Volume 87, Number 4 • October, November & December 2010

# VDA Virginia Dental Association Journal

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Dr. Michael Abbott - VDA President 2010-2011

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Virginia Dental Journal

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**Volume 87, Number 4**
October, November & December 2010

## HEADLINES & ARTICLES



## DEPARTMENTS




Due to the recent fire at the VDA Central Office we have relocated to a new temporary home. The VDA Leadership is currently researching options for a permanent space. We will be sure to update you as we have more information.

**Please make note of our new contact information.**

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# Message from the Editor

## Dr. Richard F. Roadcap

Left homeless by a July 29 fire, the VDA staff found refuge in the nearby offices of the Medical Society of Virginia. New quarters were occupied several weeks later, but they were grateful for the temporary housing. "Super hospitable" and "made to feel very welcome" were some of the comments regarding MSV's reception of the sojourners. Executive Director Dr. Terry Dickinson said this interlude could open new lines of communication between the professions.

Regarding the health of our patients, how well do dentists and physicians communicate with each other? Recent literature suggests there's much room for improvement. A 2008 study reported that French physicians considered their relationship with dentists "nonexistent".[1] Rapport on this side of the Atlantic may not be much better. Our patient base is getting older, sicker, and more medicated with each year that passes – and the need for dentist-physician collaboration has never been greater. We may see our patients more often than MDs: 74% of Americans who visit the dentist are seen two or more times a year.[2] As such, dentists may be more likely to encounter changes in medical history, allergic reactions, new symptoms, and medication side effects than our colleagues in medicine. It's commonplace to register new patients who need pages added to their health histories just to list prescription medications.

When do dentists need to consult MDs prior to beginning treatment? There's no good answer: much depends on the doctor's level of training, comfort level, and knowledge of the patient's medical history. Patients with complex medical histories present a challenge to even the most knowledgeable practitioner. The nature of the treatment rendered plays a role, depending on whether the procedures are inconsequential, benign, or invasive. One dental school, The University of Detroit Mercy, concluded that eliminating unnecessary medical consultation requests (CRs) improved physicians' responses.[3] An example of a needless physician consult would be asking if SBE prophylaxis is required for a patient with coronary artery stents but no history of valve replacement; the guidelines in this circumstance are clear and irrevocable. Alas, Detroit Mercy found even after in-service training faculty and students soon lapsed back into old habits and resumed sending gratuitous CRs.

One entry that seems to improve all forms of professional correspondence: specifics. In addition to requesting specific medical information, scripted questions for different disease entities improve physician responses.[4] Most physicians haven't been trained in dentistry and most dentists (with the exception of my colleagues in Oral and Maxillofacial Surgery) haven't attended medical school. MDs may not understand the intricacies of our treatment, and can't distinguish the gravity of different procedures. It's incumbent upon us to lift the veil on our proposals for the benefit of our patients. Communication can take many forms: USPS, fax transmissions, e-mail (be certain to have signed Privacy Act disclosures on file), or phone. Each of us has a preferred medium, that with which we are most comfortable.

A few suggestions for getting prompt and accurate replies from our colleagues in medicine:

• Be specific – indicate the medical concern, treatment proposed, and any postoperative considerations.[4] Ask for information, not carte blanche.

• Be persistent – if a reply is not forthcoming in a reasonable amount of time, follow-up. How often have we failed to return a phone call or reply to a letter? Understand that your communiqué may pass through many hands before it reaches the MD.

• Be fair – state your planned treatment in layman's terms, if needed. Don't expect physicians to research their answer prior to a reply.

• Be kind – engage the physician's staff in the same manner you would like your staff to be treated. Address them by name. A brief thank-you note will make the inevitable future contacts more cordial.

Good communication requires effort from both parties. Focusing on the health of our patients will improve relationships with physicians, and other health care providers. Increasingly complex health histories will demand that dentists, as healthcare professionals, adopt a more disciplined approach to achieve a better working relationship with medical providers.


1 Tennebaum, A., et. al. Improving the physician-dental surgeon relationship to improve patient care. Presse Med 2008; 37 (4 Pt 1): 564-70

2 Jeffcoat, M. A matter of life and death. JADA 2002; 133(2): 142-3

3 Geist, S.R., and J. R. Geist. Improvement in medical consultation responses with a structured request form. J Dent Educ 2008; 72(5): 553-61

4 Brown, R., A. A. Farquharson, and T.M. Pallasch. Medical consultations for medically complex patients. J Calif Dent Assoc 2007; 35 (5): 343-49

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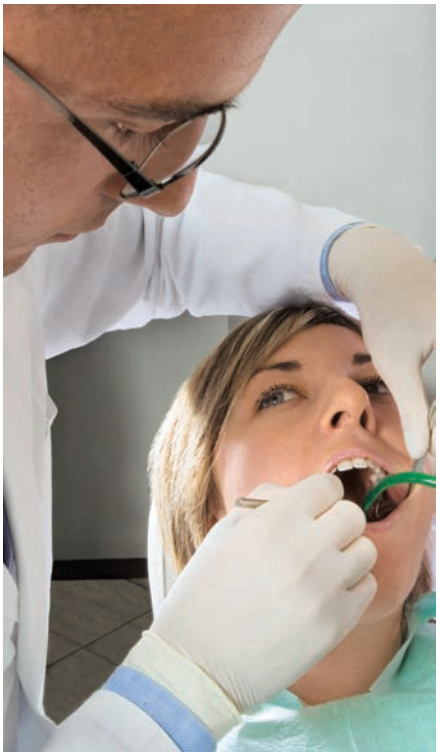
# GETTING OPPORTUNITIES TO OPEN WIDE



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# Message from the President

## Dr. Michael Abbott

*Dr. Michael Abbott addressed the VDA membership at the annual Governance meeting, Friday, September 24, 2010 in Roanoke.*

Let me say what an honor it is for me to stand before you today. There was a time I never thought this day would get here. I want to thank you for being here, thank you for your time for your hard work and your commitment to serve. It has been an interesting journey from the beginning as a delegate to standing here as your President- Elect. Please be assured that I stand before you today, the same person that you have known for many years. I remain totally approachable, but please remember this is a democracy we each have a chance to speak then we vote and the majority rules.

When I started the journey, I was asked by a dental student "What does a VDA president do?" That question started my reading of the leadership literature. This was a natural response for me. So I read Bennis, Kotter, Goldman, the servant leadership literature and others. None of these authors made much sense to me until I read Chris Lowney's book *"Heroic Leadership"*. This book is about the Jesuits and how they formed their leaders. The Jesuits avoided a flashy leadership style. They equipped their recruits to succeed by molding them into leaders who:

1. Understood their strengths, weaknesses, values and had worldview
2. Confidently innovated and adapted to embrace a changing world
3. Engaged others with a positive, loving attitude
4. Energized themselves and others through heroic ambitions

The leader determines where we need to go, points us in the right direction, gets us to agree that we need to get there, and rallies us through the inevitable obstacles that will separate us from your goal. That is what a VDA president should do. This is a description of my plan for your next administration. As you will see, this is not the command and control model that will rely on one person to lead the rest. In other words: "We are all leaders. Leading all the time, often in small and unintended ways. "

Harry Truman said it best when he called leadership "the art of persuading people to do what they should have done in the first place."

On July 28th increasing membership was the primarily focus on my administration as your President. To that end via a conference call that night the membership committee agreed to a goal of increasing the full dues paying members by 100 with 0% non-renews next year. I felt this was an important goal for this committee.

We cannot expect that by doing the same things we have always done before that we will reach this goal. I have heard, that the definition of insanity is doing the same thing time and time again, but to expect different results. We must do something now to stop the erosion in our market share or the organization will not be here in the future. The entire membership must be responsible for increasing our membership market share. That is the membership committee cannot reach this goal alone we must all be involved.

We will have a leadership conference this year and I have asked your Board of Directors to identify 10 -15 new leaders within each component. Remember that the challenges that the VDA now faces as we move forward into an uncertain future: our future is undecided. We need a plan for an ideal future and we will need the right people at this conference to create that plan for our future. They will become our future leaders.

Please know that:" Membership still Matters"

The next night I received the fateful telephone call from Dr. Dickinson. It was July 29th. The VDA building was struck by lightning caught fire and was a total loss. The staff did what they had been trained to do. They obtained the back-up of the computer data and then escaped the building and are all OK, for that we are so thankful. The building can be replaced but your well trained and experienced staff cannot. We will come out of this tragic loss a better organization.

Winston Churchill said it best, "Success is not final, failure is not fatal, it is courage to continue that counts."

I must thank a few people as I start out. First my wife and children, who are in attendance here and I would like to recognize Carol, Tom, Katie and Kelly, and my Component members who are to numerous to name; these folks gave me the opportunity to serve this organization and grow within this organization.

As I started out this talk I stand before you today a simple man who is proud to serve the organization during the next year as its President.

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# Trustee's Corner

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

**Difficult Choices**

As autumn begins our attention turns to the start of school, cooler weather, football season, and every two years, our political elections. Like it or not, it is our opportunity to select the individuals that will represent our interest in the state and federal governments. Their responsibilities are immense, they develop the budgets that set our taxes, and they develop policy that affects our lives, and there are sworn to protect the interest of our states and nation.

Interestingly, as a member of your professional organizations, the VDA and ADA, you also have the opportunity to select your dental leaders who in many respects have the same kind of responsibilities for your profession as the publicly elected officials. If you think about it, they establish a budget that sets your dues (taxes), they establish policy (through the House of Delegates) that affects your livelihood, and they are sworn to protect the interest of the profession and the public that we serve (advocacy).

When your representatives meet in Orlando for the House of Delegates they have a daunting task. There will be significant policy issues debated that could have huge impacts on the practice of dentistry, as well as tough decisions on the budget of the ADA and the dues necessary to support the association. During difficult economic times, as we are experiencing at present, leaders must evaluate all programs and initiatives based on their cost relative to their value for our membership. Having said that, there are some basic functions of the ADA that are essential to our mission and are difficult to neglect.

