing Size of Dental Establishments

By: H. Barry Waldman, DDS, MPH, PhD; Dolores Cannella, PhD; Allen Wong, DDS, EdD; Steven P. Perlman, DDS, MScD, DHL (Hon)

Abstract

The increasing size of dental establishments has become a reality in the delivery of dental services. Despite the increasing employment, annual expenditures of more than $100 billion, and evolving settings for care, planning for oral health services has not shed its perception of dentistry as a side show for general medical care. Planning for the future must recognize the evolving landscape for the delivery of oral health care.

Introduction

It was not that long ago when most dentists (predominately, white American males) practiced as sole proprietors with perhaps a dental hygienist, and one or two female assistants/receptionists/and other titled employees. (The primacy of male practitioners is undergoing change as the percentage of female first-year dental students increased by 34 percent between the 1999-2000 and the 2008-09 school years. In that same period, the number of male first year dental students increased by 2 percent. In 2008, 2,174 females and 2,744 males enrolled in first year dental school classes throughout the country. (1) Over time, the individual dentist, his (maybe her) one or two employees and the patients learned about each other's lives, and their joys and sorrows, as they chatted during the annual and semiannual visits. While many reluctantly visited their local dentists, the personal relationships, to some extent, lessened the patient's anxiety. In the past, it may well have been the experiences in this setting which attracted succeeding generations of men and women to a career in the profession.

The changing dental practice setting

Establishments: Just as local pharmacies, groceries, neighborhood attire locations and general medical practices are being replaced by conglomerate chains, box stores, group practices and health maintenance organizations, so too are many small dental establishments.

The Census Bureau defines an establishment as a single physical location where services are performed. It is not necessarily identical to a company or enterprise, which may consist of one or more establishments. In addition, one or more practitioners may be present in an establishment. Throughout this presentation, (except where specified) the term "dental establishment" refers to those facilities 1) with employees and 2) subject to federal income tax. Employers may include multi-practitioner settings (including both specialist and general practitioners at the same location) with increasing numbers of employees, ranging from secretaries, dental assistants, dental hygienists, and office managers, to third party associates, "salon personnel" (who augment dental services with activities more often associated with locations which cater to relaxation sessions) and a seemingly endless array of front and back room personnel. Government agency programs (hospitals and health department clinics) are not included. (2) The term "small establishments" refers to those facilities with less than five employees.

The pronounced transformation to larger dental facilities was quite evident between 1980 and 2007. During these years, there was a national increase of almost 41,000 dental establishments, but a decrease of 8,300 small dental establishments. In 1980, small dental establishments represented 69 percent of all dental facilities, compared to 40 percent in 2007. In the period between 1997 and 2007, there was a decrease of more than 4,100 small dental establishments and an almost two thirds increase (63.8 percent) in facilities with 20-49 employees. By 2007, dental establishments with less than five employees and those with 5-9 employees, each represented 40 percent of the total number of dental establishments; 17 percent of establishments had 10-19 employees. (Table 1)

Between 1980, 1997 and 2007, the employees in the average establishment increased from 4.1, to 5.7, and then to 6.5 individuals. While there is no such thing as an "average" dental establishment, comparisons between averages (over time and between locales) do provide a picture of the evolving practice of dentistry. The "average" number of employees was determined by dividing the total number of dental employees in the country and in the states by the number of dental establishments in the particular area. (Table 1)

As a result of a one-third increase in the national population and a 47 percent increase in the number of dental establishments between 1980 and 2007, there was a decrease in the national population-to-dental establishment ratio from 2,643 to 2,368 residents per establishment. (5,6)

Dentists: During 1997-2007 the number of U.S. private practicing dentists increased from 147,778 to 166,837 individuals (a 12.9 percent increase) and the general population increased by 12.6 percent, from 267.7 million to 301.6 million residents.* In terms of the number of residents per private practicing dentist, there was very limited change: from 1,811 to 1,807 individuals. (2-4)

The number of professionally active dentists (includes dentists in private practice, as well as dentists using their dental degree in some other fashion, e.g. research, administration, and dental education, who to a greater or lesser extent provide direct patient care) increased from 160,781 to 181,725 individuals. (5,7)

**The numbers of dentists reported by the ADA Survey Center include respondents to the Distribution of Dentists Survey. General practitioners and specialists (self reported and as such may include non-board and board certified individuals). The questionnaires were sent to all dentists of record regardless of Association membership status, practice status, or licensure. After repeated mailings, telephone interviews were carried out with non-respondents. The final adjusted response rate was 82.8%.(7)*

Distribution of dental establishments by state

National numbers and averages tend to mask the wide range of developments in the various states, and various regions within a state. For example, between 1997 and 2007:

- There was an increase of more than 3,500 establishments in California but a decrease in the numbers of establishments in the District of Columbia and ten states (Connecticut, Iowa, Louisiana, Michigan, Minnesota, Ohio, Pennsylvania, Rhode Island, West Virginia and Wisconsin).

- The population-to-establishment ratio remained the same in South Carolina and Washington and decreased in nine states (Arizona, California, Idaho, Massachusetts, Mississippi, Nevada, North Carolina, North Dakota, and Utah). In 2007, the population per establishment ranged from 1,780 in Utah to 3,390 in Mississippi.

South Atlantic States: During this same period, there was an increase of more than 2,500 dental establishments in this region, including an increase of 275 establishments in Virginia. The combination of an increase of almost one million residents and the increase 275 dental establishments in Virginia resulted in an increase of about one hundred residents per establishment in the state. There was an overall increase of 145 residents per establishment in the South Atlantic Region and 39 residents per establishment nationally (Table 2)

Number of employees: The proportion of establishments with less than five employees decreased nationally but increased in Alaska and Nevada. In 2007, the percent of establishments with less than five employees ranged

from 18.3 percent in Delaware to 52.2 percent in New York and 61.1 percent in the District of Columbia. In Virginia, the percent of establishments with less than five employees decreased from 46 percent in 1997, to 36 percent in 2007. (2)

The average number of employees per establishment increased in all states but decreased in the District of Columbia. In 2007, the average number of employees ranged from 4.6 in the District of Columbia, to 5.5 in New York and 9.9 in Delaware. Between 1997 and 2007, the average number of employees per establishment in Virginia increased from 5.7 to 7.0 individuals. (2,6)

Dental establishments with no employees

Despite the fact that an increasing proportion of the more than 126,000 dental establishments in 2007 had more than five employees, there were an additional 39,455 dental establishments (including about 35,000 individual proprietorships) subject to federal income tax that had no employees; i.e. no employees reported for tax purposes. These facilities report almost $2.9 billion in gross receipts (an annual average of $73,200 in gross receipts per establishment). The number of dental establishments with no employees ranged from less than fifty in North Dakota, Vermont and Wyoming, to more than a thousand in nine states (Georgia, Illinois, Maryland, Massachusetts, Michigan, New Jersey, North Carolina, Ohio and Pennsylvania), and more than two thousand in Florida, more than three thousand in Texas, more than four thousand in New York and more than six thousand in California. In 2007, in Virginia, there were 899 establishments with $52 million in gross receipts (an annual average of $58,000 in gross receipts per establishment). (9)

Given the general increasing numbers of employees per dental establishment, how does one account for the great number of facilities with no employees? Suggested establishment arrangements might include:

• Using contract employees provided by an employment agency, whereby the staff works for the agency and not by the dentist-owner of the establishment.

• Use of family members as auxiliary personnel and where no reports are made for Social Security and income tax purposes.

• Hiring individuals who are paid in cash with no reported withholding taxes and unemployment insurance.

Active private practitioners in the South Atlantic Region

Between 1997 and 2007, the number of private practitioners in the Region increased from 22,868 to 27,737 individuals (21.2 percent increase). During this period the population increased by slightly less than 20 percent. As consequence there was a slight decrease in the population-to-dentist ratio (2,109 to 2,085 individuals) in the Region. In Virginia, there was an increase from 3,389 to 4,047 practitioners (20.3 percent increase) and a 14.4 percent increase in population, resulting in decrease in the population-to-dentist ratio (1,987 to 1,890). (Table 2)

Benefits of a larger size dental establishment

While efforts may be made to maintain the personal relationships that existed in smaller facilities, as establishments increase in size, all too often a certain degree of formality, changes in personnel, changes due to HIPAA and other legal issues, and sheer complexities of size may intervene. Nevertheless, there are significant advantages to increasing the size of the dental establishment. These include:

• Additional dental practitioners to share coverage responsibilities, cooperate in treatment consultation and planning, support in emergency situations, maintain services during vacation periods and illnesses, and import continuing education developments into practice activities.

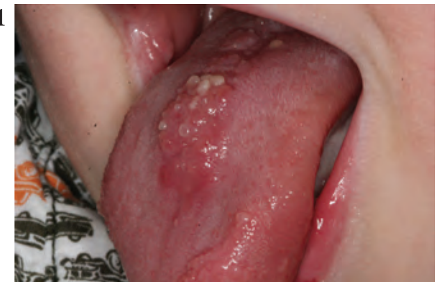
Continued on page 48

PathologyPuzzler

with Dr. John Svirsky

A small child (white male, age nineteen months) presented with an irregular, pebbly, white and red lesion of the mid-dorsal tongue measuring 2 cm by 1.3 cm in greatest dimensions. There also appears to be a lesion of the left dorsal anterior lateral tongue (Figure 1).

Figure 1



A differential diagnosis would include which of the following?

a. Focal inflammatory fibrous and epithelial hyperplasia
b. Inflammatory papillary hyperplasia
c. Median rhomboid glossitis
d. Papilloma.
e. Hemangioma
f. Lymphangioma
g. Cystic hygroma
h. Pyogenic granuloma
i. Peripheral giant cell granuloma
j. Squamous cell carcinoma

Continued on page 51

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Letters to the Editor

Oral Sex and Oral Health

Henry Botuck, DDS

According to the Oral Cancer Foundation, cancers of the floor of the mouth, cheeks, and alveolar ridges are associated with alcohol and tobacco use. But, cancer of the base of the tongue, the throat, and the pharynx are associated with human papilloma virus-16 (HPV-16). The CDC says that about 25% of oral cancers and 35% of throat cancers are associated with HPV. The papilloma virus HPV-16 is a sexually transmitted disease that is mainly known for its association with cervical cancer. However, it has also been linked with cancer of the penis and cancer of the anus.

The Oral Cancer Foundation (www.oralcancerfoundation.org) strongly supports the use of the human papilloma virus vaccine, Gardasil®, for both boys and girls before they become sexually active. (CDC recommends it for girls.) Now, with the publicity of a prominent actor having oral cancer, there is renewed interest in the media about this disease.

So, what is the dentist's role when it comes to oral cancer? Is it limited to detection only, or do we also have a responsibility to educate our patients as to how to prevent it? Do you only talk to your patients about prevention of tooth decay and periodontal disease? Do you at least mention the known causes of oral cancer to your patients, and if not, why not?

The title "doctor" comes with responsibilities. We need to educate our patients about all of the known associations with the development of oral cancer, including the human papilloma viruses. Their reaction would probably be, "How do you get Human Papilloma Virus?". The answer is a non-judgmental: "It is a disease that is sexually transmitted, specifically, through oral sex." In addition, those patients who have children should be urged to consult with their pediatrician about their daughters and sons being vaccinated with Gardasil®.
Bringing up a topic that involves sex is new in dentistry. So, keep it simple. Keep it brief. And only give as much non-judgmental information as you are comfortable giving. Think about, and plan beforehand, how you might approach this delicate subject. Choose your words carefully. Role-play a conversation using a staff member, your spouse, or a colleague. Remember, you could be saving someone's life.

And, of course, be sure to do a thorough oral cancer examination of patients of all ages at every examination appointment.

Keeping Dentistry as a Major Health Profession

Marvin E. Pizer, DDS, M.S., M.A.(Ed.)

I have always been involved in education, having had the privilege of teaching dental, medical, nursing and college students. For obvious reasons dental education has intrigued me most of all. Dental Education is the foundation for maintaining our profession as one of the best health professions.

There are ten suggestions which I feel need to be looked at to sustain Dentistry as a lead health-care profession.

1. Recruit the best students. There is a significant resource of talented young people in our high schools and colleges who are seeking a health care profession, but are undecided which one to choose. It is this resource that should be exposed to the dental profession. How can we accomplish this? A specialized committee of informed, impressive, and convincing dentists should speak at the honor societies in high schools and colleges on how our profession affects our lives as well as our patients. A second approach to visibly interested students is to invite them to our offices exposing them to the many services we perform and how Dentistry affects the lives of our patients.

2. Pre-dental students, while pursuing the dental school admission requirements, should be advised to take calculus and statistics if they show inclination towards research.

3. Since dental and medical schools have essentially the same requirements, the pre-dental students should take the MCAT examination which is more comprehensive than the DAT.[1]

4. Dental School admission requirements should be essentially the same as Medical School. The grade-point average of presently admitted dental school students is 3.5.[2] Dental School should not be the pathway to an M.D. degree.
5. The dental curriculum should never reduce the Basic Sciences to give emphasis to technical or psychomotor skills. At a nearby Dental School, the basic sciences were reduced 20% to allow sophomore dental students to treat patients. This should be corrected. Some of the senior dental students could not write prescriptions. With the increase in geriatric patients, dentistry must understand altered physiology, pathology, pharmacology, and microbiology. After all, we do utilize local anesthetics, prescribe medications, and perform surgery on patients many of whom are affected with systemic disease.

6. For obvious reasons, the dental curriculum should contain courses in psychiatry, geriatrics, emergency medicine and legal medicine.

7. Before rotations begin in the Junior Year, there is a definite need for dental students to understand the Scope of Dentistry, also the scope of each of the nine recognized dental specialties. A doctor from each of these specialties should elaborate the entire scope of his/her dental specialty.

Continued from page 9

8. In many medical schools, the medical and pharmacy students make hospital rounds together, usually with an attending physician and nurse. Junior dental students should participate in these hospital rounds. This would be of tremendous benefit for the future dentist as well as producing a professional relationship to the future physician, pharmacist and nurse. I would suggest 4-6 weeks, part-time on the Internal Medicine Service.

9. Senior dental students should have the option of spending 6-10 weeks in a dental specialty of one's choice. The remainder of the year in University Dental Clinic and finally performing as a family dentist in a rural and economically depressed area of the state, always under the supervision of a competent dentist who resides and practices in that locality.

10. (A) Replace practical state board examinations with a mandatory 1 year ADA approved general practice residency. New York and Delaware at present require 1 year Residency for licensure. In Connecticut, California, Minnesota, and Washington State, a graduate can choose a 1 year GPR or take the state board examination for licensure.
(B) Dental graduates all get the same degree from U.S. Dental Schools (DDS or DMD). Every dentist is obligated to note deficiencies in dental education. Each of you can correct and change dental education. Your changes can significantly affect your prestige and the future of the profession.

Here are mechanisms available for such actions:

1. Work through your Dental Alumni Association

2. Publish Editorials in the State Dental Journal (I do)

3. Write to the ADA Council on Education

4. In Virginia- Contact Board of Directors of the Virginia Dental Association (the VCU dean is a member).

5. Make a financial contribution to your dental school, with an accompanying letter.

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[1] Kaplan Courses Phone #703-336-8500- American College Testing Program (2010)
[2] ADA Communication (2010)
[3] ADA Communication (2010)

Articles of Interest

VDA Services Announces the Endorsement of ProSites

VDA Members will receive an exclusive 25% discount from one of the premier dental professional website development firms in the country

The VDSC Board of Directors is pleased to announce the endorsement of ProSites, a website development and Internet marketing firm. Founded in 2003, ProSites has developed a unique WebEngine Technology that has fully automated the creation of high-quality websites for over 5,000 dental clients nationwide.

After a thorough evaluation of the marketplace, ProSites was selected as the only website development firm recommended for use by VDA Members. VDA Services President, Dr. Lanny Levenson, remarked: "The ProSites technology is impressive; they are truly innovators in the market. They are able to offer a turnkey solution to dental offices that want a professional website and it can be up in running in less than an hour!" ProSites offers dental practices a comprehensive website solution that has the look and feel of a completely custom site for a fraction of the cost.

Websites developed by ProSites use the latest technology to help dental offices communicate with current and potential patients. With detailed dental information and a complete video library, ProSites has a robust content offering in addition to easy to use site editing tools that allow you to upload your own text and case photos. ProSites customers can also rest assured that they will have the latest technology on their website at no additional cost. When a new feature or upgrade is introduced by ProSites, all current clients are given the opportunity to update their sites free of charge, a unique benefit to choosing ProSites. Additionally, the ProSites model is comprehensive, for one set-up fee you are able to access all of the features available such as flash video, unlimited pages, and the ability to choose a new website design at no additional cost.