For instance, if you were elected to represent the VDA in Orlando, would you recommend cutting our programs that promote standard development? That would include our research division, the ADA Seal, the Paffenbarger Research Center, and of course the accreditation of our educational programs and schools. Or maybe you would cut our advocacy efforts on behalf of the membership at the national and state level. Of course without those programs we would surely experience more intrusion into our practices like OSHA, HIPAA, "Red Flags", non-covered dental services - the list goes on and on. Or you might cut programs that provide direct member support. Products and services like our insurance and retirement plans, the practice management and support materials, continuing education, dental well-being support, contract analysis service, the support for our constituent societies, and many, many more would be affected.

As you can see, these are difficult choices, but hopefully the new strategic plan to be presented at this year's House of Delegates will serve as a guide. The new plan is simple, easy to understand and emphasizes member service and advancement of the profession. Used as a guide for budgeting, the plan should focus our resources in a more directed manner.

The four Goals of the plan are:

1. Provide support to dentists so they may succeed and excel throughout their careers
2. Be the trusted resource for oral health information that will help people be good stewards of their own oral health
3. Improve public health outcomes through a strong collaborative profession, and through effective collaboration across the spectrum of our external stakeholders
4. Ensure that the ADA is a financially stable organization that provides appropriate resources to enable operational and strategic initiatives

In closing, I wish to express the support of the 16th District for our members in Virginia during your rebuilding process at your headquarters office.

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# Letters to the Editor

## Our Aging Patient Population

Marvin E. Pizer, D.D.S., M.S., M.A. (Ed.)*

Have you noticed the changing appearance of your family physician and dentist's reception room? It's not the pictures on the wall, or the new lights, or the magazines on the bookshelf -you guessed it-it's the ever increasing number of elderly patients!

This circumstance dictates the changes and challenges the dentist and physician are, and will be, facing in the future. What is a geriatric patient and what special skills will be required of healthcare professionals to effectively and competently treat these patients? Let's define geriatrics!

Geriatrics is defined as that branch of medical science which treats the aged who have physiological and pathologic changes.

In this paper only the physiological changes in patients 70 years and older (as they relate to dental practice) will be presented. The geriatric population in the United States is approximately 35 million as of 2010. This number will increase significantly due to the "baby boom" after World War II, the influx of immigrants, preventive medicine and the enormous progress in medical technology. The dentist, the staff and office environment must adapt to this clientele. The dentist must recognize the physiological aging process to practice efficiently on this population.

Below are listed physiological facts involving the body systems and how they relate to dental practice:

i. FACT: CARDIOVASCULAR SYSTEM -The normal cardiac output in a healthy young male is about 5.6 liters per minute, (10% less in females). At the age of 80 the cardiac output declines to 2 liters per minute. When an adult male who weighs 70 kg and is 80 years old stands up from a reclining position, the cardiac output decreases another 20%. With the loss of elasticity in the aorta, a reduction in strength of the cardiac muscle, changes in venous return, and narrowing of the arteries, cerebral ischemia frequently results, which if persistent, will produce necrosis of brain cells and subsequently congestive heart failure (CHF).

DENTIST'S RESPONSIBILITY:
(1) Check vital signs and medical history.
(2) Rule out CHF (If in doubt call PCP).
(3) Chair time -45 minutes maximum.
(4) Patient in CHF -treat only pain and infection at initial visit.
(5) Patient in reclined position in dental chair -should sit upright for 2-3 minutes and then stand adjacent to chair for another 2-3 minutes before leaving operatory.
(6) Recheck Vital Signs before leaving office.
(7) Evaluate patients general status - patient may need to have competent individual accompany the patient home.
(8) Dentist and assistants must have an accessible Emergency Medical Kit and Oxygen, be competent in CPR, and an assistant available to telephone for additional aid.

ii. FACT: RESPIRATORY SYSTEM -The airways within the respiratory tract, including the air sacs, become rigid in the aged. This increases the vulnerability to COPD and pneumonia. The vital capacity (the total movable air in the lungs) decreases significantly in the elderly due to loss in resiliency of the lung tissue. The firm costal cartilages and loss of tone in the repiratory muscles also decrease the vital capacity. In the elderly person, utilizing 4 liters of air while standing, another 15-20% of capacity is lost when reclining.

DENTIST'S RESPONSIBILITY:
(1) All of dentist's responsibilities in I (above).
(2) Do not treat patient in the supine position -This permits the diaphragm to push the contents of the abdominal cavity superiorly compressing the pulmonary tree and induce dyspnea in the aged. Preferred position would be to have the head and shoulders slightly elevated in the dental chair.
(3) If patient is administered oxygen it is well to remember that 100% oxygen can cause respiratory arrest, since adequate carbon dioxide is necessary to stimulate the respiratory center in the brain of the COPD patient.

III FACT: INTEGUMENTARY SYSTEM -A lack of sebaceous and sweat glands secretions accompanied by the loss of subcutaneous adipose tissue are the major reasons for dry, wrinkled skin and broken skin in aged patients. This makes this population susceptible to infections, pruritus and even malignancies of the skin.

DENTIST'S RESPONSIBILITY:
(1) Coat the commissures of the lips with petrolatum before, during and after intra-oral treatment.
(2) Retract gently
(3) Evaluate skin on face and neck for suspicious lesions.

IV FACT: NEUROLOGICAL SYSTEM -Due to the loss of neurons in the aged, there is a decrease in brain function, and brain size. This results in a loss in the sending and receiving impulses in both motor and sensory nerves. These degenerative changes in the autonomic and central nervous systems are reflected in the five (5) sense organs.

(1) Eyes: The inability to focus on near objects (presbyopia) and cataracts.
(2) Ears: Neural and vascular changes produce loss of high frequency hearing, with hearing disability. There are also changes in the inner ear producing balance problems and falling.
(3) Taste: Loss of taste buds in the tongue and decreased salivary gland secretions
(4) & (5) Smell and Touch Decrease due to loss of neurons and vascular changes.

DENTIST'S RESPONSIBILITY:
(1) Have patient wear dark glasses while in dental chair.
(2) Patient's vision must be adequate to read instructions on medications and post-operative care.
(3) Dentist should speak slowly and distinctly, as well as louder, when necessary.
(4) Dentist should remove mask when conversing with patient since many aged patients resort to lip reading.
(5) Move patient's head slowly and gently when necessary, to avoid vascular and inner ear changes resulting in vertigo.
(6) Pulp testing may not be accurate due to loss of sensory impulses and ischemic pulps.
(7) Mastication and occlusal equilibration may be difficult to evaluate due to a decrease in sensory and motor impulses from the teeth and muscles of mastication.
(8) In verbal communication with geriatric patients, the dentist may have to repeat more than once or twice before patient comprehends the conversation.

V FACT: DIGESTIVE SYSTEM: -There is a decrease in secretions from the major and minor salivary glands due to atrophy of mucous and serous cells.

There is also decreased muscular activity due to the loss in response to the usual stimulus in the gastrointestinal tract. This decreased peristalsis in the colon frequently results in constipation with hemorrhoids.

DENTIST'S RESPONSIBILITY:
(1) Do not prescribe narcotics for pain since they increase constipation.
(2) Have soft cushion for patients with hemorrhoids to sit on.
(3) Most medications prescribed will take longer to take effect, but may persist longer due to decreased peristalsis. In some elderly patients the usual medication may not be effective due to vascular and enzyme changes added to the decreased response from neurons.
(4) Check all medications before prescribing. Response from drugs in aged patients is very unpredictable.

VI FACT: GENITOURINARY SYSTEM: -The aging process involves loss of nephrons consequently a diminished glomular filtration rate. The urinary bladder loses its capacity to hold urine resulting in nocturia, frequency, dysuria and a tendency toward urinary incontinence. The male prostate gland hypertrophies with age (BPH) and this accentuates the above symptoms. In the aging female a common physiological finding is a prolapsed uterus.

DENTIST'S RESPONSIBILITY:
(1) Have patient void prior to treatment.
(2) If patient needs to void during treatment, quickly approve. If patient feels weak or pale, send dental assistant with patient to restroom.
(3) When prescribing medication, remember the aging process will slow renal secretions.

VII FACT: MUSCULOSKELETAL SYSTEM: -The aging process changes the composition of bone. There is usually an increase in the mineral content, but a decrease in the organic matrix resulting in brittle bones. Older bones have irregular margins and spurs which result in restricted motion in the senior patient. There is frequently excessive bone around joint margins resulting in osteoarthritis. The geriatric patients skeletal muscles lose their efficiency and fatigue sets in faster. The muscle fibers degenerate with age and are replaced with fibrous connective tissue which reduces muscular strength.

DENTIST'S RESPONSIBILITY:
(1) Do not force mandible to open mouth. This may result in subluxation or dislocation of the condyles in the TMJ.
(2) Do not keep patient's mouth open for extended periods of time.
(3) Allow patient to rest (close mouth) periodically during treatment as the aged patient develops muscle fatigue early and often.
(4) Extreme care doing extractions as the aging process leaves brittle bone just waiting to fracture from dental trauma.
(5) Extraction sites (sockets) will heal much slower in the geriatric patient.
(6) Post-treatment trismus is common following extended procedures.

VIII FACT: IMMUNE SYSTEM -In the aged the antibody response to an antigen is significantly reduced. Cellular immunity is decreased. Autoantibodies and abnormal immunoglobulins increase.

DENTIST'S RESPONSIBILITY:
(1) Be aware of oral and facial infections because of increased susceptibility.
(2) Wear clean, new mask and gown with each senior patient.
(3) Use sterile gloves, only autoclaved instruments and as clean an operatory as possible.
(4) A decrease in aerosols and treatment time can minimize infection.
(5) Examine closely the facial skin, and hard and soft tissue intraorally -a compromised immune system is considered a major factor in neoplastic proliferation.

The aging process will vary from patient to patient. Some patients will look their chronological age while others will appear younger or even much older, but considered healthy. Within the individual some systems may age faster than others. Almost all dentists have seen healthy teeth and alveolar bone on one side of the mouth and just the opposite on the other side. All healthcare professionals have heard their patients say "all my diseases are on this side of my body".

In conclusion, geriatric dentistry will always be more time consuming, challenging, gratifying, and maybe financially rewarding.

If you are fortunate dear colleague, you will some day be the healthy senior patient sitting in a dental chair with your mouth wide open! (Not too wide).

*Formerly:
Lecturer, Physiology and Anatomy, University of Virginia, George Mason College, Fairfax, Virginia -1968, 1969 Adjunct Professor, Medical Physiology, The American University, Washington, DC -1979 -1988 Clinical Professor, Oral and Maxillofacial Surgery, MCV School of Dentistry, Virginia Commonwealth University, Richmond, Virginia -1984-1990

# OSHA Standards

## Dr. Henry M. Botuck, Component 8 Chair, Infection Control & Environmental Safety

To the editor of the VDA Journal:

I have noticed a trend in dentistry to ignore some basic OSHA standards, and both VDA and ADA publications seem to advertise this as the norm. I reference the July, August, September 2010 VDA Journal cover, and page one of the ADA News of June 21, 2010. Both feature our colleagues helping the disadvantaged by donating their time and expertise at a MOM project.

Also noticeable are the bare arms of the dentists and assistants at these events. The OSHA bloodborne pathogens standard requires sleeves to be long enough to protect the forearms when the gown is worn as PPE (i.e., when spatter and spray of blood, saliva, or OPIM to the forearms is anticipated).

We do need to advertise the good works of dentists all over the country. But, I cringe when we also advertise our ignorance and the flaunting of OSHA regulations designed for our own protection and the protection of our staff.

# An Interview with:

## Dr. Michael Abbott - 2010-2011 VDA President

**VDA Journal:** What would you like to accomplish during your term as VDA President?

**Dr. Michael Abbott:** Prior to July 29th, I would have answered this question with increasing the membership numbers and the market share. Now, my answer would be to rebuild the VDA central office. I believe now that both goals are important to our organization.

*"I was about two years old - 1954 - my Mom took the photo at the Heironimus Department Store in Roanoke"*

*"I was a Cub Scout in '62...my 'den mother' took the picture."*

**Journal:** Is the debate on health care reform over? What role(s) do you see for organized dentistry in the near future?

**Dr. Abbott**: No, I do see an ongoing process that will be paralyzed by the lobbyists for big business. We, as dentists, need to be proactive and attentive to the proposed changes. Dentistry continues to be an attractive and desirable profession.

**Journal:** Dentists, as businesspersons, are always cost-conscious. Do you have any proposals that would add value to VDA membership?

**Dr. Abbott:** I am open to any suggestions that are brought about from our membership committee. One specific incentive that might benefit membership, for example, would be to automatically enter the member in a raffle for a weekend getaway or big screen television.

**Journal:** What would you do to reverse the decline in the VDA's "market share", that is, the percentage of Virginia dentists who are members?

**Dr. Abbott:** As I have said before we as an organization must stop the decline in the market share or we will not be here in the future.

**Journal:** Does your specialty, oral surgery, give you different perspective as President? In what way?

**Dr. Abbott:** Oral surgery is a dental specialty that works closely with the general dentist to provide optimal care to our patients. I feel that being involved give us a different perceptive in which we view the world, but in the end we are all dentists. I am here to listen to problems and help resolve the problems that all of our practices face.

**Journal:** Who are some of your mentors and role models?

**Dr. Abbott:** Where do you start? I feel that my family dentist and friend Dr. Walter Dickey had a huge influence on my development as a dentist. Of course the many past Presidents of the VDA have been role models for me. And finally, my friend Dr. Terry Dickinson has been instrumental in my development in the VDA.

**Journal:** What changes in the VDA do expect between now and, let's say, 2015?

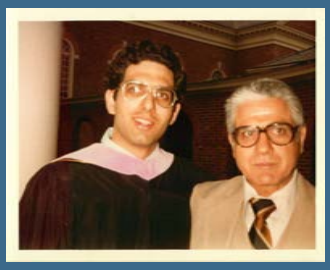
**Dr. Abbott:** I think we as dentists will see some changes in the way we practice that will increase the procedures that we now perform. These changes will positively impact the perceived access to dental care problem.

**Journal:** One last question – what would you like to be doing five years from now?

**Dr. Abbott:** Hopefully, I will be able to continue the practice of oral and maxillofacial surgery and stay active in the many aspects of organized dentistry.

*Top left photo caption: "We celebrated our 25th anniversary (and my 50th birthday) at the Greenbrier. (Clockwise) next to me is my wife Carol, my son Tom, and daughters Kelly and Katie. We've been there often."*

*"We always wore white shirts at Our Lady of Nazareth School. I was in the fourth grade and my teacher was Mrs. Mears. I attended the Catholic schools until we moved to the county, and my Mom said it was too far to drive."*



*"When I graduated from dental school in '78 we attended the ceremony at the Coliseum. The dental school graduation was held at a Baptist church in Richmond. My Dad is with me in this picture."*

*"The family went with me to an air show at the Roanoke airport...this is the tail end of a B-17 that landed. Dr. Scott Anderson, who's now a pedodontist, took this photo."*

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# **Dental Ethics –** The Short Course

By: Thomas J. DeMayo, DDS - Ethics and Judicial Affairs Committee

As dentists and citizens we have an obligation to conduct our personal and professional life in accordance with the moral rules of society. The following four tenets are not novel, but if we adhere to the philosophies behind them, we can better serve our patients, the community at large, and ultimately the profession.

I. "Above all do no harm". This statement has often been attributed to Hippocrates and Galen, but was actually coined in the seventeenth century by Thomas Sydenham, an English physician. In Latin, "PRIUM NON NOCERE" was orally handed down from mentor to student until the nineteenth century when it debuted in print within the medical literature. It has since become the principal precept of medical ethics. Its specific application in dentistry will be discussed below under Nonmaleficence.

II. The ADA's Principles of Ethics and Code of Professional Conduct. This should be read in its entirety by every dentist; a brief synopsis is included. There are five principles that should be the guideposts of the profession: Patient Autonomy (self governance): The patient must be informed about treatment alternatives, the confidentiality of the patient record must be safeguarded. The dentist has an obligation to furnish the patient (if requested) with a copy of the patient's record (or a summary of the record) including duplicated radiographs, either gratuitously or for a nominal cost; Nonmaleficence (do no harm): The dentist is obligated to provide the patient with a proper diagnosis and treatment and to refer when necessary, keep knowledge and skills current, and avoid practice if personally impaired; Beneficence (do good): The dentist must promote the patient's welfare and provide service to the public at large; Justice (fairness): The dentist must deliver care without prejudice and is obliged to report gross or continual faulty treatment by other dentists. A dentist must not imply mistreatment if their version of preferred treatment differs from another dentist; Veracity (truthfulness): A dentist must not recommend the removal of amalgam or other accepted dental material for the sole purpose of removing "toxic substances" from the body. A dentist must practice only evidence based dentistry and avoid quackery. A dentist must be honest with third party payment programs. He or she must report adverse reactions. A dentist must not be misleading in professional announcements or advertising. A dentist must disclose conflicts of interests. A dentist must be truthful in published communications, delineating sources if applicable, and claim only earned advanced academic degrees. A retired dentist's name can only be used by a practice for a period of one year after his or her departure. A dentist must not represent him or herself as a specialist unless he or she has completed an ADA accredited specialty program. If a general dentist is limiting his or her practice to a specific area of dentistry that is recognized by the ADA as a specialty area, they must identify themselves as a general practitioner in their announcement of practice limitation. If a dentist has received advanced full time training, of at least twelve months duration in an advanced education program that is not accredited as an ADA Specialty program, he or she must identify himself or herself as a general dentist and that the announced area of dental practice is not recognized as a specialty area by the ADA.

III: I include the International Principles of Ethics for the Dental Profession, approved by the FDI World Dental Federation in 1997, and stating that the dentist:

• will practice according to the art and science of dentistry and the principles of humanity and will safeguard the oral health of patients irrespective of individual status

• should refer for advice and/or treatment any patient requiring a level of competence beyond that held

• must insure professional confidentiality of all information about patients and their treatment

• must accept responsibility for and utilize dental auxiliaries strictly according to the law

• must deal ethically in all aspects of professional life and adhere to rules of professional law

• should continue to develop knowledge and professional skills

• should support oral health promotion

• should be respectful of professional colleagues and staff

• should act in a manner which will enhance the prestige and reputation of the profession

IV. The Dental Pledge, written by Dr. Rob Strauss and a group of dental students from VCU School of Dentistry; it was later adopted by the American Dental Association and reads:

"I, as a member of the dental profession, will keep this pledge and these stipulations:

• I understand and accept that my primary responsibility is to my patients, and I shall dedicate myself to render, to the best of my ability, the highest standard of oral health care and to maintain a relationship of respect and confidence. Therefore, let all come to me in safe knowledge that their total health and well-being are my first consideration.

• I shall accept the responsibility that as a professional, my competence rests on continuing the attainment of knowledge and skill in the arts and sciences of dentistry.

• I acknowledge my obligation to support and sustain the honor and integrity of the profession, and to conduct myself in all endeavors such that I may merit the respect of my patients, colleagues and my community. I further commit myself to the betterment of my community and for the betterment of society.

• I shall faithfully observe the Principles of Ethics and Code of Professional Conduct set forth by the profession.

All this I pledge with pride in my commitment to the profession and the public which it serves."