As part of the endorsement, VDA Members are now eligible for a 25% discount on website development costs from ProSites – an exclusive member benefit! For more information on ProSites, please visit www.prosites.com/vda or call 888-932-3644.

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A message from Dr. Randy Adams
liaison, Old Dominion Dental Society

I'd like to introduce myself – my name is Randy Adams and I am the liaison between the Old Dominion Dental Society (ODDS) and the Virginia Dental Association. As the liaison, my function will be to coordinate the exchange of information between the two groups.

I was born and educated in Danville, Virginia. I graduated from Hampton University in 1968 and received my D.D.S. from Howard University in 1972. I completed my residency in Pediatric Dentistry at the Medical College of Virginia. I have a private practice in pediatric dentistry located in historic downtown Richmond. Our practice specializes in dentistry for infants, children, adolescents and patients with special needs.

I am board certified in pediatric dentistry and also in special care dentistry. I am married with two adult daughters and five grandchildren. My interests include golf, fishing, and boating. There'll be more information to follow on the ODDS.

Contact Dr. Adams at:

300 W. Broad Street
Richmond, VA 23220
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randyadamspedo@hotmail.com

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Trustee's Corner

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

Turning challenges into opportunities

It is this time of year that we all look forward to new beginnings and are busy setting our goals for 2011. This is also true for the ADA Board of Trustees, officers, and staff. However, before we can look to the future and its opportunities and challenges, we should take a minute to review the accomplishments of 2010 and examine the "State of the ADA".

Our association was extremely fortunate to have one of our own, Dr. Ron Tankersley, serving as president this past year. Dr. Tankersley provided evenhanded leadership with a clear vision of where to focus our resources. He and his wife Gladys were the consummate first couple and their gracious "Southern Hospitality" was instrumental in helping to heal some divides on the board. Under his guidance, the association was able to move forward with much needed reorganization and implementation of new internal systems and controls. Even though many of those changes are a work in progress, we are definitely moving in the right direction and are better positioned to serve the needs of our members.

Some of the most significant accomplishments include: the completion of hires in all of the critical staff positions, integration of new budgeting and accounting software, complete reorganization of the ADA subsidiaries providing better governance and an arm's length relationship necessary for legal compliance, and some successes in our advocacy efforts, particularly with dental-friendly amendments to the Red Flags regulation and Obama care.

Looking forward to 2011, it is my hope that the Board of Trustees will spend much more time at our meetings discussing and developing strategies for shaping the ADA agenda for the coming year, as well as, years ahead. It is likely that we will be presented with significant challenges that, if handled correctly, could be potential opportunities. The most pressing issue revolves around access to care and the use of staff as care extenders. We must develop a strong communication plan to present the association perspective on midlevel providers in the broader discussion of access to care. Parties outside of dentistry, like the Pew and Kellogg Foundations have focused all of the attention on a DHAT model for increasing workforce, with complete disregard to projected increases in trained dentists resulting from the new dental schools opening and being considered. They have failed to consider the impact of expanded duty dental assistants - if fully utilized throughout the country- or the numerous other factors that affect the under utilization of dental services. The ADA will focus our attention on those solutions that have the potential to be the most effective at reducing barriers to care. In the current environment where there are limited public resources, we must also emphasize those programs and solutions that can make a significant impact on patient's health at the lowest necessary investment. Certainly from a member's perspective, this may be the biggest challenge facing our profession, but rest assured there will be other issues as yet unforeseen that will arise. With the talented staff at the ADA and with strong leadership from the Board of Trustees, we can turn all of the challenges to opportunities. It is my goal to provide real value to our membership that translates to professional success in the coming year. Wishing you the very best in the New Year.

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Dental Ethics – Reading Between The Lines

By: Sarah Friend, DDS - Ethics and Judicial Affairs Committee

Everyone has a story to tell. Many of our elderly patients reminisce about the good old days while sitting in our chairs, entertaining us younger folk with stories of yesteryear. Their decades are like chapters in a history book, still unfolding with a notion of the end hurrying towards them, anticipating how that final paragraph will be written. Often their visits to the dentist seem more like appointed socialization, releasing them from their loneliness and isolation at home. Many of us listen with quiet patience while others of us are hurried to keep up with our hectic schedules. What we hear and what we interpret may require us to stop and read between the lines.

Mary was one such patient. In her early nineties when I first met her, she came to see me because she was concerned that her front teeth were turning black. She suffered from vision and hearing loss, along with severe arthritis. Otherwise, she was relatively healthy and in pretty good shape to be ninety. Every tooth in her mouth, aside from a few severely decayed anteriors, were broken to the gum line and infected. She prided herself in never having had a toothache but just wanted her teeth to be white like they were in her youth. She told me she didn't have a lot of money and I could tell by looking at her ragged clothing that she was not well off. She always wore a coat, stating that she was cold, even if she wore sandals in the winter. Being cold-natured is not uncommon for many of our elderly patients, after all. She smelled of cigarettes, though she did not smoke. She never asked us to donate our time and resources, but we did.

Over the next few months my staff and I worked with Mary to give her smile back to her. She tolerated her full mouth extractions very well, better than most young adults I know, without any reported pain. Her weight remained stable, stating she was eating well. A caring neighbor always brought Mary punctually to her appointments. While we were working, she would reminisce about her family. At Christmas time, she pulled out some old pictures, showing us the son she lost on Christmas Eve, stating that Christmas remains a sad time for her. She was sad, also, because there was no money for any presents. But then she would pull out pictures of her great-grandchildren sitting on her lap and would smile again. Though they were toddlers and very young children, they were almost as big as she was. Mary would tell us how she would babysit these great-grandchildren, watching over them while their parents were away or at work. She stated she lived with them, though none of us ever met her extended family. My staff and I always got a hug at the end of her visits and a "Love ya'll". We were never quite sure as to what was fact and what was exaggerated. We did know that she was depressed about her life situation and felt that she was at least getting a little love and much needed attention when she was in our office.

Mary came back on the rare occasion for denture adjustments. Many appointments were made, but few were kept. Her phone number was out of order when we tried to follow-up. When she did come, Mary would ask me to refill her prescription arthritis medication because she had run out or the bottle had been lost. Once she came for a denture adjustment without her dentures. Was Mary starting to experience the effects of dementia, we wondered? Something was different in the recent months, but we unsure as to what was really happening in her life.

After some investigation we learned that Mary did, in fact, live with her daughter and extended family and probably was left alone with young children. Mary was not capable of really caring for herself, much less small children. Her telephone number and address changed because her family was evicted from their low-income apartment due to filth. Thus, her caring neighbor was no longer able to watch out for her and bring her to appointments. The sister from whom she received her hand-me-down clothing had died and no effort had been made to buy adequate clothing for Mary. Her daughter was using her prescription pain killers, which is why Mary had none. Her family was using her social security income to buy cigarettes and beer, leaving Mary without her basic necessities. When I asked Mary's daughter if the dentures were at home, she told me they were, in fact, probably under the bed, but there was so much trash that they couldn't find them. Mary was living in filth, suffering from emotional, financial and physical neglect. Mary was a victim of elder abuse.

The ADA's Code of Professional Conduct under Beneficence ("do good") states that "dentists shall be obliged to become familiar with the signs of abuse and neglect and to report suspected cases to the proper authorities consistent with state laws." It is our ethical obligation. The ADA's advisory opinion 3.E.1. also states: " Dentists have a concurrent ethical obligation to respect an adult patient's right to self-determination and confidentiality and to promote the welfare of all patients. Care should be exercised to respect the wishes of an adult patient who asks that a suspected case of abuse and/or neglect not be reported, where such a report is not mandated by law. With the patient's permission, other possible solutions may be sought."

In Virginia, we are required by law to report suspected cases of abuse, neglect or exploitation of an elder (age 60 or older) or an incapacitated adult (ages 18-59) to Adult Protective Services. Likewise, we are required to report suspected cases of child abuse to Child Protective Services. These reports may be made anonymously. If you do provide records or information in good faith and without malicious intent, you will be immune from any civil or criminal liability. To make a report, contact your local department of Social Services or the 24-hour, toll-free hotlines:

Adult Protective Services: 1-888-832-3858

Child Protective Services: 1-800-552-7096

Some signs of abuse, neglect or exploitation may include:

-Lack of food, clothing or shelter and lack of assistance in obtaining these basic necessities

-Verbal abuse by a family member or caregiver (verbal assault, threat, intimidation, humiliation)

-Unwanted sexual activity

- Physical abuse resulting in pain or injury; bone and tooth fractures, lesions, hemorrhage, retinal detachment, cigarette burns, bites

-Delay in medical care ,missed appointments or frequent changes in health care providers; medications not being picked up or being used by another family member

- Financial exploitation -the illegal use of an adult's property or financial resources resulting in another individual's profit or advantage

We, as dentists, need to take the time to listen to our patients, observe their nature and behavior, along with their physical and dental conditions, and be able to recognize and report abuse and neglect.

Congratulations

Virginia dentists deserve a big pat on the back for a job well done.

By: Dr. Bruce Hutchison, Chair, VADPAC

We, the VDA, successfully introduced legislation to the 2010 General Assembly and followed through, supporting it with phone calls, emails, and personal visits, and got legislation passed and signed into law so dental insurance companies in Virginia cannot intrude further into your practice and set fees for services and procedures they don't even cover. To us - it seemed easy to understand - it was blatantly unfair. Others, however, did not see it our way. The opposition we faced was enormous. Labor unions, the Virginia Chamber of Commerce, and of course, the insurance industry were all against our bill. I saw a list of about 25 organizations that were all against us.

It is estimated that Delta Dental of Virginia spent over ONE MILLION DOLLARS to fight against their own provider network of dentists. Their public relations campaign included posters and fliers, multiple newspaper full page ads, and having their consumer phone lines answered with the message- "Did you know that the dentists of Virginia want to make you pay more for your dental care?" The insurance industry lobbyists were all over the General Assembly. Again - these ads were all focused against the dentists in Delta's own network!

But we prevailed. WHY?

First - our message was on target and it was simple - it is not fair to tell dentists what they can charge for a service not even covered by the insurance company. If they want to control the fee - they should at least be willing to pay a good portion of that fee.

Second - we have a terrific lobbyist in Chuck Duvall. Chuck is so well respected in the General Assembly that every single legislator tells us "Chuck represents you so well. He tells it like it is and keeps his word." So Chuck's leadership was another critical factor.

Third - Laura Givens and the VDA staff did an awesome job of organizing, contacting dentists, arranging schedules, scheduling buses for visitations, providing box lunches and generally organizing everyone so that dentists were constantly walking the halls of the General Assembly office building.

And finally – YOU - the dentists of Virginia saw the importance of this issue and dove in. You all contacted your legislators, made phone calls, sent emails, and visited them in Richmond. We had five or six dentists every day in Richmond until our bills got passed. You made a difference. You should be proud of this accomplishment. It is huge.

Did you know that when the Senate and House full committees met, one day after the other, the rooms were filled by dentists, dental staff members, dental spouses, VCU dental students and VDA staff members? So full in fact - that the insurance and labor union lobbyists couldn't get in the room or find a place to sit. There were hundreds of us there. That was something to see.

But, what now? Do you think the insurance companies are going to crawl into a hole and leave us alone? If anything- we have awakened a sleeping giant. Now they understand they can't just push us around without a fight. They will be back and continue their assault on our freedom of practice. Make no mistake - they want you - the dentists - to be under their complete control and work for them, to follow their rules, and to be held under their thumb. They want to control what you do and how much you charge - all in the name of looking out for the best interests of the patient. They want the patient to think they care more about the patient than we do.

We know that's a crock. But what do we do?

We must be prepared to continue the fight. The dentists of Virginia must remain players in the game and not be satisfied to sit on the sidelines and observe. We won this battle, but the war goes on. It becomes even more significant that we do the following:

One- Contribute to VADPAC- the Political Action Committee of the VDA. This PAC enables us as a group to influence the legislators. We don't buy votes, but our contributions do buy an ear willing to listen. Our arguments must be sound. We have always argued for what is best for our patients. To this day, I have never felt that the VDA has ever approached the legislators with a self-serving interest. Everything I have witnessed has been for better patient care. I am very proud of that.

Two - Contribute to your local legislators, meet with them, hold and attend fundraisers for them, work on their campaign committees, show your support. Let them know who you are and what issues are important to you and your patients.

Three - Get to know your legislators, meet with them and keep in touch with them. That way, when the time comes, they will consider you a friend as well as a constituent. Friends listen to friends.

Four- Volunteer at our MOM projects and at your local free clinics. Our participation in these events is noticed by the legislators. It gives them reason to pause and think "Hey, these dentists are doing their part to assist the citizens of Virginia. They are givers, perhaps we should help them a little." Truly, the more you give away - the more you get.

So, congratulations, Virginia dentists! You won a very important battle and there is cause for celebration. But the war on us and our patients' best care will continue. We must be prepared. So get involved. Volunteer your talents and your money, stay in contact and develop relationships with your legislators - and continue to look out for and serve the dental needs of our fellow Virginians. You must decide who controls our profession and if you want to continue to practice as you do today. You must be willing to write the check and make the trip when necessary or there will be nothing left of this profession for the students who follow us - many of whom are your children. You alone will decide our future, now is the time to commit to making that happen.

VADPAC UPDATE

The Virginia Dental Political Action Committee

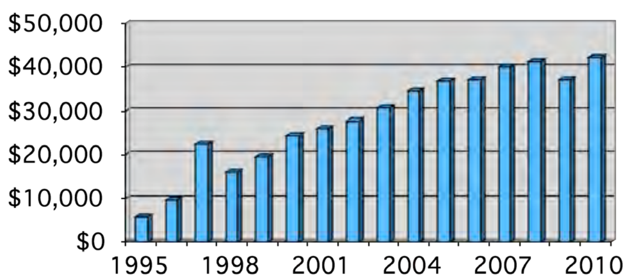
As indicated in the last issue of the VDA Journal, the 2010 VADPAC Contribution Goal was reached and surpassed! We have now entered a new year and hope that you all will send in your contributions again and urge you to increase your level of giving. 2011 is an important election year in Virginia with members of both the House of Delegates and Senate up for re-election. Money is an essential aspect of achieving success in your legislative efforts for the profession of dentistry and safe and accessible dental care for all citizens of Virginia.

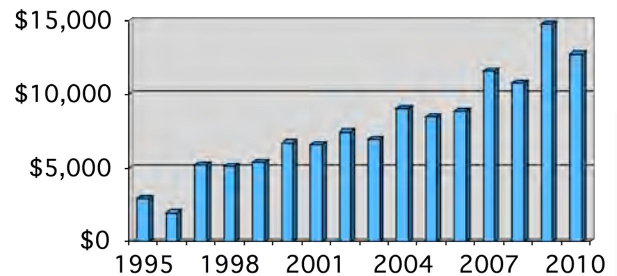
Below are the 2011 VADPAC Contribution Goals, broken down by components.

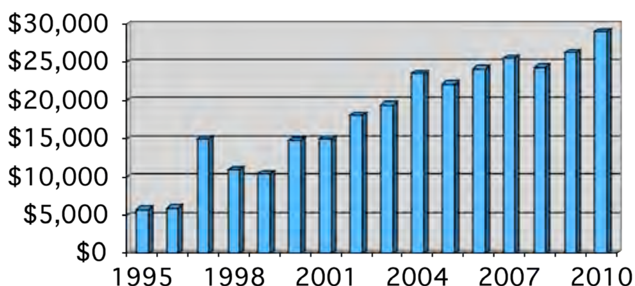
Component	2010 Total Contributions	2011 Contribution Goal
1	$42,316	$44,000
2	$28,984	$25,000
3	$12,740	$12,500
4	$60,981	$60,500
5	$28,213	$28,100
6	$24,667	$23,000
7	$27,936	$30,000
8	$136,950	$132,000
TOTAL	**$362,787**	**$355,100**

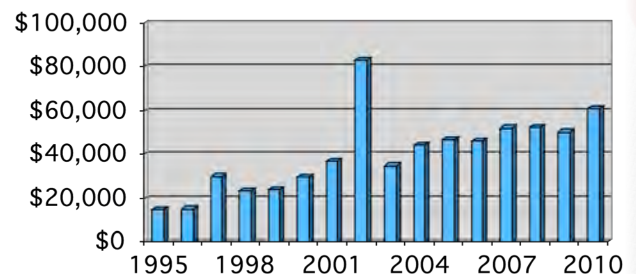
The challenge is to surpass this goal once again! Please make a VADPAC contribution when sending in your membership dues or contact Laura Givens at 804-288-5750 or givens@vadental.org.