Finally, I'm certain that during our formative years within the profession, each of us had a respected mentor or colleague teach us how we should treat our patients. For me it was simple but powerful. "Always treat your patient as if he or she were a beloved family member" or "always treat your patient as you yourself would want to be treated".

If we allow the tenets discussed to govern our daily practice of dentistry, we may (as described in the Hippocratic Oath) "enjoy life and art, be respected while we live and remembered with affection thereafter. May we always act so as to preserve the finest traditions of our calling and may we long experience the joy of healing those who seek our help".

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# VADPAC UPDATE

## The Virginia Dental Political Action Committee

The 2010 VADPAC Contribution Goal has been surpassed! There are still two components (#1 and #7) who have not reached their goal. We would hope that we can close with all components at 100% of goal.

We would like to thank all VADPAC contributors! Over 30 members have contributed at the Apollonia Level ($1,009) and over 90 have contributed at the Governor's Club or higher level ($684+). Their names are recognized with great appreciation below.

Apollonia Club Members (all Apollonia members are also Governor's Club members)
Drs. Michael Abbott, Anne Adams, Carl Atkins, Alonzo Bell, Scott Berman, David Black, Dana Chamberlain, Greg Cole, Tom Cooke, Charlie Cuttino, Vince Dougherty, Sam Galstan, Michael Gorman, Ralph Howell, Bruce Hutchison, Ron Jessup, Jeff Kenney, Rod Klima, Lawrence Kotler, Melanie Love, Rodney Mayberry, Michael Miller, Scottie Miller, Lawrence Muller, Joe Niamtu, Kirk Norbo, Rod Rogge, James Schroeder, Cynthia Southern, A.J. Stenger, Don Trawick, Bradley Trotter, Gus Vlahos.

Governor's Club Members
Drs. Jason Abel, Keith Austin, Stephen Bailey, Steven Barbieri, Richard Barnes, Thomas Bays, Bill Bennett, Herbert Boyd, Dennis Cleckner, Thomas Cox, Jeff Cyr, Jeffrey Day, James Dollar, Ronald Downey, Thomas Elias, Steven Evens, Gisela Fashing, Raymond Finnerty, Steven Forte, Ronald Fuhrmann, Madelyn Gambrel, Charles Gaskins, Glenn Gerald, Garrett Gouldin, Ed Griggs, Glenn Harrison, Heidi Herbst, Christopher King, Deidra Kokel, Penny Lampros, Lanny Levenson, Robert Levine, Michael Link, James Lupi, Bruce Markoff, Harold Martinez, Anne McDonald, Benita Miller, Howard Mitnick, James Nelson, Arthur Novick, William O'Donnell, Thomas Parrott, Smita Sabharwal, Walter Saxon, Robert Simmons, Victor Skaff, Neil Small, John Stephenson, Matthew Storm, David Stuver, Edwin Torrey, Bill Viglione, Ronald Vranas, Jack Weil, John Wheless.

The below chart illustrates the total contributions, broken down by components. Review this chart to see where your component stands.

**VADPAC Contributions**
See Where Your Component is and
What You Need to Do to Meet Your Goal

| Component | % of Members Contributing to Date | % of Goal Reached | 2010 VADPAC Goal | Amount Contributed to Date | Per Capita Contribution | Amount Needed to Reach Goal |
|---|---|---|---|---|---|---|
| 1 | 53% | 95% | $44,000 | **$41,816** | $244 | $2,184 |
| 2 | 59% | 119% | $24,300 | **$28,984** | $254 | $0 |
| 3 | 51% | 101% | $12,500 | **$12,641** | $273 | $0 |
| 4 | 48% | 101% | $60,000 | **$60,681** | $260 | $0 |
| 5 | 50% | 101% | $28,000 | **$28,212** | $236 | $0 |
| 6 | 61% | 112% | $22,000 | **$24,667** | $273 | $0 |
| 7 | 50% | 93% | $30,000 | **$27,936** | $242 | $2,064 |
| 8 | 51% | 105% | $130,000 | **$136,950** | $264 | $0 |
| **TOTAL** | 53% | 103% | $350,800 | **$361,887** | $256 | $0 |

Total Contributions: $361,887
2010 Goal: $350,800

**GOAL HAS BEEN REACHED!**

If you have not yet contributed to VADPAC as a 2010 contributor, please contact Laura Givens at givens@vadental.org or 804-288-5750.

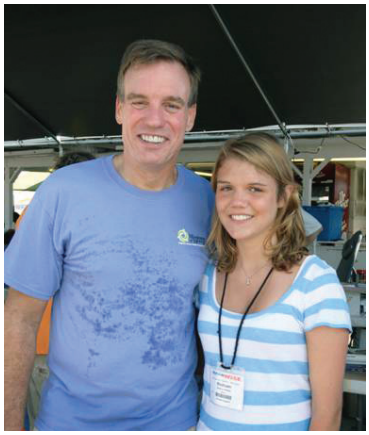
# Senator Mark Warner Volunteers and Visits with Patients at the Wise M.O.M. Project

By: Laura Givens, Director Legislative & Public Policy

*Dr. Terry Dickinson, VDA Executive Director speaks with Senator Warner.*

U.S. Senator Mark Warner attended the Wise M.O.M. Project, July 23-24, 2010. The Senator has participated at several M.O.M. Projects in Virginia throughout the past few years. This year he brought several staff members as well as his daughter Madison. Senator Jim Webb, who was unable to attend, also sent several staff members.

Senator Warner, along with his daughter and staff members from both his and Senator Webb's office were able to lend a hand and also to witness the levels of treatment and hard work done by the dentists, hygienists, assistants and other MOM volunteers as they provide comprehensive care to patients, many in desperate need. The VDA was incredibly grateful that the Senator and legislative staff members took time out of their schedules to volunteer at this life-changing M.O.M. Project. It is quite obvious that Senator Warner is committed to providing access to dental care for those less fortunate in the Commonwealth.



*Senator Mark Warner and daughter Madison Warner, who also served as a volunteer at the project.*

# VDA's 2011 Legislative Day on the Hill: Mark Your Calendar!

By: Laura Givens, Director Legislative & Public Policy

**Attention VDA members! Please mark your calendars for the VDA's Legislative Day on the Hill: Friday, January 21, 2011.**

While association leaders, committee members and dentists statewide are involved in legislative affairs on an ongoing basis, the Legislative Day on the Hill is the most important day of the year for VDA members who want to have their voice heard at the General Assembly. In order for the Virginia Dental Association to be successful in its legislative efforts, it is vital that each of you play an active role in the political process. Your participation proved to be successful this past legislative session when the General Assembly agreed with dentists and oral surgeons, almost unanimously in both House and Senate, and passed legislation proposed by the VDA to restrict insurance companies from mandating fees for procedures for which they are not paying. This is a great opportunity to thank them for their support.

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

We encourage you to attend this special event and contribute your perspective on the issues of the day to our elected officials and policy-makers. Registration will begin in November. Please contact Laura Givens at (804) 288-5750 or Givens@vadental.org if you are interested

# VDA Fundraiser for Senator Edd Houck

By: Laura Givens, Director Legislative & Public Policy

The VDA hosted a fundraiser for Senator Edd Houck on June 8, 2010 at the home of Dr. and Mrs. Stanley Dameron in Fredericksburg. Senator Houck represents the counties of Culpeper, Louisa, and Madison and parts of Spotsylvania County and Fredericksburg city. The Medical Society of Virginia and other health care entities participated.

Senator Houck has provided outstanding leadership in the Virginia General Assembly on issues of vital importance to dentists, our patients and the health care community. As Chairman of the Senate Education & Health Committee and the Senate Finance Subcommittee on Health and Human Resources, as well as a Budget Conferee, he has been there for our patients and our profession when it counts.

The event was attended by over 60 VDA members, other health care providers and their guests. It was a great opportunity for the VDA member dentists to thank Senator Houck for his support and understanding of health care. Guests were also able to hear from the Senator on what to expect in regards to health care in the Commonwealth of Virginia and nationwide.

*L-R: Dr. John Rose, Andi Dameron, Dr. Stan Dameron, Senator Edd Houck and wife Dana Houck*

# New Virginia Law Prohibiting Dental Benefit Plans from Mandating Non-Covered Services: Effective July 1, 2010

By: Laura Givens, Director Legislative & Public Policy

The VDA introduced legislation this year to prohibit dental benefit plans from mandating fees on non-covered services. Due to the hard work of VDA members, lobbyists and other members of the dental community and thanks to the great understanding and support of the Virginia General Assembly, the bill passed through the chambers and was signed by Governor McDonnell in April.

As of July 1, 2010, dental benefit companies in Virginia no longer are allowed to mandate fees for non-covered services. Many questions have arisen with this new legislation. Below are some frequently asked questions and information that may be helpful as you continue to participate with your dental benefit plans and make decisions to participate with additional plans.

**Frequently Asked Questions Regarding Dental Benefits Plans**

1. If a patient's dental benefit plan is an out of state company, do they have to abide by Virginia laws and regulations?

•If the dental benefit plan sells insurance here in Virginia (outside of an Erisa or self-funded plan) the company must register with the State Commission of Insurance and, therefore, must abide by Virginia law.

•If the dentist is unsure of whether or not the particular company is registered in Virginia, he/she should ask the dental plan.

2. If a dentist signed a contract prior to July 1, 2010, would this law pertain to the contract?

•If a dentist signed a contract prior to the date that this law is effective (July 1, 2010), then he/she is bound to the contract, even if non-covered services are included. If the dentist wishes to no longer accept the amendment concerning the non-covered services, he/she should give the appropriate notice as indicated in the contract.

3. Does the new law apply to services that are covered but the patient has used all of his/her benefits so the fee will not be covered?

•Once the patient has met his/her maximum reimbursement amount, the dentist must still honor those 'over max' fees for the 'covered' services.

4. What if a dental benefit plan with which a dentist is a provider currently includes non-covered services in the contract and they say that the new contract will not change?

•Some individuals you speak with at dental benefit plans may not yet be aware of this new law or not be well-informed since it is new. If you need proof of the new law, please visit the Virginia General Assembly Legislative Information System website and enter bill number SB622 to view the legislation, as signed into law by the Governor. Again, this became effective July 1, 2010. If you have trouble finding a copy of the legislation, please contact the VDA.

5. What if a dentist is considering signing a contract(s) with a dental benefit plan but needs some guidance on the language and implications before signing?

•The ADA provides a Contract Analysis Service to ADA members free of charge through their state dental society. This service offers analysis of third-party contracts and informs members in clear language about the provisions of the contracts so they can make informed decisions about the implications of participation. If you would like to take advantage of this service, please contact Laura Givens at the VDA by calling 804-288-5750.

•The ADA Contract Analysis Service is not intended, nor should it be regarded, as legal advice. You are strongly urged to consult your personal attorney before signing any contract.

6. What kind of assistance is available for a dentist who is a provider with a dental benefit plan and has an issue with the company (i.e. complaints with assignment of benefits, denial of claim, explanation of benefits, unauthorized ADA code change, etc.)?

•The VDA offers assistance with these complaints. Please contact the VDA at 804-288-5750 to receive a Complaint Resolution Form. These are reviewed by the VDA Dental Benefits committee.

•You can file a complaint with the Virginia Bureau of Insurance. For information on the claim process, you can contact the following email address at bureauofinsurance@scc.state.va.us. You can also call their Ombudsmen and Consumer Service Hotline at 1-877-310-6560.

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# Lightening Strikes the VDA Central Office

## A recap

*Shannon Jacobs (VDA Director of Publications & Virginia Meeting), met an eye witness in the CVS parking lot (across the street from the VDA Building) who supplied these photos of the intense flames. He described the heat he felt from across the four lane street "like standing next to a huge bonfire".*

*Another eyewitness photo of the smoke that could be seen and smelt for miles.*

*Dr. Terry Dickinson, VDA Executive Director, took this photo from the Henrico County Firefighter's ladder truck.*

### HENRICO COUNTY -

**The following is a press release written by the Henrico County Fire Department:**

On Thursday July 29th a severe thunderstorm swept through Henrico County causing major damage and three major fires in its wake.

The first fire was located in an apartment complex in the West End of Henrico.

The second fire involved a single family residence and was located in the 600 block of Carrington Green Place.

The third fire was at 7525 Staples Mill Road. This is a commercial building housing the Virginia Dental Association. It was reported by the buildings occupants that they heard a "boom" and felt the building shake. The occupants self evacuated with the assistance of a volunteer firefighter from Hanover County who was nearby at the time. After the occupants had come out of the building, they saw smoke coming from the roof at the front left side of the building.

The first arriving crews found fire from the roof. A "second alarm" was called to bring more equipment and personnel to the scene to assist in the firefighting operation Due to the advanced progression of the fire; it was fought from the outside with large caliber handlines and aerial master streams. There were no reported civilian or firefighter injuries. The building is a total loss. This fire was confirmed as a lightning strike.

During the period of the storm and immediately after (5:00pm-8:30pm), Henrico County 911 received 131 calls for service.

In the first twenty five minutes, Henrico responded to and mitigated three major fires, and a smaller fire in the East End of the County. There was a power failure at the communications center due to a lightning strike that caused the county to go to a back-up dispatch system. The large volume of calls and the power failure associated with this time frame, taxed the Division's resources to its limit. This resulted in extended response times.

Hanover Fire and EMS assisted Henrico Fire in mutual aid, providing two engine companies to help mitigate the high call volume.

## A Sense of Normalcy

An update from the VDA on the "Phoenix Project"

On Thursday, August 26th, the VDA staff moved into their temporary office space in the Glen Forest Office complex, in Richmond, VA. The space is less than two miles from the old site but to many feels like a world away.

Prior to the move the staff has been working between their personal home offices and the Medical Society of Virginia. "It's like having the family back together", commented Linda Gilliam, Director of Finances.

The new space features moderate sized offices for each staffer with great views from the 3rd floor windows. Rental furniture now furnishes the space and the staff are getting adjusted to their new "home".

Frequent office supply runs and visits from our technical support specialist have been a normal occurrence as the staff gets back to "business".

Dr. Terry Dickinson, VDA Executive Director reports "We have a long way to go...". Dr. Dickinson has been busy looking for a permanent location and working with the insurance adjusters, on top of all his normal responsibilities.

The staff would like to thank all VDA members and friends for their patience and support while they transition. We are all glad that things are starting to feel normal again.

# ViewPoint:
## The VDA Staff's perspective on Thursday, July 29th

### • Bonnie Anderson, Director of Administrative Services/Assistant to the Executive Director

I left work at 5:00pm on July 29th hoping that I would get home before the storm got too bad. I sat at the stop light in front of the office and felt a little apprehensive when I saw two bolts of lightning come straight down (side by side at the same time) ahead of me, but never dreamt that 20 minutes later the building would be struck by lightning. At 6:15pm I got the call that the building was destroyed. To say it was a shock doesn't even begin to cover what I felt hearing the news.

The outpouring of concern and offers of help has definitely been amazing. We have been made to feel very welcome by the Medical Society of Virginia and appreciate the use of their lunch room to regroup. The VDA is up and running thanks to the fact that Leslie walked out of the building with the server backup tapes. Fortunately no one was hurt and the VDA will be back functioning better than ever.

We are looking forward to moving into temporary office space in the near future and eventually our permanent new VDA home.

### • Elise Rupinski, Director of Marketing and Programs

The night of the fire when I left the office, I ran to my car in a hurry because the storm was getting really bad. Traffic was horrible and the damage was already apparent from the storm; I was so relieved when I finally made it home safely. While I was packing for a weekend trip I turned on the news to find out how long the storms would last. I heard the forecast and resumed packing until I heard the reporter mention a fire on Staples Mill Road. I looked up and saw the VDA office building engulfed in flames on the television. Panic washed over me as I ran downstairs to get my cell phone to call Dr. Dickinson. When he answered, he said simply "it's all gone."

Thankfully, Leslie and Barbara had gotten out of the building quickly (and with the server backup tapes in hand – thank you Leslie!) and no one was hurt. We are now working to get back to business as usual and I am so thankful for all of the offers of help, the support from members, vendors and others in the community – the outpouring of support has truly been amazing.

### • Laura Givens, DDS Case Manager-Director of Legislative and Public Policy

I was shocked when I received the phone call that the VDA building was on fire on the evening of July 29th. It was devastating news and my first concern was that Barbara and Leslie were in the building when I left that evening a little after 5:00 p.m. I was so relieved to hear from Leslie and learn that they had both gotten out safely. Barbara and Leslie are true heroes. Leslie acted quickly and grabbed our back-up tapes, which stored all of our electronic files. Barbara and Leslie worked together to save our precious documents and then to safely exit the building. We owe them so much appreciation.

I personally would like to thank everyone who has reached out to help me and our staff as we try to pick up the pieces. I feel so fortunate to work with such a great group of people and to have such a supportive circle surrounding us, especially during this challenging time. I am happy to be getting back to business and looking forward to a fresh start and wonderful future for the VDA! Thanks to everyone for your thoughtfulness and constant support.

### • Linda Gilliam, Director of Finance

Resilience: Thursday, July 29th started like any other summer day, hot and steamy. We were all hopeful for a break from the heat of mid summer. There were promises of showers in the late afternoon as a cold front was predicted to move through our area which would cool things down considerably. Hopefully this would help relieve some of the heat we had all been experiencing.

About 6pm I received a call at home from Dr. Dickinson that the building had been struck by lightning and had been destroyed. A million thoughts rushed through my head. Was any one still in the building, had anyone been injured or worse, how could this happen. We had been in this building since 2001 and had many lightning storms but none that had caused any damage other than when Isabel came through one summer and tore some shingles off the roof. Little did I know the extent of the damage until I arrived at what had been our office.

As I was standing there watching the last firemen from Station 5 roll up the hoses, I thought of the years I have worked for the Virginia Dental Association and the many changes in our organization. In the 19+ years of employment with the VDA there had been many changes but none that touched my heart like this.

I thought back to some of our history, in the early years of our organization when there was a smallpox epidemic that forced the VDA to cancel the annual meeting; the terrorism attack of 2001 that forced us to cancel yet another annual meeting and would change the hearts and lives of each American. I thought of the many leaders in our organization that have passed on the torch and left a legacy of leadership for each of us to follow.

One word comes to mind as I think of our organization "resilience". We are a strong organization with staff, officers and members that are dedicated to the profession of organized dentistry. Our building is gone, but the heart of our organization still remains in the people that make up the VDA. A building can be replaced, but what makes us who we are the people and the commitment to volunteerism that abounds in the heart of this organization and sets us apart.

Our spirit has not been broken. We are as strong as our membership and commitment and we are tough. We will bounce back and be better through this experience, and so we pick up the pieces and get back to the business of caring.

### • Kate Hanger, Director of VDA Foundation

The day of the fire I had a 5:00 appointment a half mile from the VDA. When I left the office the storm was just starting and there was already a lot of lightning.

It was almost 6:00 when I got in the car to go home. I had a message from Gwen Gardner with Commonwealth Oral and Facial Surgery. "Kate, I just heard on the radio there's a structure fire near the train station on Staples Mill Road. I hope it's not the VDA and y'all are all safe".

The office was just down the road and I looked in that direction but didn't see anything. I sat at the light and thought "Maybe I should drive back over there and see". But then I thought "No, of course it's not the VDA", and got on 64 to go home.

I called Gwen back and left a message saying I didn't know what the fire was but hoped it wasn't the VDA, then I called Laura.

"What time did you leave the office?"
"Elise and I left right at 5:00, why?"

"Gwen left me a message saying there was a structure fire by the train station."