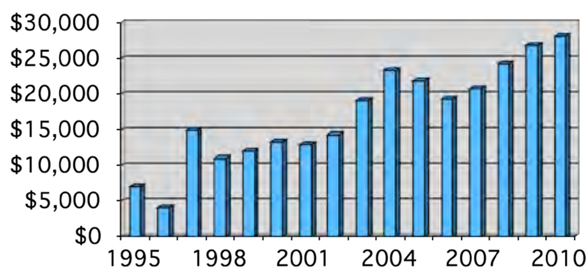
VADPAC has grown substantially over the past few years. 2010 stands as the most successful year to date, however; it has not been a consistent increase. The below graphs compare the total amount of contributions from 1995-2010 for each component.

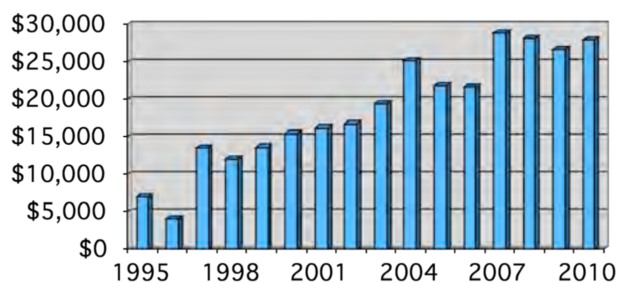


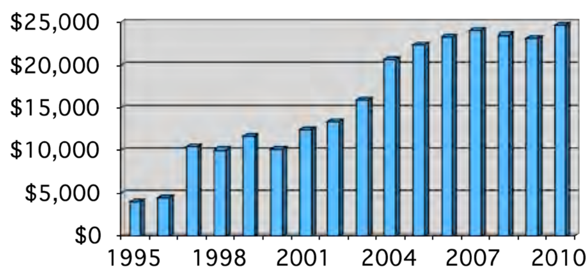


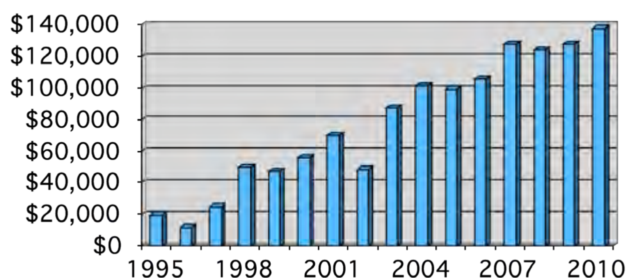












We would like to thank all 2010 VADPAC contributors! Their names are recognized with great appreciation below.

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Dental Offices to Be Exempt From Red Flags Rule

By: Laura Givens
VDA Director of Legislative & Public Policy

On December 8, 2010 the U.S. House of Representatives passed legislation (S. 3987) exempting certain businesses, including dental practices, from the Federal Trade Commission's (FTC) Red Flags Rule. President Obama is expected to sign the bill by the end of the month. This is due to the hard work of the ADA and to the efforts of members like you in writing your lawmakers and lobbying on Capitol Hill.

ADA President Dr. Raymond Gist stated that "This legislation is important for practicing dentists who are mindful of their budget and their time. This rule would have put an unnecessary demand on resources and forced dentists to comply with yet another regulation." The ADA estimates the nationwide savings associated with this exemption to be $72 million for dental offices.

The Federal Trade Commission (FTC) issued a final regulation implementing the Fair and Accurate Credit Transactions Act of 2003 (FACT Act) on November 9, 2007 in an effort to fight the problem of identity theft. The FACT Act requires financial institutions and creditors to develop and implement written identity theft programs, referred to as Red Flags program. The FTC included dental offices under the Red Flags Rule if it is considered a "creditor" and it has at least one "covered account." A red flag is defined as some event, document, information, or attempted transaction that should alert the business or healthcare practice that someone is not who he or she claims to be. By being covered under this law, all dentists would be required to implement a Red Flags program.

The American Dental Association (ADA) immediately expressed strong opposition to this rule as they believed it to be a false interpretation of the intent Congress when the FACT Act was implemented. The Red Flags Rule was to go into effect on January 1, 2008, however; it was delayed by the agency and expires on December 31, 2010.

This victory for the dental profession is another great example of why it is so very important to be involved in grassroots efforts for your profession and to contribute to ADPAC and VADPAC. If you have any questions on contributing to your PAC, please contact Laura Givens at 804-288-5750 or givens@vadental.org.

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Virginia Democrats Fall to the GOP Wave: 2010 Congressional Elections Results

By: Chuck Duvall and Dennis Gallagher, VDA Lobbyists

There were no state races in 2010, only US Congressional races. Incumbent Democrats Glenn Nye, Tom Perriello and Rick Boucher fell to the GOP wave. Democrat Gerry Connolly in Northern Virginia took the race by less than a 1000 votes. Below are the results from these races:

· 2nd District

Scott Rigell spent nearly $2 million of his own money to promote his campaign themes of limited government, lower taxes and job creation. He is known in the Tidewater area as owner of Freedom Automotive, employing 240 employees at his area car dealerships.

· 5th District

State Senator Robert Hurt, a lawyer from Chatham, beat incumbent Tom Perriello by nearly 9,000 votes. The freshman Democrat won the closest race in the country two years ago with only a 700-vote win over Virgil Goode.

· 9th District

House of Delegates' Majority Leader Morgan Griffith defeated veteran Democrat Rick Boucher on the issues of cap and trade and Boucher's Democratic voting record. Griffith is a lawyer who lives in Salem.

As two members of the General Assembly were elected to Congress, Governor McDonnell will call a Special Election before Session starts in January. With Griffith's election to Congress, the House Republicans will have to elect a new Majority Floor Leader. Kirk Cox, from Colonial Heights, is speculated to be the front-runner.

L-R Dr. Craig Dietrich, Congressman-elect Robert Hurt and Dr. Mark Crabtree

VADPAC Fundraiser for Delegate Tim Hugo in Centreville

By: Laura Givens, Director, Legislative & Public Policy

A VADPAC fundraiser for Delegate Tim Hugo was hosted by Dr. Bruce and Nancy Hutchison at their home in Centreville on November 10, 2010. Delegate Hugo represents the Commonwealth's 40th district, which encompasses part of Fairfax County and serves as the chairman of the House Republican Caucus. Several dentists and other guests from the district attended the event to thank him for his support of the dental profession. It was a great opportunity for the constituents in attendance to speak with Mr. Hugo about issues in their district and what is to be expected in the coming year.

L-R Dr. Rod Klima, Nancy Hutchison, Dr. Bruce Hutchison, Delegate Tim Hugo and Dr. Tim Golian

VDA Fundraiser for Senator Ralph Northam

By: Laura Givens, Director, Legislative & Public Policy

The VDA hosted a fundraiser for Senator Ralph Northam on October 28, 2010 at the home of Dr. and Mrs. Vaughn Mayo in Virginia Beach. Senator/Dr. Northam represents the 6th District of Virginia, which includes the counties of Accomack, Mathews and Northampton and parts of Norfolk City and Virginia Beach City.

Senator Northam is a pediatric neurologist and has provided outstanding leadership in the General Assembly on issues affecting the health care community, including those involving dentists and their patients. Since assuming his role in the legislature, he has been a strong supporter of the dental community, and the VDA appreciates this support.

The event hosted by the Mayos was attended by approximately 60 VDA members and guests. It offered a great opportunity for VDA member dentists to thank Senator Northam for his support and discuss current issues facing our profession. Guests were also able to hear from the Senator on the importance of making their voices heard on issues they feel are important.

L-R Dr. Vaughn Mayo, Jill Mayo, Pam Northam, Lisa Morgan, Dr. Mike Morgan, Senator Ralph Northam and Dr. Ralph Howell.

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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.

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Workplace Harassment Extends Beyond Employers

By: Keith Kerns, Esq. - Ohio Dental Association Director of Legal and Legislative Services

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Harassment claims by employees have become common in professional settings. Dental hygienists, dental assistants or other dental office staff members in a position to make a claim of workplace harassment are likely to be seen by a jury as sympathetic and in a weak position to defend against the harassment of employers or coworkers. Even if the employer dentist is not the harasser, he or she may be held liable for another employee's harassment.

Because of this, most employer dentists understand the importance of being vigilant in refusing to engage in, or to tolerate, harassment in the dental office by any employee. But what if the alleged harassment is perpetrated by someone other than an employee? Could an employer dentist be held liable for the actions of non-employees, such as patients, vendors, suppliers or delivery personnel? Surprisingly, the answer is "Yes."

There are two main theories for workplace harassment claims: quid pro quo harassment and hostile environment.

Quid pro quo harassment occurs when an employee's submission to unwelcome harassment is an express or implied condition for receiving job benefits, or an employee's refusal to submit results in tangible job detriment. Quid pro quo harassment is typically not at issue when discussing the alleged behavior of non-employees.

In certain instances, however, employer dentists could find themselves facing charges of hostile work environment harassment as a result of the actions of non-employees. The hostile work environment harassment occurs when conduct has the purpose or effect of unreasonably interfering with the employee's work performance or creating an intimidating, hostile or offensive working environment. The hostile environment theory does not require a supervisory relationship or a tangible benefit or detriment.

Unwanted advances and harassing behavior by non-employees occurs more often than one may believe.

In the early 1990s, researchers in the Department of Public Health Dentistry at the Oregon Health Sciences University conducted a survey of dentists and dental hygienists and found that 44 percent of those dental professionals experienced one or more verbal advances from patients within a five-year period. Twenty-three percent of the same respondents reported experiencing at least one physical advance from a patient during the same time period.[1]

A more recent survey of practitioners in New Zealand found that in a one-year period over 15 percent of the practitioners were verbally abused, over 6 percent were sexually harassed, 3.5 percent were assaulted and nearly 2 percent had been stalked by patients or their relatives.[2]

Courts have held that employers may be liable for harassing actions of non-employees, like patients, vendors or delivery persons, if the employer knew or should have known about the harassment and failed to take immediate and appropriate corrective action.

Employers don't have a duty to secure a completely harassment-free work place at all times, but they do have an obligation to swiftly address any issues that come to their attention. It's important to note that employers are not liable for any offensive behavior by non-employees committed outside of the workplace.

In instances of non-employee harassment, courts review an employer's response to the situation with a critical eye. Consequently, employer dentists should take staff reports of off-color language, unwanted advances, derogatory comments and other offensive behavior by non-employees seriously.

If faced with such a report, employer dentists can limit their exposure to liability for an employee's harassment claim by promptly and thoroughly investigating the report and taking steps to prevent the problem from occurring in the future. All actions taken by the employer dentist should be documented in a confidential file.

Ultimately, the employer dentist must decide upon an appropriate action to address the situation. That action could take multiple forms depending on the circumstances surrounding the allegation, including but not limited to:

• Terminating a patient from the practice.

• Discussing the alleged behavior with the patient or vendor and asking them to cease the activity.

• Ensuring staff members are not left alone in the office with the non-employee in question.

• Notifying the delivery person or vendor's supervisor and requesting a change in personnel when dealing with the office.

• Notifying the appropriate law enforcement agency in instances of assaults.

Employer dentists are encouraged to work with an attorney if faced with such a situation and take appropriate measures in light of the facts surrounding the complaint to prevent its occurrence in the future.

Failing to take corrective action when an employer dentist knows about harassment in his or her office, even if caused by non-employees, could have devastating consequences.

References

1. "Sexual advances by patients in dental practice: implications for the dental and dental hygiene curricula." Chiodo, et al., Journal of Dental Education, Sept. 1992.
2. "Aggressive acts by patients against general practitioners in New Zealand: one-year prevalence." Gale, et al., New Zealand Medical Journal, July 2006.

Legal Briefs is intended to offer information and general guidance but should not be construed as legal advice and cannot be substituted for the advice of the dentist's own legal counsel. Dentists should always seek the advice of their own attorneys regarding specific circumstances.

The MOM Project

Celebrating 11 Years Making a Difference

49 missions
39,000 served

$20.7 million
in services

Become a part of the largest two and three day dental clinic of its kind.

M.O.M. will be an experience you will never forget.
“Make a difference” in the lives of others.

Join the MOM Team!

11 YEARS OF SERVICE TO THE UNDERINSURED !

I would like to volunteer at:

Middle Peninsula MOM 2011
(Gloucester)
- ☐ Saturday, February 19, 2011
- ☐ Sunday, February 20, 2011

Northern VA MOM 2011
- ☐ Friday, March 11, 2011
- ☐ Saturday, March 12, 2011

Roanoke MOM 2011
- ☐ Friday, April 1, 2011
- ☐ Saturday, April 2, 2011

Wise MOM 2011
- ☐ Friday, July 22, 2011
- ☐ Saturday, July 23, 2011
- ☐ Sunday, July 24, 2011

Grundy MOM 2011
- ☐ Saturday, October 1, 2011
- ☐ Sunday, October 2, 2011

I prefer to do:

- ☐ Fillings
- ☐ Extractions
- ☐ Triage
- ☐ Endo
- ☐ X-rays
- ☐ Sterilization
- ☐ Children only
- ☐ Adults only

NAME

SPECIALITY

ADDRESS

CITY / STATE / ZIP

PHONE NUMBER

EMAIL

***LICENSE NUMBER REQUIRED

PLEASE NOTE: A COPY OF YOUR CURRENT BOARD OF DENTISTRY LICENSE MUST ACCOMPANY YOUR REGISTRATION! (VDA FAX # 804-288-1880).

For more information on the Missions of Mercy projects and to register online please visit us at www.vadental.org.
Contact Barbara Rollins at VDA: 804-288-5750; email: rollins@vadental.org; FAX 804-288-1880.

Hope you can join us!

Outreach

MISSIONS OF MERCY

2000-2010

Mission of Hope

Thousands of Virginians do not have access to dental care (predominantly the uninsured, the underinsured, the unemployed). They face extreme pain, discomfort and embarrassment on a daily basis. In response to this need, the Virginia Dental Association Foundation has partnered with the Virginia Dental Association, VDA Component Societies and various organizations to provide dental care in underserved areas through Missions of Mercy (MOM) projects. Together, we are working to "make a difference."

- **49 Completed Projects**
- **11 Years of Service to those in need**
- **38,600 Patients treated**
- **$22 Million in donated dental care**
- **11,500+ Volunteers**

These outreach projects are having a remarkable impact on the dental health of underserved Virginians—but they are not the solution to the problem. MOM demonstrates the commitment of the Virginia Dental Association Foundation in waging the effort to fight against poor oral health (recognized nationally as the "silent epidemic"). MOM has been used as a model in twenty other states including North Carolina, West Virginia, Maryland, Texas, Kansas, Connecticut, South Carolina, Colorado, Nebraska and Arkansas. ***MOM—"Caring made visible."***

Join the MOM Team!
To volunteer or make a contribution:
www.vadental.org

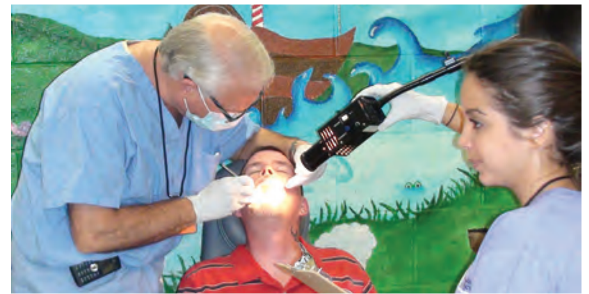
www.vadental.org

Outreach

Missions of Mercy
Virginia Dental Health Foundation

Riverview Elementary / Middle School Hosts 7th MOM Project in Grundy, Virginia

By: Barbara Rollins - Director of Logistics, Missions of Mercy



Returning for the 7th MOM project at Riverview Elementary and Middle School in Grundy, VA, some 214 volunteers (dentists, hygienists, dental assistants, VCU Dental School staff and dental and dental hygiene students) provided over $564,000 in free dental care for 517 Southwest Virginia residents.

Dental procedures offered included:
517 Exams
147 Cleanings
1,408 Extractions
612 Fillings
26 Full sets of dentures
15 Complete dentures
11 Partial dentures
12 Denture relines
8 Denture adjustments/repairs
18 root canals
623 X-rays
142 Fluoride treatments
8 Sealants

> “We all face a critical question at some point in our lives ‘what do you want your life to stand for?’”
>
> “The good news is that it is not too late to be the person you want to be. And yes, we are all called to serve.”
>
> Dr. Terry Dickinson
> Executive Director, VDA
>
> *Taken from his acceptance speech for the American Dental Association 2010 Humanitarian of the Year Award, October 9, 2010*

Outreach

Volunteers traveled to Grundy from IN, NY, WV, PA, MD, TN, MA and throughout Virginia!

Through the 7 Grundy MOM events 3,300 Southwest Virginia area residents have received free dental care valued at $2.4 million!

Since the first MOM project at the Lonesome Pine Airport in Wise, Virginia, 49 MOM projects have been completed over 11 years (2000-2010). 11,500+ volunteers have provided 38,600 patients with $22 million in free dental treatment.

11 Years - 49 Projects – 11,500 Volunteers – 38,600 Patients - $22 Million in free dental care

Wish to volunteer?
Register at www.vadental.org.

M.O.M. Through the Eyes of an Endodontist

By: Dr. Trisha Krause

While between patients nearly five years ago, I received a call from a colleague asking if I would be willing to join Dr. Jim Lance and volunteer as an endodontist at the Wise county Mission of Mercy Project that July. Initially, I pretended to know exactly what a "MOM" project was although I truly didn't realize the extent of the mission. It seemed that Dr. Lance, who had potentially been to more MOM projects than years I had been alive, was going to be the only endodontist at the site which was preparing to see over 1,500 dental patients. Dr. Lance was not one to ask for help but, with the amount of potential work to be done in mind, he asked if I would join the MOM family in southwest Virginia for a few days of remote dentistry.

After clearing up details with the VDA weeks before, and Mapquest route in hand, I began the trek to Southwest Virginia unsure of what to expect once I arrived. The first fog-filled rainy morning at the fairgrounds was awe-inspiring and my eyes did not know where to focus first- the breathtaking local landscape, the throngs of patients, the numerous dentists, auxillary staff and volunteers or the fact that the dental clinic was outside!

I found Dr. Lance immediately and he gave me a brief orientation and then helped me situate my first patient. That first day at Wise was initially confusing and more challenging than I had anticipated. Our shared dental unit was a beautician's cart on wheels made to suit a mobile endodontist and we were treating patients while sitting in pooling rainwater. But once a rhythm was established, not only did the sun appear to dry the wet fairgrounds but my enthusiasm and excitement began to build. I couldn't wait to share the news with family and friends of who I treated, how many I treated, and how it seemed to change not only their perspective that day, but my own.

Not long after our partnership in Wise, Dr. Lance asked if I would continue to travel to Virginia MOM projects while he transitioned into true retirement. His shoes could not be filled, but I was delighted to carry on his legacy. Thankfully, with my husband Sanjay in endodontic residency, I had his full support and eager help of his resident classmates. At times with the residents' presence it felt like the endodontists outnumbered the patients in need! The trips to Wise, Grundy and the Eastern Shore became road trips with great friends and the work at the projects brought us closer to understanding what it means to help a neighbor in need. With each passing project I have not only made lasting friendships with dentists from around the state but I have had the enjoyment of seeing patients from years past who continue to comfortably maintain their endodontically treated teeth.

With each passing year my vision for endodontics at MOM projects has evolved and reached higher standards. At my first project Dr. Lance encouraged me to "feel the apex" rather than rely on apex locators or radiographs given our limited resources. Since I was trained without such reliable acute tactile sensation, I asked for more radiographic support to improve diagnosis and treatment for our patients. The dental supply companies, who continue to provide generous support to MOM projects, do their very best to lend us portable x-ray equipment, laptops and sensors when they are available. It is my dream to someday have an endo-dedicated x-ray unit, laptop and sensor and perhaps even a microscope to further enhance our abilities so that we may be able to treat not only anteriors and premolars but molars more effectively. With each project the endodontic team, which includes endodontists from across the state, receives generous support and encouragement from the VDA and MOM Project as a whole, and we hope to continue to provide excellent endodontic care for years to come.

As I reflect on the MOM projects of the past, each project has its special moments of making a personal connection with a patient and relieving his or her pain or saving an anterior tooth from extraction. But my favorite project remains the Wise county MOM due to its location and diverse patient population. Truly, where else can you feel a breeze on your face and see the sun in the sky while doing the job you love?

Thank you to all the volunteers who served in our most recent M.O.M. Project in Grundy!

Amy Adams
Molly Adler
Rhiannon Aesy
John Aiken
Dr. Steve Alouf
Corey Andeson
Melissa Artrip
Chezdan Baker
Rachel Barone
Dr. Baughn
Ken Bernstein
Elizabeth Berry
Dr. Sanjay Bhagchandani
Taylor Blake
Leigh Blakiston
Tracey Bourassa
Emily Kate Bowen
Charlie Boxx
Jennifer Boyland
Dr. Carol Brooks
Bridgette Brown
Gina Buracker
Evon Bush
Jamie Campbell
Jacque Campitell
Estella Catron
Dr. Glenn Catron
Chrystal Chase
Houman Chegini
Yamileth Chin
Aileen Chyn
LaToya Clark
Steve Clawson
Jessica Clevinger
Andy Coalter
John Coffey
Katie Coffey
Kristin M. Coffield
Dusty Cooper
Bridget Corley
William Corley
Stacy Cornett
Zachary Counts
Katie Cox
David Dalling
Dr. Charles Davis
Brooke Dellinger
Dr. & Mrs. Michael Dishman
Jigmey Dorjee
Ana Cristina Dunn
Dr. David Durham
Ashley Edlin
Karla Feghali
Dr. Bob Findley
Pat Finnerty
Dr. Scott Firestone
Kathleen Foreman
Dr. Steve Forte
Stevie Forte
Vicky Fuzaylova
Kathy Gardner
Dr. Mark Glovis
Paru Gopalan
Greg Gray
Dr. & Mrs. John Gunsolley
Bill Hall
Donna Hall
Crystal Hayes
Marc Henner
Melissa Hensley
Jerry Hernandez
Brian Herod
Heather Herrera
Heidi Hessler-Allen
Aaron Seth Holland
Brian Hone
James Huang
Dr. Wally Huff
Ken Huffman
Dan Jacobson
Ingrid Johnson
Dr. Jones
Jeremy Jordan
Sarah Kandrac
Alexa Karatsikis
Sherry Kardes
Steacey Kardes
Sukhvir Kaur
Emily Keeton
Kristopher Keeton
Dr. Carol Kelly-Mueller
Sharon Kennedy
Kandice Klepper
Jo Koontz
Karen Kraus
Dr. Trisha Krause
Dr. Laskin
Ginly Lau
Annie Leffingwell
Conner Leftwich
Greyson Leftwich
Dr. Lanny Levenson
Jennifer Lysenko
Hannah Mabe
Brian Mahoney
Fatima Mashkoor
Bailey McBride
Stephanie McMullen
Mallory McMullin
Chrissy Ogura Meyers
Faye T. Miles
Dr. Scottie Miller
Shawn Mitchell
Tammy Moore
Lissa Morrison
Demetra Moynihan
Dennis Moynihan
Amber Myers
Arya Namboodiri
Ajwad Naqvi
Elizabeth Neal
Russell Neal
Joshua Nehring
Matthew Nellor
Phillip Nguyen
Dr. Nathaniel Nicholson
Julia Niculescu
Earl Nightengale
Dr. Tiffany Nightengale
Dr. Justin Norbo
Alex Norton
Dr. Susan O'Connor
Andrea Onderdonk
Devin Orvin
Dr. Philip Pandolphi
Nick Pappas
Ally Clay Peterson
Helen Pham
Sepideh Radparvar
Mary Disa Raulfs
Jennifer Reese
John Reynolds
Dr. David Ritchie
Sharon Ritchie
Erik B. Roberts
Adriana Rocazela
Dr. Juan Rojas
Barbara Rollins
Joe Rollins
Nancy Rosales
Angel Royston
Patrick Ruck
Sina Sadeghi
Aaron Scheps
Gary Schmied
Geoff Schreiber
Emily Schroeder
Robbie Schureman
Dr. Ross Shelburne
Dr. Roy Shelburne
Kimberly Short
Tyshika Showell
Lawrence Shtarkman
Kristi Sinclair
Ryan Smagalski
Callie Smithson
Dr. Patrick Sprague
Matthew Stafford
Olivia Stallard
Brant Stanovick
Rebecca Strunk
James Sung
Alice Surine
Annette Templeton
Dr. David Templeton
Hayley Templeton
Cory Thompson
Jon Mark Thompson
Kelly Thompson
Jo Tice
Pat Tisdelle
George Tolson
Laura Tolusso
Matthew Tomoda
Chris Tracey
Thinh Trinh
Melanie Truong
Laura Turner
Katie Vo
Ben Waldman
Victoria Walker
Jagmeet Warraich
Needa Waseem
Lauri Weisflog
Austin Westover
Mana Westover
Arlene Will
Aaron Wilson
Dr. Roger Wood
Philip Worthington
Dr. Laurence Wynn
Erin Wyrick
Timothy Yang
Daniel Yeager
Jeff Yelle
Dr. Andrew Zale

Head Start Dental Home Initiative Comes to Virginia - Your Chance to Help all of Virginia's Kids Have a Dental Home

By: Sarah Bedard Holland, Executive Director, Virginia Oral Health Coalition

Poor oral health, even in the earliest stages of life, has serious implications for a child's long-term health and well-being. In Virginia alone, dental disease resulted in 250,000 lost school hours last year. And as all of us in the dental community know, the negative affects go well beyond learning readiness and attention span; poor oral health leads to a myriad of other dangerous and costly health issues. While the American Dental Association recommends that a child visit a dentist when the first tooth erupts, many parents, caregivers and educators are not aware of the important role early dental visits and an established dental home play in preventing dental problems.

The Virginia Oral Health Coalition, in partnership with the Virginia Commonwealth University School of Dentistry, has launched the Virginia Dental Home Initiative to help all Virginia kids have a dental home.

The initiative includes free workshops (that include 6 no-cost CE credits) for dentists, dental hygienists and early childhood educators (such as Head Start providers) which are designed to teach both the clinical skills necessary to provide dental care to young children and strategies and techniques to help educate children and parents about the importance of a dental home and a lifetime of good oral health.

In addition to the valuable clinical and behavioral training, the initiative fosters relationships between area dentists and local early childhood educators ultimately leading to more dental homes for young children.

Head Start educators and area dentists practice knee to knee exams.

"You are not healthy if you have poor oral health," said Tegwyn Brickhouse, DDS, PhD, chair of the Virginia Oral Health Coalition and chair of the Pediatric Dental Department at Virginia Commonwealth University, "I hope that by bringing dentists and Head Start Providers together we can start children on a path toward a lifetime of comprehensive dental care, and ultimately excellent oral health."

To date training has been offered in Orange and Williamsburg. Additional workshops will be scheduled in southwest, central and northern Virginia throughout 2011. For more information on the Virginia Dental Home Initiative, please contact Sarah Bedard Holland sholland@vaoralhealth.org or 804.288.5750.

DentaQuest Foundation Supports Mission of Excellent Oral Health for All Virginians

By: Sarah Bedard Holland, Executive Director, Virginia Oral Health Coalition

Outreach

The DentaQuest Foundation is making a major investment in oral health in Virginia by supporting the work of the Virginia Oral Health Coalition with a grant of $152,670. The Virginia Oral Health Coalition (VOHC) is the statewide advocacy organization created to bring excellent oral health to all Virginians through policy change, public awareness and innovative new programs. DentaQuest Foundation's support provides VOHC with the resources necessary to continue to advance solutions that promote oral health as a critical component of overall health.

All of you are well aware of the link between good oral health and general health. Unfortunately tremendous barriers exist in Virginia for many adults and children who need dental care. Only 65 of Virginia's 135 localities have a dental safety net clinic and 48% of Virginia localities are designated a Dental Provider Shortage Area. This coupled with the lack of reimbursement for all but emergency dental services for adults eligible for Medicaid makes the work of the VOHC essential.

VOHC endeavors to remove these barriers by advocating for public policy changes, such as the inclusion of oral health coverage for pregnant women receiving Medicaid, and increasing public awareness of the importance of oral health through oral health literacy campaigns, the Virginia Dental Home Initiative and other innovative programs.

VOHC's membership is diverse and growing. It includes private practice dentists, dental safety net clinics, the Virginia Dental Association and organizations representing groups in need of oral health access. Members, in addition to participating in workgroups that focus on public awareness, advocacy, workforce and data issues, are invited to participate in CE classes provided by the coalition and to hear from experts in oral health at VOHC quarterly meetings. To join the Virginia Oral Health Coalition or learn more about its priorities and programs please visit www.vaoralhealth.org or contact Sarah Bedard Holland, VOHC's executive director at 804.288.5750 or by email sholland@vaoralhealth.org.

The DentaQuest Foundation is a philanthropic organization supported by the oral health family of companies that includes DentaQuest, one of the nation's largest dental benefits providers, serving more than 12 million members through both commercial and government dental programs. The DentaQuest Foundation supports the enterprise mission of improving oral health for all Americans through its support of prevention and access to oral health care, and through its partnerships with funders, policy makers, and community leaders. For more information, please visit dentaquestfoundation.org.

Kavo Dental Group Teams Up With Missions of Mercy

RICHMOND: The Virginia Dental Association announced that KaVo Dental Group pledged an additional $50,000 in equipment and supplies to the Virginia Mission of Mercy Project.

Accepting the gift on behalf of the VDA, Dr. Terry Dickinson said "We are grateful for the continued participation of the KaVo Dental Group with the important work of the Mission of Mercy Project in Virginia. This equipment will help us extend a hand to those across the Commonwealth who don't have regular access to dental care."

DEXIS Vice President Bryce Servine made the presentation today and restated his commitment to the M.O.M. projects and to the VDA saying "DEXIS is one of the founding sponsors of the American Dental Association program, Give Kids A Smile and has been working with this philanthropic endeavor since 2003. DEXIS also started working with the Virginia Mission of Mercy program shortly thereafter under the leadership of Dr. Terry Dickinson. We are delighted some of our sister companies, Gendex and Pelton and Crane are able to join us in assisting Dr. Dickinson and the VDA to start the restoration project after this tragic fire. We are honored to be a part of such an impressive charitable program."

The VDA served 4,646 patients in 2010 at 6 MOM projects in 6 cities; contributing $3.3 million in services to patients in need of care.

Donated Dental Services - An Update

By: Kate Hanger - Director of Programs, Virginia Dental Association Foundation

Joan Smith

On Friday, November 5th, Donated Dental Services patient Joan Smith visited the VDA office with goodies for the staff. Joan and her "assistant" brought fruit, nuts and candy to thank us for the free dental care she received through Donated Dental Services.
When Joan applied to the program her diabetes had gotten out of control because her poor oral health made it difficult to eat a proper diet. Now, after having extractions by Dr. Jeffrey Cyr and receiving dentures from Dr. Elizabeth Wilson and Drake Precision Dental Lab, Joan's diabetes is manageable and her overall health has improved dramatically! Although the photo is a bit blurry you can see what a beautiful smile Joan has and she tells us she gets compliments on her new teeth all the time. Thank you Dr. Cyr, Dr. Wilson, and Drake Precision Dental Lab for all you do through the Donated Dental Services program. And thank you Joan for your thoughtful gift!

Connie Bruker

It was my pleasure meeting and treating Connie Bruker. She is a delightful lady and now with a full compliment of teeth she is more confident and healthy. The Donated Dental Program is a great way for people like Connie to receive quality dental treatment in a friendly and caring environment!

Dr. J Keller Vernon, Colonial Heights

Donated full upper and lower partial dentures provided by:
Jerry Vick
Fitz Dental Lab
Richmond, VA

Dr. Robert O'Neill provided Ms. Bruker's oral surgery.

Robert Gillie

It was my pleasure to help Mr. Robert Gillie through the VDA Donated Dental Program.
He first presented with overwhelming periodontal disease. He'd had many physical problems earlier in his life and oral hygiene took a backseat while he battled to get healthy. My friend, Dr. Paul Brinser, extracted his teeth and after a period of healing, we again met and began to make him some teeth.
He is very friendly with a subtle but sharp sense of humor. We had fun getting the look and feel he was after. He brought his Mom and sister at the try in appointment. After some good natured discussion, we all agreed on his new look.

He is quite pleased with his new teeth and so am I. Thanks to Goodwin Lab, I can always count on them.

Mr. Gillie now has a big smile for the Holidays and beyond!

Dr. Michael R. Hanley, Chester

Core Business Skills For Successful Business Owners

(Prelude To An Educational Event on April 29, 2011)

By: E. Wayne Bullis, Ed.D., CRFA

Many dentists ultimately want to have ownership in the outcome of businesses in which they practice. As a business, not just a dental office, successful dental practices don't just happen. Leadership and vision, organization and tracking of results, effective employment practices, branded marketing, and understanding how to create a business of value are among the cornerstones of business success.