I told Laura would call her back if I heard anything more. Then Gwen called and said "Kate it IS the VDA! They've got it on the news and the building is a-blazing'!".

Gwen's got a great sense of humor but she's not a teaser. Still I said "Gwen, are you messing with me?"
"NO, your building is on FIRE!"

I called Laura.

"Gwen said it IS the VDA, she's watching it on the news!"

"Barbara and Leslie were still there when I left. I'll call Leslie."

"I'll call Barbara."

When Barbara answered her cell phone it sounded like chaos in the background.
"Oh, it's gone. I saw my computer melt away…"
I was totally stunned. I asked Barbara if they were okay and she said yes. Then I listened to her talking to the fireman and heard her tell him what had happened.

After I hung up the phone I was completely shocked. I actually pinched myself a couple of times. It's cliché, I know, but it didn't seem like something like that would ever really happen.

### • Barbara Rollins, Donated Dental Services Assistant Project Coordinator

Amazing how quickly life can change. It appeared to be just another thunderstorm. Most everyone else left

The Virginia Dental Association and VDA Services are Proud to Present:

# Bugs that Will EAT You!

*and*

# Great Cases with New Faces Pathology Update

*A Continuing Education Vacation to South Beach, Florida with*

## John A. Svirsky, D.D.S., M.Ed.

Professor of Oral Pathology
Virginia Commonwealth University School of Dentistry

## February 11—12, 2011

## Miami Beach, FL

## COURSE DETAILS

**Tuition**: $379 DDS/DMD; $149 for all other participants

**Registration**: Call (804-288-5750) or email (Rupinski@vadental.org) Elise at the VDA

**CE Credit**: 8 CE Lecture Hours — 8:30am-12:30pm on Friday, Feb. 11th and Saturday, Feb. 12th

**Audience**: Dentists, Hygienists and Assistants

**Venue**: DoubleTree Surfcomber Hotel, 1717 Collins Ave., Miami Beach, FL

**Description**: "Bugs that Will Eat You" will delve into unusual systemic diseases with oral manifestations. Areas covered will include STDs, tuberculosis and a potpourri of bacterial, viral and mycotic infections. "Great Cases with New Faces" is back by popular demand from the South Beach group. This interactive course will present a variety of Dr. Svirsky's most interesting recent cases which the audience will help to

## HOTEL DETAILS

**Room Rate:** Mention group code VDA for special rate of $259/night

**Deadline**: Must book by 12/27/10

**Reservations**: Call 305-532-7715 or visit www.miamisouthbeachsurfcomber.doubletree.com

## Join Us in South Beach!

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VDA Services and the Virginia Dental Association designates this activity for 8 continuing education credits.

for the evening only minutes earlier noting the "bottom" would probably drop out before they were able to get to their cars. Then, that "crack" of lightning. It seemed to strike very close by but how would you know for sure. Leslie called out that her phone was dead and I quickly noticed my phone was out as well. Not the first time that had happened. But, this "crack" of lightning was like none I had ever heard. I walked down the hall and to the server end of the building and noticed a fairly strong electrical burning smell. Calling back to Leslie she came around, tried to get the server up but with no success. The electrical smell seemed to be strengthening. Realizing this could be involved, Leslie called 911 on her cell phone calling back that "all circuits" were busy. I walked back to my office and tried calling as well but the 911 line just rang and rang. Even in that short time when I entered my office there was now a strong burning smell, not electrical, more like something was burning (and most likely it was). Thinking we may need to evacuate the building (eventually) I looked around to see what I might take down to the bottom of the stairs to leave and pick up on my way out the door. At this point the fire alarm had not gone off so we did not really have that sense of emergency. Walking down the stairs with MOM laptops in hand, the building was starting to show signs of fumes that burned your eyes, even smoke. When I got back to the top of the stairs it was even more noticeable. I walked around to Leslie's office and she came out of the server room stating she had gotten the back up tapes to the server. We looked at one another and decided it was time to leave the building. Leslie gathered her keys and bag and we started down the stairway. Standing at the door we looked around and the fumes were increasing as was the smoke, upstairs and down.

In the parking lot others had seen the smoke coming from the roof of the building and were also trying to call 911. They quickly asked if there were others in the building as it was now obvious, the attic was on fire! We moved our cars to the McDonald's parking lot next door and watched in utter amazement. Surely the fire would be contained. Our calls to Dr. Dickinson alerted him of the severity of the lightning and he was on his way. Of course it seemed like a very long time before the fire trucks arrived. There was white smoke coming from the server end of the building and black smoke coming from the other end. Then flames broke through the roof. The firemen arrived and what a team of professionals! The fire was eventually extinguished but it smoldered for sometime afterwards. Let it be said, firemen are incredible people. They put their lives at risk in fighting the fire that eventually consumed a large portion of the second floor of the VDA building and left the first floor soaked in tens of thousands of gallons of water.

Most importantly, everyone got out safely. The VDA building at 7525 Staples Mill Road will not be recovered. However, the VDA central office will relocate and come back better and stronger than ever!

## • Shannon Jacobs, Director of Publications & Virginia Meeting

On Thursday, July 29th, I was busy trying to map out a plan to reorganize my office. Space was always at a premium at the VDA building and the supplies for the Virginia Meeting seem to grow a bit each year. I had my plan set and approved by Dr. Dickinson. My husband and I had already decided we would spend some of the next weekend, at the office, moving everything around. I neatly packed up everything on my desk so it would be easier to move later.

I left the office at 1:00pm on Thursday to attend a software update seminar in the Short Pump area. Once the seminar was over I drove home to pick my daughter, Simone, up from daycare. We weathered the storm and once it was just about over I headed to a PTA Board meeting at Simone's school

While I was in the PTA meeting I started getting calls and text messages but ignored them all until I got one from my husband saying "Call Me...Urgent". I excused myself from the meeting and tried calling him back but the school has really bad cell phone reception. I went down to the school office and used a phone there. When he picked up he said "You're not going to believe this but the VDA Building is on fire. Everyone says it's a complete loss".

I left the meeting and we all decided to go see the damage for ourselves. Simone was very concerned about her artwork that I had displayed in my office. If you've ever been to my office it was filled with pictures of her and tons of her artwork.

We had to weave through the back roads to get to the office since all the main roads were now closed. Once we got to the CVS parking lot (across the street from the VDA building) I got my first look at the damage. I got really anxious because I started to think of all that was lost. The back up for our publications and absolutely everything in my office were gone. I could tell that there was NO hope of retrieving anything. I kept thinking, what if I had just taken home that little box I packed up since it contained all the items on my desk... including the publication back ups.

Simone is only six years old and it was really hard for her to understand that everything in Mommy's office is gone. Even her artwork. The next day I remember her asking me if the picture with the clown was okay. I had to explain that all the "things" in my office were gone but that Mommy and all her friends at work were okay and that was what was really important. Things can be replaced and work that was lost can be done again but we can't replace "people". That's the "take away" from this whole experience. The VDA is not a building, an event, a Journal, it's people that make up the VDA. I have great trust in our leadership and know they will make the right decisions for the VDA as we move forward.

Thank you to everyone who has expressed their support for us as we rebuild. The Medical Society of Virginia has been so super hospitable. THANK YOU!

## • Dr. Terry Dickinson, Executive Director

I received an email from Leslie dated at 5:15 pm (July 29th) saying 'still looking into it, but our vadental.org is down, not sure what happened. Will keep you posted.'

Shortly thereafter I received a phone call from Barbara saying smoke was coming out of the roof of the building and they couldn't get through to 911 and would I try. I did finally get through as I was getting in the car to head to the office.

I had no idea what was awaiting me as I thought just a small lightening strike, no problem- Henrico's Fire Department would quickly put it out and we would just have a small mess to clean up as a result. By then I was about 1 mile from the building when I noticed the large plume of dark smoke rising from where I thought our building was located. Getting even closer, it was obvious it was our building and it was no small event as there were 5 or 6 fire trucks, including 2 hook and ladder trucks now shooting water into flames leaping above our roof.

My heart sank and I simply couldn't believe what I was witnessing. How could this be happening to the VDA? Luckily, I was able to get by the fire trucks and turn on the street just past the building and park in the McDonalds next to our building.

Leslie, Barbara and I stood in disbelief as we watched our building burn out of control for what seemed like an eternity and feeling completely helpless as there was nothing any of us could do to save our VDA building. My first thought was that Barbara and Leslie got out in time and were safe.

My next thought was about the challenge awaiting us. Having never experienced a loss like this, I think I was numb as the parts of what lay ahead overwhelmed me for a moment. Where do you start? By then Linda Gilliam and her husband were on site as well as Chuck and Linda Duvall, all equally stunned at what we were seeing. By then my phone was ringing madly. One of the first calls was from Secretary of Health, Dr. Bill Hazel offering help in anyway followed by continual calls from members and friends wanting to know how they could help.

As the firemen took metal hooks and broke out the windows of my office along with Linda and Barbara's offices, I knew we were facing a mess simply from the amount of water being shot through those 3 windows into the flames inside. I was later told by the Henrico Fire Department Captain that around 100,000 gallons of water were 'poured' into the building, so what the fire didn't get, the water finished it off. I could see pictures and objects on the walls inside the offices disappear in the torrent of water pouring in through those windows.

On the lighter side, I, for some reason, remembered the threat by my daughter several weeks ago to come up to my office on a Saturday and 'clean it up- I don't know how you can find anything in this office'. Well, I thought, check that off!

And, I received a text from an unnamed member wanting to know if I had managed to save the VDA rug! I admit that did bring a smile to my face. Then, all the parts of what we were facing, in particular the computers (Barbara did manage to get 4 laptops out and Leslie grabbed the back up tapes- probably shouldn't have stayed to get those..), seemed to pile up as the thoughts of where to start once again confronted me.