Leadership and vision provide the underpinnings for creating, articulating, and moving towards the company's ultimate goals. Having an organized office with effective systems, efficient technology, and results-oriented tracking of income, expenses, and other initiatives that can be used for planning are keys to understanding and promoting profitability. Knowing and following best practices in business and employment law can avoid volatile, expensive, and time-consuming legal issues. Effective and distinct branding and marketing can create a public image and message that differentiates one's services within the community. And ultimately, the fruits of hard work put into the business can be a part of planning for retirement if critical steps are taken to create value and capture it.

As a dental community, you have the opportunity learn about critical skills necessary to create and operate a successful business. On Friday, April 29, 2011 a one-day intensive educational event, co-sponsored by the Virginia Dental Association and the Business Consulting Team of The Bullis Financial Group, Inc., will be held at the Ramada Plaza Hotel in Richmond, Virginia. This "mini boot-camp" will provide information focused on helping dentists build and improve core business skills. A general outline of the break-out presentations follows:

Session A:
Mr. James McIntosh, President of Non-sense At Work, a leadership training and business consulting company, will discuss "From Dentist To Business Manager To Practice Leader In Six Steps."

Session B:
Mr. Duane Deskevich, Managing Partner and business and real Estate attorney at Cawthorn, Rowe, Picard, Deskevich, and Gavin will discuss "Legal Risks of Business Ownership."

Session C:
Mrs. Karen Elliott, Employment Law Attorney at Sands-Anderson, will give a presentation on "50 Ways To Avoid Being Sued By Your Employees."

Session D:
Mr. Charles S. Pearson, Jr., CPA, President Of Charles S. Pearson,CPA, PC will discuss "Bookkeeping and Accounting: Effective Tools To Create A Profitable Future."

Session E:
Mr. Adam Mead, President of The Creative System, a branding and marketing company, gives tips on "Creative Marketing On A Shoe-String Budget."

Session F: Dr. Wayne Bullis, President of The Bullis Financial Group, Inc. will discuss "My Business Is My Retirement Plan - - Or Is It?!"

Mark Your Calendar Today!

Building Better Business Skills
A Mini Boot Camp for Dentists:
An Educational Experience

April 29, 2011

ADA C·E·R·P® | Continuing Education Recognition Program

The Virginia Dental Association is an ADA CERP Recognized Provider

ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry.

Attendees will rotate though each of the break-out sessions. Mr. Robert Snorbus, Regional Manager for Research with The Federal Reserve Bank will give a lunch-time presentation about business trends in Virginia, with some focus on the Central Virginia area (of importance to the future of business ownership). Six continuing education (C.E.) credits will be given to attendees. A continental breakfast, buffet lunch, and reception following the event are included in the admission price.

Do you want to learn more about being an effective business leader? Do you need a "get-a-way from the office" with a purpose? Mark the date, April 29, 2011, on your calendar. More information will follow in future editions of "Etch" and in mailings. We hope to see you there!

THE Virginia MEETING

Williamsburg Lodge

June 16-18, 2011

Colonial Williamsburg®

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www.virginiameeting.org

Dates to Remember

Please make note of these important dates for the Virginia Meeting.

Register before April 30th and receive the early bird discount pricing!

• **Registration Begins**	**March 14, 2011**
• **Registration brochures to be mailed**	**Mid March 2011**
• **Early Bird Registration DEADLINE**	**on or before April 30, 2011**
• **Hotel Reservation DEADLINE**	**May 16, 2011**
• **Pre-Registration DEADLINE**	**June 3, 2011**
• **Onsite Registration**	**June 16-18, 2011**

Lodging Information

We are delighted to be back in historic Williamsburg for the 2011 Virginia Meeting. Colonial Williamsburg offers a full range of lodging options.

Williamsburg Lodge & Conference Center
310 South England Street
Williamsburg, VA 23185

Deluxe: $229
Superior: $204

Williamsburg Inn
Main Building: $395
Providence Hall: $289

Woodland Hotel & Suites:
Superior: $139

Phone reservations: 1-800-HISTORY or 1-800-261-9530
Virginia Meeting Discount Code: 5507

Online reservations: https://resweb.passkey.com/go/5507

Speaker Sneak Peek

This listing is a sneak peek of our CE programs for 2011.
A full list of courses will be published in February.

Thursday, June 16, 2011

Speaker	Course Title
Align Technologies	Invisalign Clear Essentials 1
Amy Kirsch	AM - Scheduling for Success
Amy Kirsch	PM - Dynamic Internal Marketing & Customer Service

Friday, June 17, 2011

Speaker	Course Title
Bruce Christopher	AM - Why Are Women So Strange & Men So Weird?
Bruce Christopher	PM - Are We Having Fun Yet?
Dr. Steve Poss	AM - The "Nuts & Bolts" of Adhesive Dentistry - Sponsored by Dentsply Caulk
Dr. Steve Poss	PM - Predictable Direct Resin Restoration (Hands On) - Sponsored by Dentsply Caulk
Tidewater Center for Life Support	AM - Healthcare Provider CPR
Tidewater Center for Life Support	PM - Heartsaver CPR

Saturday, June 18, 2011

Speaker	Course Title
Bruce Christopher	Why Are Women So Strange & Men So Weird?
Tidewater Center for Life Support	AM - Healthcare Provider CPR
Dr. Kimberly Reynolds	AM - Creating a Good Life: Longevity, Health and Well Being
Dr. Bruce Azevedo	Advanced Dental 3D Imaging Interpretation - Sponsored by VAE - Virginia Association of Endodontists
Witt Mears Partners	How to Live Well Through Retirement - Sponsored by Witt Mears, PLC

Bambi vs. Godzilla - How to Deal with Difficult People

By: Bruce Christopher, Psychologist (2011 Virginia Meeting Speaker)

Difficult people are everywhere! They can be our co-workers, customers, supervisors, neighbors, and even family members. Difficult personality types can drain us of our energy and move us from a positive position to a negative state of mind very quickly. Many of us would like to avoid interacting with difficult people, or even worse, we can't help but react to them with frustration and defensiveness.

Imagine this scenario, you are sitting in a dental office reception room waiting calmly for your appointment. Then, a well dressed professional looking man walks into the waiting area, strolls up to the to the receptionist and says, "Good afternoon, My name is Mr. Jones, I am here for my three o'clock appointment." The receptionist greets him warmly, looks down into her scheduling book, turns the page, looks up and says, "Mr. Jones, I can see here that your appointment is for next Thursday at three o'clock, not today."

"What?!", he explodes, "Do you think I'm incompetent and don't know how to read a calendar!! What is your name young lady?! I'm going to talk to the doctor about you and your employment!!!"

I asked an audience in one of my corporate seminars the question of why there are difficult people, and why do they do what they do? With quick wit, a woman exclaimed, "Because they are evil!" Though it may feel that way sometimes, in actuality, difficult people do what they do for a very strategic reason.

Think about the dental office story; why would this man explode in front of the receptionist in this manner? Because more likely than not, she is going to try to fit him into the schedule that day. You see, difficult people do what they do, not because they are evil, but because it works.

It is a strategy of problem-solving which they learned in childhood and carry into their adult relationships. Much of our personality development is a result of how we learned to handle conflict as children. In our preceding example, Mr. Jones most likely figured out as a child, that a way to handle conflict and get his needs met is by throwing a temper-tantrum. His behavior in the dental office is a micro-cosm of how he attempts to solve problems as an adult. Probably he explodes in the other relationships of his life as well; he explodes at his kids, his wife, and his co-workers. He has become an EXPLODER.

The first rule of thumb to realize when encountering a difficult person is to

understand that they are not evil; they are simply displaying for you their primary defense mechanism and their unconscious strategy of getting their needs met. It is unconscious because most often, the individual is blind to their own behavior. You may recall talking to an exploder in your life and pointing out to them that they are yelling at you. "I am not yelling!!!!", they may shout as their volume escalates even more.

How do we deal with these difficult personality types? Can we change them? The answer to the second question is no. You cannot change someone else; in fact, the more you try to change them, the more resistant they will become to your efforts.

Though you cannot change difficult people, you can deal with them by employing the technique of what I call "The Surprise Effect." The Surprise Effect means four things; first, it means that you can do the exact opposite of what people expect you to do, second, it means you can take control of your own responses, third, it means you can be proactive with people and not reactive, and fourth, it means you can interrupt frustrating and dysfunctional patterns of behavior in relationships.

This works because most interpersonal interactions have an expected routine or outcome. For example, the expected outcome of anger is defensiveness. If someone explodes at me with anger, you can pretty much expect that I will become defensive and may even explode back.

On the flip side, what if instead of buying into the expected argument, I could re-script my own responses and do something totally unexpected and unanticipated? That would result in a different outcome!

In my seminar, I ask a volunteer from the audience to help me demonstrate the power of the Surprise Effect. I ask my helper to stand facing me with about two feet distance between us. We put both our hands up, palms facing forward, and on the count of three we will apply pressure on each other's hands, trying to cause the other to loose their balance. However, these directions are a set up from me. Instead of pushing back on my "opponent" as he or she expects, I do the opposite by pulling my hands back at the last moment. The result is invariably that the other person falls forward, loosing their balance while I stay centered, balanced, and empowered. I have surprised them by doing the exact opposite of what they have expected me to do.

Great communicators know how to do this intuitively. Instead of buying into the expected routine or outcome, they change the rules of the game by employing the Surprise Effect. If you can do it, the Surprise Effect allows you to stay centered and balanced, while your antagonist will loose center and balance.

For example, during a planning meeting you are giving a presentation about current trends in your industry. Right in the middle of your speech, one of your competitors yells out, "You know, you are really full of S __ __ __!" What would you do or say? The expected response might be for most of us to become defensive, or worse yet, maybe even reactive and yell back, "Well, you are too buddy!"

But imagine using a Surprise Effect to do the exact opposite of what your rival expects you to do -- perhaps you could use humor and say, "That is an amazing insight, most people take months to reach that conclusion, you came to it in only 45 minutes." This is actually a true story. It worked wonderfully; everyone laughed and the dialogue opened up to a more receptive audience.

The Surprise Effect shows us that we cannot change or control other people, but we can change and control our responses in any difficult situation. It helps us to see that we can interrupt the pattern of expected outcomes which difficult personality types are often counting upon.

There are six basic difficult personality types which I talk about in my seminar. Remember that these personality types are really defense mechanisms which the individual developed in childhood as a way to deal with conflict or get their needs met.

Let me introduce them briefly to you. First are the TANKS & EXPLODERS; these are the intimidating and aggressive personality types which use power to demand that their needs be met. Exploders often believe that no one will listen to them unless they blow up!

Second, are the SNIPERS; these people use sarcastic and cutting jokes to distract attention from their own feelings of insecurity or incompetence onto to a more likely target. They use humor to get in a dig at someone else.

Next are the KNOW-IT-ALLS; they believe that "to be right is to be liked", so they use intellectualism to impress others and gain status. They tend to be group dominators and may grasp for the spotlight in staff meetings.

Then come the WET-BLANKETS & FIRE-HOSERS; these are the complainers and chronically pessimistic/negative individuals in our personal and professional lives. They tend to be missionaries of misery and like to point out to others how bad things can get around here. They often feel powerless to do anything about it, so they tend to complain and throw a "wet blanket" on new and good ideas.

Fifth on the list are SUPER-AGREEABLE CHARMERS; they are socially seductive and charming, yet tend to be super unreliable. Because of their high need for approval and fear of rejection, they tend to become accommodating and may often over-extend themselves trying to meet other people's needs. But in the process may begin to "drop the ball" on personal and professional commitments and will attempt to use social charm as a way to distract attention away from the broken promise.

Finally, are the CLAMS & INDECISIVES; they tend to clam-up in the face of risk. In the sense that they are perfectionists and fear failure, their strategy is to lay back and remain indecisive in the hope that someone else will take the risk and decide for them.

It is essential to note that these are simple defense mechanisms which people use in a pressure situation. We can all be found in some degree in each of these defensive strategies. When the pressure is on, some of us clam up, some of us explode, and some of us try to charm our way out. Many of us have a primary style with which we are most comfortable, and this integrates into our personality and becomes a way we handle conflict as an adult.

I encourage the people in my seminar to come up with a "Behavioral Map" which they can use whenever they encounter a difficult personality type. Your "Map" can include two columns for each of the six difficult personalities. Take six pieces of paper, label each sheet of paper at the top with the six personality types outlined in this article. Draw a line down the middle of each sheet; label the left-hand column "What I Should Not Do" and label the right-hand column "Surprise Effects."

It is possible to restructure interpersonal events by being prepared with a Surprise Effect. For example, a few years ago I was living in an apartment complex and I had recently taken up a new hobby of boating. So I purchased a boat. While having no place to store my boat, I asked the management of the apartment complex if I could temporarily take up two parking spaces to pull in my boat until I found adequate space. No problem they said.

One night while parking my boat, a car squeals into the lot and an irate gentleman begins to explode at me, "I can't believe you are taking up two spaces!! You know, we pay rent here too!!!"

I remembered my training on the Surprise Effect; I calmly waited until he was finished and then I surprised him by saying, "Sir you are absolutely right." The change which came over his face was amazing! "I am?", he said. "Yes", I continued, "I realize that you pay rent here too and that there are too few spaces; but I want you to know that I got permission from the management to do this and that it is a very temporary situation." At the end of our brief conversation, he literally said, "Well. . .okay, and I'll watch the boat for you."

In less than two minutes he went from being my antagonist to being my ally and protecting my property! Why did this happen? Because I surprised him by doing the exact opposite of what he expected me to do. He was anticipating my defensiveness and anger, while instead I listened and acknowledged his feelings of frustration. I didn't try to change him or talk him out of his anger, but rather, I controlled and changed my own responses.

There are many Surpass Effects which you can employ in any situation and with all of the six basic difficult personality types. I encourage you to have fun and think up two or three effective Surprise Effects which you can apply with the difficult people you interact with in your personal and professional life.

See Bruce Christopher at the 2011 Virginia Meeting.
Registration begins March 14, 2011.

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Events

Annual VDA Golf Tournament

in Memory of Dr. Donald Martin

Thursday, June 16, 2011

Golden Horseshoe Golf Club
Gold Course
401 S. England Street
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Designed by Robert Trent Jones Sr. and son Rees Jones, each course is consistently highly rated by golf publications. The Gold Course is located just south of the Historic Area. With its convenient location and scenic fairways, the Golden Horseshoe Golf Club is golf at its finest.

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Friday, June 17, 2011

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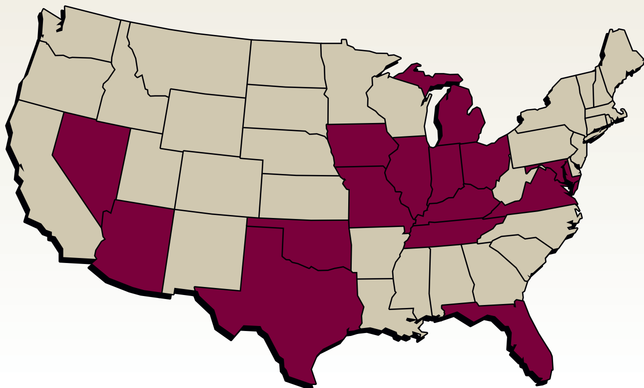

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Dental Direct is Lead Sponsor of Virginia HR Managers Meeting

By: Elise Rupinski, VDA - Director of Marketing and Programs

The Virginia Dental Association's Dental Direct Reimbursement and Assignment dental benefit program was pleased to be a Diamond Sponsor of the 2010 Virginia Society of Human Resource Managers (SHRM) Meeting at the Hotel Roanoke in October. This was the third year that Dental Direct has been a premiere sponsor of the Virginia SHRM meeting. The meeting drew over 600 human resource professionals from across the Commonwealth for two and a half days of continuing education, speakers and HR industry exhibitors.

Dental Direct is a self-funded dental benefit that is a departure from traditional dental insurance. Based on simplicity and freedom-of-choice, the Dental Direct model is supported by both the Virginia Dental Association and the American Dental Association. Dental Direct Reimbursement and Assignment plans are for groups and can be customized to meet the needs of employers of all sizes.

At the Dental Direct booth in the exhibit hall, representatives from the VDA, Benefits Administration, Inc. and Simple, Inc. were pleased to talk with meeting attendees about dental benefits and more specifically about Dental Direct. At a break-out session during the meeting, Mr. Roger Schultz of Simple, Inc., had the opportunity to talk to meeting attendees about key benefits decisions and how to evaluate all of the options on the marketplace. He used the opportunity to provide some insight into the potential cost savings to employers of self-funding benefits such as vision and dental. Meeting attendees were pleased to learn about the options available in the dental marketplace and many stopped by the booth to learn more about Dental Direct.

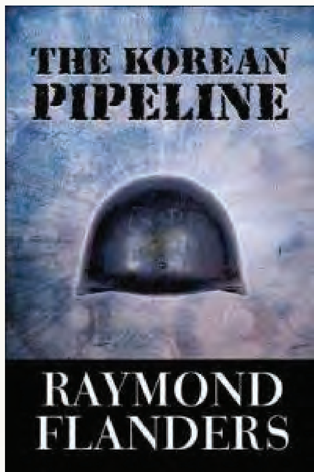
Employer groups of all sizes are able to offer Dental Direct Reimbursement and Assignment to their employees. At the meeting, human resources professionals from employers with as few as 10 and as many as 600 employees were interested in finding out more about Dental Direct. Mr. C. P. Coyner of Benefits Administration, Inc., the third-party administrator for the VDA's Dental Direct plans, noted that "several of the companies that stopped by the booth could see some significant cost savings with a switch to Dental Direct from a fully insured plan. We are looking forward to the opportunity to present these firms with proposals in the coming weeks."

For more information about Dental Direct Reimbursement and Assignment, please visit www.vadentaldirect.com or contact Elise at the VDA (877-726-0850, Rupinski@vadental.org).

DENTAL DIRECT

Extraoral

By: Dr. Elizabeth M. Wilson



The Korean Pipeline

By: Dr. Raymond Flanders

ISBN-13: 978-1615821969, $24.95
Publisher: PublishAmerica, 2009, Frederick, MD

Over recent months, events in North Korea and South Korea have raised alarming tensions in that area, resulting in much speculation and apprehension in our country and others. Is North Korea preparing for war with South Korea? Should the United States intervene? If so, to what extent? Could the transition of power from Kim Jung Il to his son explain the North's actions in some way?

Well, I have no idea. Admittedly, I had little knowledge on the history of those two countries beyond, embarrassingly, "M.A.S.H." and the show's mostly light take on the Korean War. And after the recent "escalation", I became concerned. Fortunately for me, a dental colleague recommended *The Korean Pipeline*, a novel detailing the entirety of the war itself. Woven throughout are the personal stories of three soldiers' gripping experience in the "pipeline", a popular name for the rapid deployment into distant Korea; and what ultimately happened to them. A note about the author: Raymond Flanders received his DDS from the University of Maryland and is a distinguished Korean War veteran, currently living in Virginia.

Broadly speaking, the bulk of *The Korean Pipeline* vividly recounts the breakneck start and then rapid and ongoing progress of the Korean War. Dr. Flanders begins with a fascinating tutorial on Korea which describes its culture, terrain and history of how the peninsula became North and South Korea. I found this section especially helpful, informative and very interesting to someone like myself (my knowledge of this part of the world was minimal). As mentioned, three specific soldiers' experiences in the war clarify and humanize what otherwise is an exceptional presentation on the specific battles and frank confusion of war. I found reading this to be very enjoyable.

For this reader, Dr. Flanders captures the mood of the times: the rampant uncertainty due to the consequences of many multilayered and controversial decisions. Again and again, goals shift and change as conditions change. Our military bravely remains focused amidst the deadly combat.

He focuses on the courage and the hardships endured by the military during what a number of people have termed "The Korean Conflict".

Both for those familiar with the Korean War (and it was indeed a war) and those merely seeking some insight into the present situation, this book is worthwhile. It is a fine read, is timely and may help us to understand possible future outcomes.

Editor's Note: Dr. Elizabeth Wilson has been a practicing dentist in Richmond since 2001. She is a delegate of the VDA, a member of the Board of Directors for the Richmond Dental Society and is adjunct faculty at VCU School of Dentistry. Email her: e.wilson45@verizon.net

VDA SERVICES ENDORSED WEBSITE SOLUTION ATTRACTS NEW PATIENTS

Today more than ever, people are turning to the Internet as a simple means of learning about their medical and dental health. Having a great website that provides information on dental procedures, conditions, and treatment options will help current and prospective patients become better informed on the services and care you provide. An effective website is also a great referral tool, because it's a simple way for your current patients to introduce others to your practice. No matter how it's used, a great website WILL help you grow your practice.

Recognizing the importance of a strong online presence, VDA Services was compelled to assist doctors in their search for an excellent dental website design firm. After carefully evaluating the website design, content, and ease of use of several website development companies, VDA Services selected ProSites as the preferred website solution for VDA members.

Endorsing ProSites was an easy decision," remarked Lanny R. Levenson, DDS, President, VDA Services. "As the industry leader, ProSites has been the choice for thousands of dentists nationwide."

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As the dental industry's fastest growing website design and Internet marketing firm, ProSites makes it both easy and affordable for dental professionals to launch a high-quality website that attracts new patients from the Internet. In addition to the excellent patient-oriented content that is provided, each website includes interactive features that help streamline patient communications and online appointment requests.

Setting the industry standard, ProSites website designs are more graphically compelling than typical dental websites. The exceptional layouts, attractive color schemes and premium photographic images are certain to impress visitors and enhance your professional image. Flash movie introductions, patient education videos, a customizable smile gallery and an online appointment request page are just some of the many elements included in every ProSites website, at no additional charge. The websites also include advanced search engine optimization (SEO) techniques for maximum exposure on top search engines like Google, AOL, Bing and Yahoo! SEO is a blend of content enhancement, link placement, and HTML code that provides optimum results for each given search query.

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Keeping your website up to date is equally as important as the content that appears on it, which is why ProSites provides free FutureNow™ assurance. FutureNow™ assurance means your website will never become outdated; because every time ProSites releases a new feature, enhancement or page option, you receive the upgrades free of charge.

Committed To Your Success

ProSites doesn't merely furnish doctors with a great website; they deliver exceptional customer service and support. Their friendly, helpful and qualified staff is ready to deliver white-glove service anytime you call. The entire ProSites team is as passionate about customer service as you are about patient care. It's no wonder why VDA Services selected ProSites as the endorsed website provider for VDA members.

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Credit Card Processing

How a Better Understanding can Benefit your Practice

By: R. Scott Johnston

As you know, many associations make a recommendation for a payment processor to provide added member benefit. As such, members of that association can benefit from competitive rates and a robust payment offering.

WorldPay (formerly RBS Worldpay) is proud to be the preferred payment processor for members of the Virginia Dental Association. And as part of this program, VDA Members can receive a free, confidential analysis to help you determine optimal rates and the payment options that work best for your practice. In addition, as seasoned veterans in the industry, WorldPay can help you determine the most cost effective strategies of card acceptance as well as how to minimize your risk and fees.

Let's face it, patients pay for services the best way they know how, with Plastic. There are countless types of cards issued by banks. These banks collect fees from both your practice and from the cardholder. For decades, the industry strategy has been to maximize profits from all card types at the business owner's expense. A large majority of these fees, known as interchange and assessment, are passed straight from the card issuers. We all like to use our rewards and airline points cards for purchases but the reality is the fees associated with these card types have become an ever-increasing expense to businesses like your practice.

There are numerous ways to help lower your fees. A good start is to have your fees reviewed by an industry expert. In addition, it is most beneficial to process your transactions with a transaction acquirer, such as WorldPay, as opposed to a bank or an independent sales organization. This ensures that multiple layers (known as gateways), are eliminated, which reduces your cost. Other proven cost-effective strategies include accepting PIN-based debit cards and entering zip codes for card-not-present transactions.

Another way to minimize credit card fees is to avoid expensive equipment leases and identify erroneous and/or misleading quotes. There are an increasing number of practices that have been subjected to non-cancelable leases for credit card machines that exceed the value of the equipment six times over (ex. $300 machines costing $1,800 over 48 months). While leasing may offer accounting advantages for more expensive equipment, it most cases it does not seem practical for a credit card terminal. In addition, quotes you believe are accurate may in fact have critical data omitted, or, provide pricing that is aimed at providing healthcare rates. Unfortunately, the issuing banks do not label transactions as health related. Please keep in mind that there are many factors involved in determining your overall effective rate for accepting plastic payments.

Does your practice currently have a billing process with outstanding balances? You may want to consider asking your credit card processing representative to assist with setting up an automated bill-pay service for your office. Some transaction acquirers can even integrate directly with your electronic claims service and operate with your practice management system. VDA Services has brought VDA members a reliable solution offered by two of their preferred providers, WorldPay and Mercury Data Exchange.

Since 2006, Worldpay has been recommended by VDA Services. For a detailed analysis of your current credit card processing fees or to find out about the services offered by Worldpay please contact Scott Johnston at 804.836.6798 or scott.johnston@worldpay.us.

New Continuing Education Opportunity!

The Virginia Department of Health, in collaboration with the Virginia Dental Association, is offering a two-day training for general dentists wishing to increase their ability to provide care for children with special health care needs and very young children. Dr. Matthew Cooke, a pediatric dentist and the Director of Healthy Athletes, Special Olympics of Virginia, will present a one-day lecture including an overview of special health care conditions, patient behavioral management techniques, infant oral health assessment and prevention, and sedation. In addition to his pediatric dental background, Dr. Cooke is a physician and dental anesthesiologist, giving him a unique perspective on children's oral health needs. Participants will put into practice what they've learned in a clinical session on the following day. A total of 12 hours of Continuing Education Units will be earned at no charge to attendees. Upcoming locations: Charlottesville (February 25 with clinical session on February 26 or March 5, 2011), Saltville (May 6-7, 2011), and Martinsville (May 13-14, 2011). Registration is limited to 15 dentists per site plus one auxiliary staff member per dentist, and preference will be given to dentists practicing in the western and southwestern parts of the state. For further information and to register, please contact Dr. Elizabeth Barrett at elizabeth.barrett@vdh.virginia.gov or (804) 864-7824.

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Co-sponsored by the Virginia Dental Association an ADA CERP Recognized Provider

This continuing education activity has been planned and implemented in accordance with the standards of the ADA Continuing Education Recognition Program (ADA CERP) through joint efforts between the Virginia Dental Association and the Virginia Department of Health. The Virginia Department of Health and the Virginia Dental Association designates this activity for 12 continuing education credits.

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VDA Services is a service mark of the Virginia Dental Association. VDA Services is a program brought to you by the Virginia Dental Services Corporation, a for-profit subsidiary of the Virginia Dental Association.

On February 4, 2011, hundreds of dental volunteers will reach out to provide much needed dental care and education to children. Please join us and volunteer for Give Kids a Smile!®.

If you would like to become part of this important initiative for children's access to dental care, contact your component secretary to find out about events in your area or consider organizing an event at your office or a local school.

Please remember to report your Give Kids a Smile!® activities to your component or to the VDA Central Office.

Email: Kate Hanger at hanger@vadental.org or fax your information to 804-288-1880.

Thank you to all participants!

Don't forget to pay your 2011 ADA/VDA membership dues!

To pay or for questions contact:
Leslie Pinkston at the
VDA Central Office
pinkston@vadental.org
804-288-5750.

Implant Prosthodontics at the VCU School of Dentistry

By David R. Burns, DMD, Professor, Department of Prosthodontics and John W. Unger, DDS, W. Tyler Haynes Professor and Chairman, Department of Prosthodontics

Dr. David R. Burns

Dr. John W. Unger

One of the more daunting tasks for any dental school is to produce a curriculum that remains up-to-date with the changes in clinical practice. An example of this at VCU School of Dentistry has occurred over the last several years involving the dental implant curriculum.

Modern dental implantology and implant prosthodontics have been around for the last twenty-five years or so and have been growing entities in prosthodontic, periodontic and oral surgery residency programs for most of that time. The predoctoral curriculum changes in this area have been slower to unfold. Over the last five years, however, this has changed dramatically. Dental implant-related treatment in general practice has taken off exponentially as practitioners have embraced this area as a new standard of care for their patients and as patient demand for treatment has driven a rapid growth in practitioner involvement.

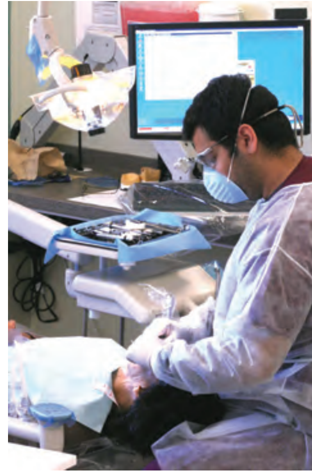
University Connections

In the spring of 2008, the Department of Prosthodontics initiated a new multidisciplinary curriculum change to meet the challenges of dental implantology in general practice. Dr. David Burns, Professor of Prosthodontics, developed a new didactic, preclinical and clinical program to provide our students with a solid educational background in the area of implant dentistry and provide the necessary hands-on experiences that students could use to draw upon during clinical practice both before and after graduation.

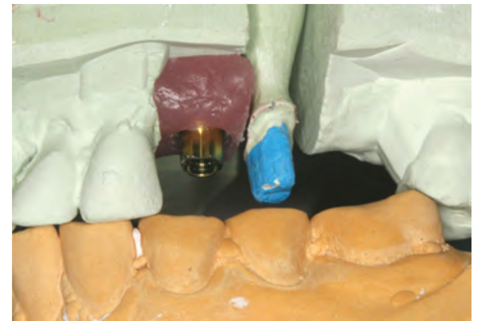
Today these activities have continued to mature and have been recognized by students as very important in their dental educational experiences as they prepare for clinical practice after graduation. The didactic course is presented during the second year of dental school training and provides a background in the biology, biomaterials and biomechanics of dental implantology, patient selection and treatment planning, site preparation and implant placement, implant prosthodontics and maintenance.

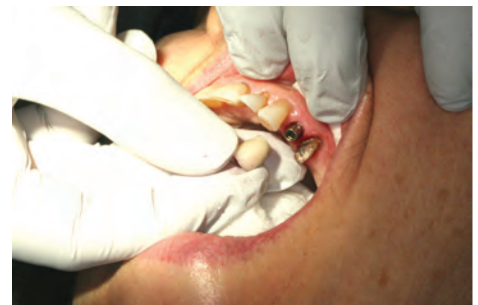
The preclinical experience, also presented during the second year, occurs in the state-of-the-art Woolwine Simulation Laboratory. Students, under the guidance of prosthodontic faculty, demonstrate treatment planning procedures and simulate clinical practice. They fabricate an implant surgical guide, make an implant-level final impression and fabricate a master cast using an implant and soft tissue replica. In addition, they fabricate an implant provisional restoration and transfer implant overdenture attachments into a mandibular denture base. Students also place a number of implants in maxillary and mandibular jaw analogs while in the preclinical laboratory under the guidance of surgical faculty.

During the third and fourth years of dental school, most students have embraced the opportunity to provide implant prosthodontic treatment. They can provide single posterior implant crowns, short posterior implant-supported fixed partial dentures, mandibular implant overdentures and selected implant-supported removable partial dentures. The School of Dentistry has developed partnerships with both Nobel Biocare and Zimmer Dental. These implant manufacturers provide the needed implant-related materials that allow us to offer treatment at a reduced cost to our school patients.



A typical treatment procedure starts out with faculty from Prosthodontics and either Periodontics or Oral and Maxillofacial Surgery who screen a patient for acceptability. Students provide a clinical examination and produce mounted diagnostic casts and then work with residents from either Graduate Periodontics or Oral Surgery for treatment planning and treatment. A diagnostic wax up is produced for the proposed treatment, and, from this, a surgical guide is fabricated. This guide also is frequently used as a radiographic guide when a cone-beam CT scan is deemed necessary.





Implants are placed by a surgical resident, and students are requested to be present during the implant placement procedure. After implant integration, students bring their patient to the implant prosthodontic clinic for implant restoration. Here, students make master impressions using impression copings, select abutments and follow the laboratory procedures as the school's in-house technicians produce the prosthesis. With the prosthesis in hand, students complete the definitive implant-related treatment for their patients and continue to follow them for further recall and maintenance.

Patients have been enthusiastic about this area of practice in the school as well. Many come to the school just to receive dental implants. Overall, patients appear to be very satisfied with the results of their treatment, and many return to the school for additional implant-related treatment.

The School of Dentistry acknowledges its responsibility to give our students an education in Dental Implantology that is at the cutting edge of knowledge and clinical practice. We remain confident that the Dental Implant Program will continue to grow and thrive as research and technological improvements take dental implant treatment to new levels.