As the fire finally died out and the fire trucks pulled out, I decided to give myself 24 hours in which to feel the loss of the VDA building and its contents, our personal property, the sadness, anger, confusion, and all the other emotions associated with a 'loss' such as this. Once that 24 hours was up, my responsibility and job was to start the VDA ' Phoenix Project' - to arise from the ashes and rebuild the physical part of the VDA. The staff and I are excited at the possibilities as we move ahead on this rebuilding project. There is no doubt in my mind that we will be better prepared for the future once we accomplish this project. It reminds me of a saying that was sent to me by a friend that we should no worry about the passing storm but rather, should learn to dance in the rain.

Remember- we are the VDA!


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Virginia Dental Health Foundation

## 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.

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**11 YEARS OF SERVICE TO THE UNDERINSURED !**

**I would like to volunteer at:**

**Grundy MOM 2010**
- ☐ Saturday, October 2, 2010
- ☐ Sunday, October 3, 2010

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

**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 # 804-261-1660 ).**

**For more information on the Mission 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!

# An Interview with:
## Robbie Schureman

*Editor's Note: Robbie Schureman is a sales consultant with Henry Schein® Dental and also the company's liaison to the Missions of Mercy project. Recently he was appointed to the Board of Directors of the VDA Foundation.*

**VDA Journal:** Tell us about your career at Henry Schein® Dental.

**Robbie Schureman:** My career with Henry Schein Dental began in 1998 as the dental store manager at the VCU School of Dentistry. After 10 years in this position, I was offered the opportunity to further my career with Henry Schein as a Field Sales Consultant.

**Journal:** What's the best part of your job? The worst?

**Robbie**: I truly enjoy every aspect of my job. I was fortunate to develop many personal friendships in the dental community while I was working at the dental school. Although it was hard to leave that position because of my relationship with many faculty and students, it has been so rewarding to now be in a position to help them grow their practices. That is the best part of my job.

**Journal:** What's the most important service you provide for your customers?

**Robbie:** Through specialized training from Henry Schein Dental, I have the tools to be a business partner with dentists, helping them to improve practice productivity and lessen stress on their whole dental team.

**Journal:** How have your clients fared during the economic downturn? What do you see happening during the next six to twelve months?

**Robbie:** There is no denying that the economic conditions have hurt the profitability of many dental practices to varying degrees. Fear of further economic downturn has affected many dentists, and we have seen this apprehension affect practices as much as the reality of the recession. However, as we approach the end of 2010 we have seen the confidence of our clients increase. This is demonstrated by their technology purchases, implementation of marketing plans, and consideration of fee increases, to name a few. I expect to see this trend continue into 2011. National studies have also indicated that patient confidence in the economy is increasing. If we can reinforce the importance of maintaining good dental health while patient spending confidence increases, dentists will continue to weather this recession well and for years beyond.

**Journal:** You're a fixture at the Missions of Mercy Projects. What compels you to volunteer such a large amount of time?

**Robbie:** To be honest, I'm honored to be able to work next to my heroes who donate their time and skills to help all the patients that otherwise would not have access to dental care.

**Journal:** As dentists, what could we do to improve the MOM projects?

**Robbie:** The dentists are what make the MOM projects so successful. We see a consistent level of volunteerism and dedication to the events. From my perspective, to enhance the care we give we could use some help in fundraising and logistics for the ongoing maintenance of the equipment that is used. Henry Schein Cares provides much of the financial support for the MOM projects, but as with any non-profit cause, we can never have too many human or financial resources. If we could encourage dentists who are not able to attend the MOM projects to work in the background to help secure support for the maintenance of handpieces, instruments, and other items, and to coordinate the maintenance between projects, that would be a tremendous help to the volunteers who contribute their time to treat the patients.

**Journal:** What occupies most of your time as a volunteer? Is there anything you would change?

**Robbie:** I'm on site at the projects to handle anything that is needed at the time. Henry Schein has a great team of support volunteers that attend these projects as well. Our technology specialist, Karen Kraus, has handled the digital X-ray for the projects, and this has greatly helped improve the patient flow and the diagnostics for the dentists. The only thing I would like to see change is the way we transport and store the technology and other expensive and necessary equipment.

**Journal:** What have you and Henry Schein® Dental learned from partnering with the VDA on outreach projects?

**Robbie:** It may sound like a cliché, but I have learned the true meaning of teamwork. Henry Schein refers to its employees as Team Schein Members and the team approach is the basis of Henry Schein's corporate culture. But it has more meaning when the team includes the dentists we serve, the patients they treat, and the organization that supports the dentists. The MOM projects have provided a unique opportunity for me to experience the power of outreach when all parts of the dental community come together for one goal. The experience of being at a MOM project is unique to each event, but the emotions I feel when everyone, regardless of position and title, comes together to care for those in need is powerful every time.

**Journal:** A few years ago you received a rare award – honorary membership in the VDA. What would you say to dentists who haven't joined?

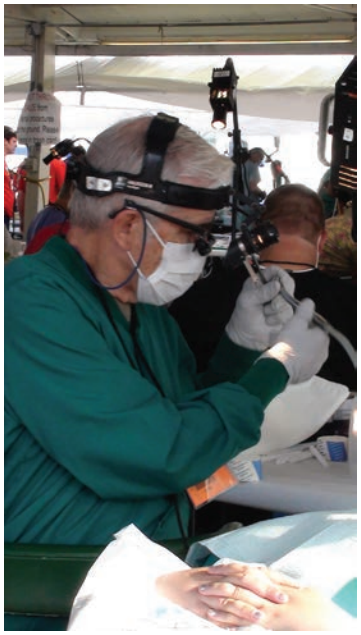
**Robbie**: It was a great honor to be recognized by my peers. I truly believe that the VDA is fortunate to have the leadership of Dr. Terry Dickinson, whose commitment and dedication to dentistry should motivate all Virginia dentists to be part of the association that exists to support their profession. We have seen the power of numbers recently with the role the VDA played in defeating the insurance companies at the General Assembly this year, just to cite one example. The VDA can only be as strong as the sum of its parts. There is no downside to membership, and a member's level of involvement is an individual decision for each dentist. I am privileged to be a member and proud to be included with the VDA as it pursues goals for enhancing the profession of dentistry, which will benefit all Virginia dentists regardless of their membership status.

# Southwest VA Residents seek dental care despite record breaking temperatures


Our appreciation goes out to the 437 volunteers (dentists, hygienists, dental assistants, staff, dental students and dental hygiene students) who made this project possible. A special thanks to the North Carolina Dental Society for the use of their new dental x-ray van!

**Wise Stats for 2010 project**
Total Patients treated: 1,406
Total value of care: $1.4 million
Total dental volunteers: 437

**Treatment performed:**
1,406 exams
196 cleanings/fluoride varnishes
1,500 x-rays
4,222 extractions
2,269 fillings
51 root canals
8 pulpotomies
10 alveoloplasties
25 full upper and lower dentures
6 complete dentures
8 partial dentures
37 relines



**Since July 2000, some 13,600 patients have received free dental care valued at $20 million. Many thanks for your calls, letters and support as we regroup and rebuild following the recent VDA central office fire.**

Outreach

## The Story of the Birthday Girl

By: Dr. Scott Miller

After over 20 cancer related surgeries and becoming disabled, Teresa received the birthday present she was hoping to receive since losing the rest of her teeth last year. Finding her way to the denture team at the RAM/MOM in Wise on Friday July 24 was just the break she needed.

The team had a patient cancellation and Teresa was in the right place at the right time. She explained her situation with a heavy heart and a quivering voice. When she was told that she could have the process started she was overjoyed. She said her birthday wish had already come true.

That night while the denture team was doing lab work a reporter from the *Washington Post* came by our makeshift laboratory (aka: "The Oven"). A lab tech's wife told Teresa's story to the reporter. The reporter, photographer and videographer showed up for the try-in the next day. When Teresa saw her teeth she began to cry (Thank God it was because she was happy and not because the heat had melted the wax!).

The lab tech that set the teeth, Tim Zuber, (a new comer to the lab team this year) was present during the try-in. Tim was so touched by her story and how much she wanted her teeth for her birthday that he processed the teeth after returning to his lab on Monday morning. Tim overnighted the teeth to my office and I delivered them today. You can see from the pictures that some birthday dreams do come true.

She wanted me to relay a message for all those involved with this year's MOM Project. She said, "I will pray everyday that God blesses each of you!" That to me is the best gift I could ever receive! Knowing that we have even more blessings headed our way may shrink that denture list even faster.

Teresa was so well pleased that the 3 1/2 hour trip to get to my office should seem a lot shorter on the way home.

Today was her Birthday and she brought the meaning of MOM to my office staff. I know my staff have wondered why I have them spend all that time helping me get things ready for Wise. They all got to see what I mean when I say the MOM project can change peoples lives. Her story in the *Washington Post* was printed on August 3, 2010.

# A Big THANK YOU to all of our volunteers that made the 2010 Wise M.O.M. Project a huge success!!

Carol Abbott
Dr. Mike Abbott
Amy Adams
Dr. Anne Adams
Amy Adams
Beth Adelson
Alyssa Adkins
Molly Adler
Rhiannon Aesy
Luke Albee
Ashley Alexander
Dr. Hina Ali
Dave Allen
Ray Allen
Kevin Allred
Dr. Steve Alouf
Zaid Alsamir
Safiya Alsogair
Delilah Anders
Ashley Anderson
Dr. Bob Anderson
Dr. John Andre
Anne Argentieri
Dr. Robert Argentieri
Sara Aron
Melissa Artrip
Zack Atwell
Donna Ayers
Tina Bailey
Tyler Ball
Matt Banghart
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Melissa Barnette
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Sarah Holland
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Outreach

## Donated Dental Services

DDS Patient: Patricia (Pat) E. Norfolk
DDS volunteer dentist: Dr. Frederick Martin Norfolk
DDS volunteer lab: Quality Dental Lab, Inc. Virginia Beach


Before


After

Pat's friend writes:

Dear Barbara,

Dr. Martin is finished with Pat and she looks wonderful! It took quite a long time but Pat is so grateful for all that Donated Dental Services did for her and I am too. I hope that God will bless all of you wonderful people who do so much good for people who have a hard life and need a little help. Pat suffered for a long, long time with her teeth until we found you angels.