Dentistry@VCU, conveniently located in downtown Richmond on the MCV campus at 520 N. 12th Street, provides complete dental care in an educational setting for the entire family. Please visit us on the Web at www.DentistryAtVCU.com, or call 804-628-2190 for more information.

David C. Sarrett, D.M.D., Named Dean of VCU School of Dentistry

By: Anne Buckley - VCU Communications and Public Relations

David C. Sarrett, D.M.D., has been named dean of the Virginia Commonwealth University School of Dentistry effective Dec. 1. He has been interim dean since earlier this year.

Dr. Sarrett will focus on building the research enterprise of the school with an emphasis on oral and head and neck cancer and bioengineering in collaboration with the VCU Massey Cancer Center and other VCU schools. He also will work to enhance the education, research and patient care outcomes through growth of the faculty in strategic areas and through faculty and staff development.

"Dr. Sarrett brings an energy and vision to the position of dean of the School of Dentistry that will provide the leadership required to sustain and strengthen the education, research and clinical missions of the school," said VCU President Michael Rao, Ph.D.

Dr. Sarrett received his D.M.D. degree from the University of Florida College of Dentistry and served on the faculty of the University of Florida College of Dentistry from 1978 until 1993. He completed a master's degree in Materials Science and Engineering with an emphasis on polymers and composites at University of Florida in 1988.

He joined VCU in 1993 as chair in the Department of General Practice Dentistry. He was appointed assistant dean for academic affairs in the School of Dentistry in 2000; became associate vice president for health sciences in 2003; and became president in 2008 of the VCU Dental Faculty Practice Association, a 501-3c corporation that operates the dental clinical practice.

Dr. Sarrett served on the American Dental Association Council on Scientific Affairs from 2001 to 2005 and is currently an associate editor for the Journal of the American Dental Association. He also is the inaugural editor for the ADA Professional Products Review.

"David is an incredibly capable leader who has been a successful scholar and faculty member at two schools of dentistry," said Sheldon Retchin, M.D., vice president for Health Sciences and CEO of the VCU Health System. "He is nationally prominent and I am delighted he has agreed to lead the school as the new dean. I look forward to working with him and continuing to build on our national reputation."

Dr. Sarrett will continue to serve as the associate vice president for Health Sciences until a search is completed for his replacement.

"Safe and Effective": Students seek to know more about anesthesia

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

Various programs at the Virginia Commonwealth University School of Dentistry are contributing to the anesthesia education of interested students through extracurricular activities and clubs. On October 15, 2010, Dr. Malinda Husson, Board Certified Dental Anesthesiologist initiated a new club for students interested in pursuing dental anesthesiology or specialties that utilize anesthesia. VCU was the second dental school to form a Dental Anesthesiologist Club for Students (DACS). Currently, there are three schools with DACS memberships: University of Pittsburgh, VCU, and UCLA. DACS seeks to preserve dentistry's historic role in the development of anesthesia, and promote education, research, and advancement of the profession of dental anesthesia. DACS members have the opportunity to learn and discuss topics such as medical emergencies, general anesthesia, acute and chronic pain management, and IV sedation. Dr. Husson has hopes that, in the future, VCU will also have a Dental Anesthesiologist residency program, expanding upon the current nine programs nation-wide.

Students at VCU SOD have also had the opportunity to get some "hands-on" learning in the area of IV sedation. The VCU Oral Surgery Club- the Osteotomes- held an IV lab in which interested students were given the opportunity to learn how and where to start IVs. Students learned about the use of butterfly catheters as well as angiocatheters, the indications for their uses, and advantages and disadvantages of each. The activity finished with students having the opportunity to start IVs on one another with the guidance of Oral Surgery Residents.

From the Leadership Conference...

"VDA Rising From The Ashes"

Over fifty leaders and future leaders of the VDA met November 12 and 13 in Richmond to chart a course for the future of organized dentistry. Management consultant and presenter Sheila Sheinberg asked participants to leave their comfort zone and undertake what she calls the "adaptive work of leadership". Active involvement in the conference was mandated of all in attendance. Two long days of interacting with other leaders were concluded by 1) asking groups to paint a picture of a grim, lifeless organization with no future and another of a vibrant, growing association in charge of its own destiny and 2) charting a course for the VDA of the future.

Sheila Sheinberg, Conference Director and Dr. Terry Dickinson

Contestants on "Here's My Agenda!"
L-R: Drs. Daniel Stockburger, Claire Kaugars, Richard Roadcap, Danielle Ryan, Sam Galstan, Craig Dietrich, Tom Cooke, Catherine Fulton

A Tale of Two Associations

By: Dr. Tom Cooke and Karen Kraus

Dental care rationed due to lack of funds

In a move that shocked many dentists, the government run health care industry now controls dental providers' income and duties. This came in the midst of the dental insurance companies' announcement to reduce the number of participating providers by fifty percent. In the same announcement, it was stated that reimbursement rates would also be reduced. Now dentists are scrambling to make sure they are credentialed.

> "There is no vaccine for 'today'."
>
> *Dr. Terry Dickinson*

When contacted, the VDA stated that they tried to meet with the industry to change the policy but were informed that the decision had already been made. Organized dentistry suffers from declining membership as the association has little political impact on the dental care delivery system. The government now controls income and duties through the government-run "dental health care industry". The VDA currently represents less than thirty percent of the practicing dentists. This was the breaking point for the VDA's long time leader and babysitter, who was quoted as saying to the members, "Take this job and shove it."

Organized dentistry achieves what the government could not

Representatives of the VDA, VCU and the state of Virginia met to celebrate the fifth anniversary of their access-to-care program, which set up and staffed clinics across the state to serve those adults in need.

Virginia dentists took control of the dental profession's future back in 2010 when Dr. Terry Dickinson, VDA Executive Director, foresaw a great need to change dentistry's course. He asked the question, "If not now - when, if not us - who?" This started the momentum which set the precedent for many other state organizations to be proactive in the delivery of healthcare across the country. As a result of this tremendous success, Dr. Dickinson has just been signed to a new four-year contract with the VDA. He exclaimed during the signing of the contract, "WHO'S YOUR NANNY????"

One of the most dramatic changes was the increase of volunteerism by the dental practitioners and auxiliaries. Underserved areas and indigent citizens of Virginia are no longer the forgotten minority. Dentists now serve as volunteers in clinics across the state. This volunteer model for dental healthcare delivery is now the model adopted by the American Dental Association for the entire country.

Welcome New Members!

December 2010

NORTHERN VIRGINIA DENTAL SOCIETY

Dr. Joshua Anderson graduated from Cayetano Heredia Peruvian University in 2000. He received his AEGD certificate from the University of Connecticut in 2010. Dr. Anderson is currently practicing in an associateship with Ahmadiyar and Associates in Stafford.

Dr. David Rad graduated in 2007 from Boston Unversity. He completed his Certificate in Orthodontics in 2010. Dr. Rad is practicing with, Yes Braces, in Fairfax.

Dr. Farshad Bakhtyari graduated from Boston University in 2002 and completed his AEGD in 2003. Dr. Bakhtyari is currently practicing in Oak Hill.

Dr. Cary Birkitt graduated from the University of Tennessee, Memphis in 2007. He is currently practicing in Leesburg.

Dr. Matthew Bolduc graduated from VCU School of Dentistry in 2009 and completed his AEGD in 2010. Dr. Bolduc is currently practicing in Springfield.

Dr. Monica Chang-Watanabe graduated from the University of Cayetano Heredia Peruvian University in 1993. She continued to complete her education at the University of Maryland in 2009. Dr. Chang-Watanabe is currently practicing in an associateship with the Arlington Center for Dentistry.

Dr. Mina Dadkhah graduated from University of Southern CA in 2006; she completed her Certificate in Pediatric Dentistry from University of MD in 2010. Dr. Dadkhah is practicing in Alexandria.

Dr. Elida Fidel completed her Certificate in Pediatric Dentistry from Howard University in 1997. Dr. Fidel is practicing with Pediatric Dentistry of Arlington.

Dr. Willie Hammontree graduated from UT Memphis in 2010. He is currently practicing with the Hughes Dental Group in Roanoke.

Dr. Sowmya Kanumilli graduated from the Boston University Henry M. Goldman School of Dental Medicine in 2009. She is currently practicing with the Aramesh Darvishian clinic in Reston.

Dr. Sahira Korton graduated from Cairo University Egypt in 1998. She then completed her MS and AEGD in 2010 from The Ohio State University. Dr. Korton is currently practicing in Falls Church.

Dr. Hung Quoc Lu graduated from Virginia Commonwealth University in 2008. He then continued to receive his certificate in orthodontics and dentofacial orthopedics from VCU in 2010. Dr. Lu is currently located in Burke.

Dr. Ann Lyles graduated from the Univ. of Southern CA in 1997. She recently transferred her membership and is located in Arlington.

Dr. Kevin Mendes graduated from Case Western Reserve University in 1991 and went onto receive his Certificate in Orthodontics in 2005. Dr. Mendes is practicing in Manassas.

Dr. Ibis Molina-Clyde graduated from Ohio State in 1996. She is currently looking for an associateship in the northern Virginia area.

Dr. Jeffrey Moon graduated from VCU School of Dentistry in 2010. Dr. Moon is currently practicing in Centreville.

Dr. David Morgan graduated from the Ohio State University College of Dentistry in 2004. He completed the Oral & Maxillofacial Surgery program at the University of Connecticut in 2010. Dr. Morgan is currently practicing with Dr. James Pell in Alexandria.

Dr. Margaret Neal-Stubblefield graduated from the University of Detroit – Mercy in 1999. She is currently practicing in Bristow.

Dr. Nadgie Ortiz graduated from the University of Puerto Rico School of Dental Medicine in 1999. She then continued at UPR to complete her certificate in pediatric dentistry in 2002. Dr. Ortiz is currently practicing with Dr. James Snyder in Alexandria.

Dr. Aisha Nasir graduated from the Tufts University School of Dental Medicine in 2009. She is currently practicing in Manassas.

Dr. Hieu Nguyen graduated from Howard University in 2009. She is currently practicing with the Optimal Dental Center group in Fairfax.

Dr. Adam Park graduated from Virginia Commonwealth University in 2010. He is currently practicing with Dr. Cusumano and Dr. Stuver in Arlington.

Dr. Snehal Patel graduated from Columbia University in 2001 and in 2007 received his MD as an Oral Surgeon. Dr. Patel is currently practicing in Lorton.

Dr. Carter Reeves graduated from the VCU School of Dentistry in 2010. He is currently practicing in an associateship with Aesthetic Dentistry of Lorton.

Dr. Jeannette Suh graduated from the Tufts Dental School in 2010. She is currently located in the Northern Virginia area.

Dr. Marvette Thomas graduated from Howard University in 1999. Dr. Thomas is now practicing in Lake Ridge.

Dr. Jair Urteaga graduated from Virginia Commonwealth University in 2009. He is currently practicing in an associateship with Wellington Dental Associates in Manassas.

Dr. Justin Zalewsky graduated from Case Western Reserve University in 2004. He then continued to complete his specialization in periodontology from Temple University in 2010. Dr. Zalewsky is currently practicing with Dr. Fagan in Alexandria.

PENINSULA DENTAL SOCIETY

Dr. Shaghayegh Kaymanesh graduated from the University of Southern California in 2009. He is currently practicing in Newport News.

Dr. Keith Vaughan graduated from VCU School of Dentistry in 2008. Dr. Vaughan is practicing with Dr. Michael W. Bowler in Yorktown.

PIEDMONT DENTAL SOCIETY

Dr. Patricia Dunbar graduated from VCU School of Dentistry in 2009 and then completed her General Practice Residency Certificate in 2010, from Bronx Lebanon Hospital. Dr. Dunbar is practicing with Danville Dental Associates.

Dr. Rajdeep Guraya graduated from the UMKC School of Dentistry in 1995. He continued to complete his specialization in oral and maxillofacial surgery in 2001. Dr. Guraya is currently practicing in Lynchburg.

Dr. Justin Loftin graduated from VCU School of Dentistry in 2009. Dr. Loftin is currently practicing in Martinsville.

Dr. Vishal Popli graduated from the Herman Ostrow School of Dentistry at USC in 2010. He is currently practicing with the Small Smiles Dental Clinic of Roanoke.

RICHMOND DENTAL SOCIETY

Dr. Sanjay Bhagchandani graduated from Tufts in 2003. He completed his Certificate in Endodontics in 2010. He is currently practicing with Endodontic Partners in Richmond.

Dr. Laura Byrne graduated from VCU School of Dentistry in 2008. She received her AEGD in 2009. Dr. Byrne is practicing with Ashland Family Dentistry.

Dr. Lawrence Hayes graduated from VCU in 2009 and is currently looking for an associateship.

Dr. Jernice Giles graduated from Meharry Medical College in 2007. She is currently practicing in Richmond.

Dr. Jake Reynolds graduated from Case Western in 2004. Dr. Reynolds received his AEGD in 2005, and completed his Certificate in Endodontics in 2009. Dr. Reynolds is practicing with R. David Pagen in Fredericksburg.

Dr. Navneet Sekhon graduated from the University of Maryland in 2009. She is currently practicing in Henrico.

Dr. Rupal Shah graduated from the New Jersey Dental School in 2006. She completed her general practice residency in 2007. Dr. Shah is currently practicing in Richmond.

Dr. Susan St. George graduated from the VCU School of Dentistry in 2009. She received her AEGD certificate in 2010. Dr. St. George is currently practicing in an associateship with Drs. Talton and Renkenberger in Richmond.

SOUTHSIDE DENTAL SOCIETY
Dr. Michael Raad completed his GPR at Boston University. Dr. Raad is practicing with Sam English and Associates in Hopewell.

SHENANDOAH VALLEY DENTAL ASSOCIATION
Dr. Danielle Ryan graduated from the VCU School of Dentistry in 2010. She is currently practicing in an associateship with Dr. Alan White in Staunton.

Dr. Michael Weiler graduated from Medical College of Georgia in 2008, and completed his Certificate in Orthodontics in 2010. Dr. Weiler is practicing with Stephen Alvis in Harrisonburg.

SOUTHWEST VIRGINIA DENTAL SOCIETY

Dr. Misty Cline graduated from the West Virginia School of Dentistry in 2008. She is currently practicing in an associateship with Lutz Family Dentistry in Tazewell.

TIDEWATER DENTAL ASSOCIATION
Dr. David Spruill graduated from the University of North Carolina in 2008. He continued to receive his certificate in pediatric dentistry from St. Christopher's Hospital for Children in 2010. Dr. Spruill is currently practicing with the Greenbrier Dental Center in Chesapeake.

Membership

In Memory Of...

Name	Component	City	Date
Dr. Leon Hecht	1	Virginia Beach	10/2/2010
Dr. Thomas J Winkler	8	Burke	11/25/2010
Dr. Jeffrey W Bass	2	Yorktown	10/6/2010
Dr. Ivan Vernon Yonce	7	Richmond	07/21/2010

PUBLICATION OF CANDIDATE INFORMATION IN THE VDA DENTAL JOURNAL

The following positions are up for election at the 2011 Annual Governance/ Membership Meeting in Roanoke. President-elect, Secretary/treasurer (two year term), four ADA Delegate positions (3-year terms) and five ADA Alternate Delegate positions (2-year terms).

All candidates must submit their CVs, pictures (color head shot preferred) and biographical information to the attention of Dr. Richard F. Roadcap, Editor, at the VDA Central Office no later than February 28, 2011 for publication in the April-May-June 2011 issue of the VDA Journal. Please submit information as a Microsoft Word attachment via e-mail to jacobs@vadental.org. Forms for submission of candidate information have been mailed to all VDA component society presidents.

Candidates for the office of President-elect will be allowed a maximum of 500 words. Candidates for all other offices will be allowed a maximum of 250 words. Candidates are asked to limit their biographical information to major accomplishments, but include such pertinent data as education, memberships, honors, positions of leadership held in the ADA, VDA and component society, and community leadership activities. Due to space limitations, the VDA Journal editor will reserve the right to condense biographical information, if necessary.

Should you have any questions regarding the Journal criteria, please feel free to contact Dr. Richard Roadcap at (804)-520-4770.

VDA AWARD NOMINATIONS

The Board of Directors Awards Subcommittee selects recipients for VDA awards which are presented at the Governance Meeting of the Virginia Dental Association. In order to select those who are most deserving of these honors, we would like to ask for your help in identifying potential recipients. Nominations for awards may be made to the Awards Subcommittee by individual members of the VDA or by components. Please submit nominations to the VDA Awards Subcommittee, attention Bonnie Anderson, at the VDA Central Office (P.O. Box 3095, Henrico, VA 23228) by April 30, 2011.

Dental Team Member Award The nominee must be a dental team member of a VDA dentist. This award may be presented to multiple recipients only when worthy candidates are recognized. The nominee(s) should demonstrate that she/he holds the profession of dentistry in highest regard, promotes the interest and betterment of the profession through the team concept of dentistry and has five or more years of experience in the dental field.

Emanuel W. Michaels Distinguished Dentist Award This award is presented to a member dentist who has demonstrated outstanding service, leadership and dedication to the profession of dentistry and for the improvement of the health of the citizens of Virginia. This award is presented only when a worthy candidate is recognized by the President and approved by the Awards Committee.

New Dentist Award This award is presented yearly to a VDA member who has been in practice ten years or less. This award is only presented when a worthy candidate is recognized. The nominee must have demonstrated leadership qualities through service to dentistry.

Special Service Award This award is presented to a non-dentist who has demonstrated outstanding service, support and dedication to the profession of dentistry. This award is presented when a worthy candidate is recognized.

Report of the ADA Delegation

By: M. Joan Gillespie, D.D.S., M.S., Chair, Virginia Delegation

The 16th District Delegation to the ADA is made up of delegates and alternates from North Carolina, South Carolina and Virginia. The VDA membership elects our representatives. The delegates include Drs. Anne Adams, Richard Barnes, Alonzo Bell, Mark Crabtree, M. Joan Gillespie, Ralph Howell, Jr., Rodney Klima, Kirk Norbo, Gus Vlahos and Ed Weisberg. The alternate delegates include Drs. Mike Abbott, David C. Anderson, Fred Certosimo, W. Vince Dougherty III, Bruce Hutchison, Michael Link, McKinley Price, Elizabeth Reynolds, Ted Sherwin and Roger Wood. Dr. Terry Dickinson, VDA Executive Director, also attends all Delegation meetings.

The Virginia Delegation met in January at the VDA Committee Meetings in Richmond and at the Governance Meeting in Roanoke. In September, we met with the North Carolina and the South Carolina Delegations at the Umstead Hotel in Cary, N.C. to discuss the proposed resolutions for the ADA House of Delegates. In October, the Delegation went to Orlando for the HOD at the ADA Annual Session.

Resolutions are discussed within the Delegations and at the Reference Committees and this year a new committee on Workforce Issues was formed. Workforce resolutions were adopted that emphasize the importance of the dentist being the leader of the dental team, stressing that examination, diagnosis, treatment planning and surgical/irreversible procedures be done by the dentist. The resolutions were prompted by the efforts of some state legislatures to create midlevel providers both within and outside of the dental team. The HOD approved a $7.00 dues increase and a special assessment of $23.00 for information technology infrastructure upgrades. The HOD also approved funding for the Health Screening Program at the 2011 ADA Annual Session in Las Vegas. Please go to www.ada.org for information on the many resolutions that were passed at the HOD.

Dr. Terry Dickinson was the recipient of the 2010 ADA Humanitarian Award and the VDA was recognized for two "Golden Apple" Awards, one for excellence in "Legislative Achievement" and the other for excellence in "Access to Dental Care Programs". Dr. David Whiston, past president of the VDA and the ADA was named president of the ADA Foundation, replacing Dr Art Dugoni. As ADA President, Dr. Ron Tankersley weathered a year filled with hard work and difficult decisions and proved to be an outstanding spokesperson for the ADA and for all of us. What a year for Virginia! Makes you feel very proud to be a Virginia dentist.

Virginia Dental Association - Board of Directors Actions in Brief

November 11, 2010

The following is reported as information only:

1. Approved: the following resolution:
   Resolution: The VDA and VDSC fund an initial meeting of "Virginia Group". The "Virginia Group" would consist of the eight states identified by the CMS as best practice states. The purpose of the "Group" is to identify common best practices based on CMS state reviews that can lead to useable solutions to access to care.

2. Approved: the following resolution:
   Background: There has been a long held informal policy that VDA officers are reimbursed whenever they are attending VDA meetings. Recently there have been some questions regarding this policy. In addition, in the current environment, there are greater concerns for both profit and not-for-profit corporations requiring higher level of organizational transparency. Therefore the following recommendation for Board Policy is put forward:

   Resolution: Officers will be reimbursed for actual expenses up to the ADA rates when attending required VDA meetings such as Board of Directors, Committee, Virginia (Annual) Meeting, Governance and VDA Subsidiaries. Reimbursement for any other meetings must receive the approval of the President of the VDA.

   According to the VDA Constitution and Bylaws officers are the following: President, President-Elect, Secretary-Treasurer, Immediate Past President, Speaker of the House, Parliamentarian and Editor.

3. Approved: The following resolution:
   Background: Raven Blanco Foundation is a group honoring a young lady who died after being sedated during a dental visit. Her family has asked the VDA to partner with them to spread "Emergency Preparedness Awareness" to patients.

   Resolution: The VDA will lend support to the Raven Marie Blanco Foundation in the capacity of: (1) supplying member's mailing addresses; (2) assisting with Journal advertisements to inform participants of the course; (3) co-sponsoring the course in spring of 2011 to assist with providing CERP credits.

Continued from page 7

• Employment of part-time dental practitioners to meet fluctuations in demands for services, as well as the need for both male and female practitioners to manage family responsibilities coordinated with professional careers.

• In addition to chairside assistance, the ability to delegate duties to a series of ancillary and intermediate personnel thereby freeing a practitioner's effort for direct patient services.

• Establishing ancillary personnel responsible in third party protocols, submissions and coordination.

• Establishing contractual arrangements with companies and unions to provide services to employees and union members.

• Increased potential for quality services based on ongoing oversight of numbers of practitioners, i.e., in-house peer review.

• Allow for different practitioners to become more proficient in particular areas of treatment.

•Permit individual practitioners to volunteer their time at dental schools, hospitals and other community service programs.

• Increased purchasing power by reducing unit costs through economies of scale.

But there can be difficulties, including:

• Clashes of personalities.

• Concerns regarding practitioner performance.

• Disagreements regarding working arrangements, contractual difficulties with third parties, equipment purchases, and hiring and firing of personnel.

• Centralizing establishment location may limit patients who prefer nearby facilities.

•Differing practitioner philosophy of treatment plans; e.g. amalgam vs. composite posterior restorations. (10)

The planning perspective

In the past decades, the emphasis on the growth in the size and complexity of medical delivery systems may have overshadowed the developments in delivery of dental services. Increasingly dental establishment configurations have undergone comparable developments resulting, in part, from:

• Government and insurance company requirements and closed panel competitive factors.

• Increasing practice overhead costs which, to some degree, can be moderated in settings with multiple practitioners. (11)

• Preference for part-time practice arrangements by the increasing numbers of female practitioners. (12)

• Significant educational and related debts upon graduation from dental school. In 2007, 93 percent of dental school graduates had debts averaging over $250,000. (12)

• The availability of expanded function auxiliaries.

• The progressive attraction of new generations of male and female students who are receptive to the idea of practicing in larger dental establishments. Similar to medical establishments, thousands of smaller dental establishments will continue to provide services in areas of the country which cannot support multiple practitioner facilities (e.g. rural and other small population areas) or in any location, simply because practitioners prefer such an arrangement.

Despite the growth in dental establishments with greater numbers of employees, the annual national expenditure of more than $100 billion for dental care and the involvement of approximately one million individuals in dental practices (including dentists and support personnel), it is the continuance of the more than fifty thousand smaller dental facilities, plus almost forty thousand establishments with "no employees," which may reinforce the impression in planning for general health issues, that dental care is a limited "side show." For example:

• The elective inclusion of Medicaid dental services for adults with the resultant severe limitation of services in many states.

• The inclusion of Medicare dental care only in medically related circumstances.

• The limited attention to dental services in the 2010 national health legislation with the result that, 1) governmental financial support for these services will continue at its historic levels of less than ten percent of total expenditures (far below the support for other major health services), and 2) out-of-pocket spending dental care will constitute about 45 percent of costs (a far greater proportion than for other major health services) and remain an impediment for many individuals in need of care. (13) In addition, this limited attention to dental services in the new legislation does not mean that government oversight will not increase.

Despite these hurdles, the general public reported increasing use of dental services. By 2007, one or more dental visits (in 2007, one year) were reported for almost two thirds (65.3 percent) of the population two years and older, including 76 percent of children 2-17 years and 58 percent of adults 65 years and older. (14) However, securing dental care continues to be a significant difficulty for individuals with financial limitations, and persons with special health care needs. For example, "The services most commonly reported as needed but not received was preventive dental care (for children with special health care needs)." (15)

Dental facilities may not have reached the size of large multi-practitioner medical establishments. Dental establishments may only show an average increase of one or two employees. However, during the past quarter of a century the proportion of dental establishments with less than five employees has decreased from 69 percent to 40 percent. The fact that dental establishments are moving beyond their historic smaller settings bears witness to the need to rethink planning for the future delivery of oral health services. The reality is that many states are considering varying levels of training for personnel to deliver dental services for their populations. The consolidation of these providers under the supervision of dental practitioners in large dental establishments, comparable to many medical practices, may well provide for both the needs of the public and the continuance of quality of services.

References

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Table 1. Distribution of dental employees by size of U.S. dental establishments: 1980, 1997, 2007 (2) **(See next page for Table 2)**

Number of establishments

Number of employees	1980	1997	2007	1997 to 2007 Number change	1997 to 2007 Percent change
1-4	59,207	55,033	50,893	- 4,140	- 7.5%
5-9	21,877	43,336	50,662	7,326	16.9
10-19	4,000	14,443	21,421	6,978	48.3
20-49	548	1,956	3,204	1,248	63.8
50+	22	140	212	72	51.4
Total	**85,691**	**114,908**	**126,392**	**11,484**	**10.0**
Employee per establishment	4.1	5.7	6.5		

Percent distribution of establishments

Number of employees	1980	1997	2007
1-4	69.1%	47.8%	40.2%
5-9	25.5	37.7	40.1
10-19	4.6	12.5	16.9
20-49	0.6	1.7	2.5
50+	< 0.1	0.1	0.1
Total	100%	100%	100%

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Table 2. South Atlantic Region population, dental establishments, and private practitioners: 1997, 2007 (2-4,6-8)

	Population (000)		Dental Establishments		Pop./ Dent. Estab.	
	1997	2007	1997	2007	1997	2007
Delaware	732	864	219	240	3,342	3,600
Dist. of Col.	529	588	333	319	1,588	1,843
Florida	14,654	18,251	6,239	7,076	2,342	2,570
Georgia	7,486	9,544	2,608	3,200	2,870	2,982
Maryland	5,098	5,618	2,389	2,554	2,132	2,199
N. Carolina	7,425	9,061	2,388	2,869	3,109	3,158
S. Carolina	3,760	4,407	1,218	1,419	3,087	3,105
Virginia	6,734	7,712	2,662	2,937	2,529	2,625
W. Virginia	1,816	1,812	589	566	3,083	3,201
Total Region	48,234	57,857	18,646	21,180	2,586	2,731
United States	267,636	299,398	114,908	126,392	2,329	2,368

	Private practitioners		Pop./Priv. pract.	
	1997	2007	1997	2007
Delaware	325	372	2,252	2,322
Dist. of Col.	631	545	838	1,078
Florida	7,029	8,761	2,084	2,083
Georgia	3,036	3,931	2,465	2,427
Maryland	3,442	3766	1,479	1,491
N. Carolina	2,767	3,682	2,683	2,460
S. Carolina	1,507	1,839	2,495	2,396
Virginia	3,389	4,079	1,987	1,890
W. Virginia	742	761	2,447	2,381
Total Region	22,868	27,736	2,109	2,085
United States	147,247	166,837	1,817	1,794

PathologyPuzzler

with Dr. John Svirsky

Continued from page 7

A differential diagnosis would include which of the following?

a. Focal inflammatory fibrous and epithelial hyperplasia
b. Inflammatory papillary hyperplasia
c. Median rhomboid glossitis
d. Papilloma.
e. Hemangioma
f. Lymphangioma
g. Cystic hygroma
h. Pyogenic granuloma
i. Peripheral giant cell granuloma
j. Squamous cell carcinoma

Differential diagnoses to be considered include e,f,g, and h.

Focal inflammatory fibrous hyperplasias are normally smooth surfaced lesions that would be rare in this location and at this age. Inflammatory papillary hyperplasia is typically pebbly, found on the palate in older individuals and has a color similar to normal oral mucosa. A papilloma is usually solitary in the mouth and does not reach a size greater than one centimeter. Some individuals with human papilloma virus lesion will have multiple lesions but they do not usually coalesce and present as individual lesions. A hemangioma could have this appearance but a lesion of this size would have a bluish coloration. A pyogenic granuloma can occur on the tongue but would have an ulcerated rather than a pebbly surface. A peripheral giant cell granuloma is similar in clinical appearance to a pyogenic granuloma but only occur on or around gingival tissue. Squamous cell carcinoma is rare in this location and would not occur at this age.

The next step is a diagnostic biopsy. The histologic results reveal mucosa covering a lesion showing dilated, lymph-filled vessels subjacent to the epithelium (Figure 2 & 3). The histologic findings are compatible with a lymphangioma, although a cystic hygroma cannot be excluded. This lesion's histologic appearance is more superficial than a cystic hygroma. The lesion clinically was much smaller than a cystic hygroma. About 50% of lymphangiomas are present at birth and 90% develop before two years of age.

Oral lymphangiomas occur at various sites, but they most frequently occur on the tongue, especially the anterior portion. This lesion involved both the mid-dorsal tongue and the left anterior lateral tongue. Usually the tumor is superficial and pebbly, as this tumor presented. The treatment is surgical excision if the size allows. Cystic hygromas tend to be larger and deeper and are found commonly in the neck. They are far more dangerous lesions and can affect the airway with a mortality of 2-5%. Fortunately, this case was a typical lymphangioma.

This case was submitted by Dr. Neil Sundheimer, an oral and maxillofacial surgeon in private practice in Akron, and Canton, Ohio.

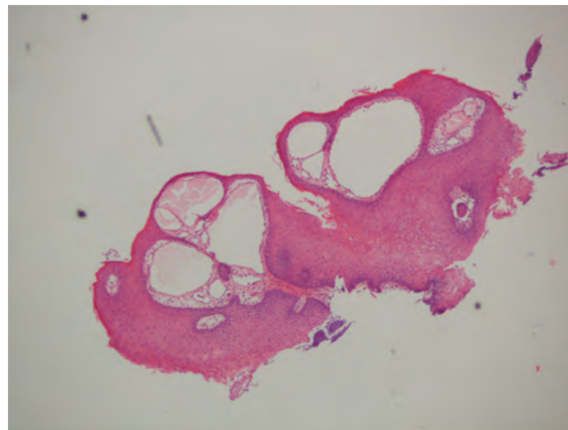

Figure 2

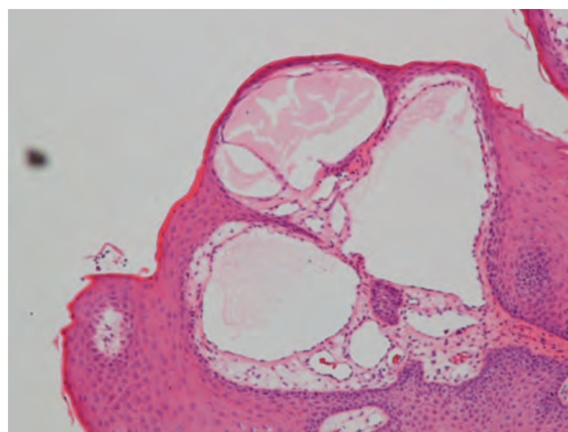

Figure 3

Classifieds

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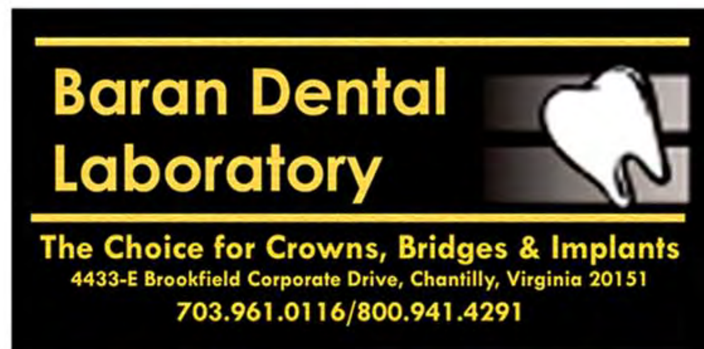

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