Thank you again.
Linda

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The VDA Foundation was recently awarded the American Dental Association's **2010 Golden Apple Award** for **Excellence in Access to Dental Care Programs**! It is through the generous contributions to the Foundation by our members that we have been able to accomplish so much.

***Thank you*** for your support in bringing hope to thousands of Virginians!

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# Oral Surgery Abstracts

**Is It Possible to Anesthetize Palatal Tissue With Buccal 4% Articaine Injection?**
**İlker Özeç; Ufuk Taşdemir; Cesur Gümüş; Orhan Solak,**
**Journal of Oral and Maxillofacial Surgery. 68(5):1032-1037; 2010**

It is well known that the palatal injection is the most painful of all injections in the oral cavity. Previous studies have subjectively evaluated extraction of maxillary teeth with the use of only Septocaine® buccal anesthesia, with some promising results that palatal injection may not be required. It is hypothesized that the vestibule-palatal diffusion of local anesthetic solution provided through buccal anesthesia may allow for adequate anesthesia for extraction thereby potentially eliminating the need for the more painful palatal injection. This study was aimed at evaluating the presence of diffused local anesthetic solution in palatal tissue and anesthesia of palatal tissue after buccal injection of 4% Septocaine® (articaine hydrochloride) with 1:100,000 epinephrine or 1:200,000 epinephrine at the premolar and molar region using magnetic resonance imaging (MRI). MRI was employed for detection of the presence of articaine solution in tissue because 4% articaine solution appears extremely bright on T2-weighted images.

The thirty healthy volunteer subjects enrolled in the study were split into two groups Group 1 received 1.7mL of 4% Articaine with 1:100,000 epinephrine to maxillary buccal premolar region and 1.7mL of 4% Articaine with 1:200,000 to contra-lateral premolar region using 27-gauge needle. Group 2 received 1.7mL of 4% Articaine with 1:100,000 epinephrine to molar region and 1.7mL of 4% Articaine with 1:200,000 to contra-lateral molar region. Magnetic resonance images were obtained before and 5 minutes after local anesthetic injection, which was followed by a visual evaluation to determine the presence of local anesthetic solution in palatal tissues. In addition, anesthesia of the palatal tissue was assessed by needle-prick stimulation pain with visual analog scale (VAS). The VAS was divided into 4 categories: 'no pain' corresponded to 0mm ,'mild pain' was defined as greater than 0mm and less than or equal to 54mm, 'moderate pain' was defined as greater than 54 mm and less than 114mm, and 'severe pain' was defined as equal to or greater than 114mm.

MR images obtained before and after local anesthetic injection did not show any signal change at the palatal region in the first premolar group or the first molar group. The mean VAS score for needle-prick stimulation in the first premolar region was 86.44 ± 39.45mm and 87.0 ± 36.28mm 1:100,000 epinephrine and 1:200,000 epinephrine respectively. For molar region it showed the approximately the same results. The VAS score corresponds to moderate pain.

Multiple previous studies show subjective anesthesia to the palatal region after buccal injection of anesthetic, which allowed for extractions using only buccal injections without the need for additional palatal injections; this finding hypothesized that the possible mode of anesthesia via only buccal injection is through the vestibule-palatal diffusion of anesthetic. However, this study shows conflicting objective results because there was no change in the anesthetic seen in the tissue of focus on MRI before and after local anesthetic injection. The authors do state, however, that there are MRI changes after 30 and 90 minutes in the palatal region, but that does not support the idea of vestibule-palatal diffusion in a manner that is timely enough to correspond to adequate anesthesia. Through the VAS score the authors also show that subjectively volunteers' palatal tissues were not anesthetized after buccal injection.

The authors were, therefore, not able to establish the presence of anesthesia or 4% Articaine HCl at the palatal tissue after buccal injection due to the inability to visualize anesthetic within 5minutes after injection on MRI and the lack of subjective anesthesia. Maxillary tooth extraction without palatal injection requires further objective investigation to explain the subjective results previous studies have shown.

Ammar Sarraf, DDS, 2nd year OMFS Resident
VCU Medical Center

**Flapless and Traditional Dental Implant Surgery: An Open, Retrospective Comparative Study**
**Rousseau, P.**
**Journal of Oral and Maxillofacial Surgery 68(9): 2299-2306, 2010**

Traditionally, osseointegrated dental implants are placed using a flap approach that requires reflection of the overlying gingival tissue on the anticipated dental implant site and surgical site closure with sutures of operator's choice. However, some would argue that there are several drawbacks to the flap approach such as loss of alveolar crest bone due to decreased supraperiosteal blood supply, postoperative blood loss, gingival recession, and pain and discomfort to the patient. Therefore, the objective of this study was to compare the flapless method to dental implant placement with the traditional flap method with regard to success, change in bone level and overall safety.

This was a single-center, open, retrospective, investigator-driven, nonrandomized, comparative study. Only patients with sufficient alveolar bone height, volume, and density and adequate or augmentable attached gingiva, especially keratinized gingiva were selected. Only Straumann® dental implants were used on all selected patients. For the flapless group, a circular incision was made down to alveolar crest with a trephine, the mucosal block was then removed, and crestal bone was curetted before placement of implant. The flap surgery was performed using a standard approach. The distance between the mesial and distal implant shoulder and the first visible bone-implant contact in each patient was assessed at time of surgery and recalled at four weeks for assessment of implant mobility. The primary success criteria were absence of the following: mobility, radiolucency, pain and infection.

A total of 218 patients requiring 377 implants were treated. Age, site of implants and size of implants were well distributed for comparison between the traditional flap approach group and flapless group. At visit #1 (2-3 months post surgery), implant success rate was 98.3% in the flap group and 98.5% in the flapless group. There were no significant differences between the two groups in terms of mobility, radiolucency, pain and infection. The only significant difference was mesial and distal bone contact at the implant shoulder, which was significantly greater in the flapless group compared to the traditional flap approach group during two-year postoperative follow up.

Based on pre- or intraoperative decision making, patients eligible for flapless surgery can benefit from a less traumatic procedure without affecting the high success rate of dental implant surgery. The flapless approach is a predictable procedure when patient selection and surgical technique are appropriate.

Nick Wang, DMD, MD, 3rd year OMFS Resident
VCU Medical Center

**Biomechanical Evaluation of Endosseous Implants at Early Implantation Times: A Study in Dogs.**
**Coelho, P.; Granato, R.; Marin, C.; Bonfante, E.; Freire, J.; Janal, M.; Gil, J.; Suzuki, M. Journal of Oral and Maxillofacial Surgery 68(7):1667-1675, 2010**

This study tested the null hypothesis that differences in surgical instrumentation, macrogeometry (surface design), and surface treatment imposed by different implant systems do not affect early biomechanical fixation in a canine mandible model. The study design included extracting lower premolars in six beagle dogs and allowing the ridge to heal for eight weeks. Thirty-six implants (12 in each group) were placed bilaterally, remaining for one and three weeks. The groups were Ti-6Al-4V with a dual acid-etched surface with nanometer scale discrete crystalline deposition (Nanotite®, Biomet-3i), Ti-6Al-4V with a titantium oxide-blasted fluoride-modified surface (Osseospeed® 4.0, Astra), and Ti-6Al-4V with a bioceramic microblasted surface (Ossean®, Intra-Lock International). Following euthanasia, the implants were torqued to interface

failure and histologically evaluated. The examination revealed that interfacial bone remodeling and initial woven bone formation were observed around all implant groups at one and three weeks. Torque values were significantly affected by time in vivo, implant group, and their interaction (P=0.016, P<0.001, and P=0.001, respectively). Group 3, group 2, and group 1 ranked highest, intermediate, and lowest, respectively. Early biomechanical fixation at one and three weeks was affected by surgical instrumentation, macrogeometry, and surface treatment. The null hypothesis was rejected.

Chris Durham, DDS, 4th Year OMFS Resident
VCU Medical Center

**Radiographic Findings in Bisphosphonate-Treated Patients With Stage 0 Disease in the Absence of Bone Exposure**
**Hutchinson, M.; O'Ryan, F.; Chavez, V.; Lathon, P.; Sanchez, G.; Hatcher, D.; Indresano, A.; Lo, J.**
**Journal of Oral and Maxillofacial Surgery 68(9):2232-2240, 2010**

Purpose: Radiographic features in patients with bisphosphonate-related osteonecrosis of the jaw (BRONJ) are well described, but less is known in bisphosphonate-exposed individuals with stage 0 disease considered at risk for BRONJ. In 2009 the American Association of Oral and Maxillofacial Surgeons set the following guidelines to identify a stage 0 disease: those with no evidence of necrotic bone but with: 1) nonspecific symptoms such as pain or odontalgia not explained by odontogenic causes or dull aching bone pain; 2) clinical findings including loosening of teeth not explained by chronic periodontal disease and/or periapical/periodontal fistula not associated with pulpal necrosis due to caries; or 3) radiographic findings including alveolar bone loss not attributable to chronic periodontal disease, trabecular bone alterations including dense woven bone, and persistent unremodeled bone in extraction sites, thickening of the lamina dura, and inferior alveolar canal narrowing. This study set out to characterize radiographic findings in a subgroup of patients with concerning clinical symptoms and bisphosphonate exposure to identify imaging features that may presage development of BRONJ.

Materials and Methods: A dental survey outlining several symptoms was returned by 8,572 Kaiser Permanente Health Plan members receiving chronic oral bisphosphonate therapy, and 1,005 patients reporting pertinent dental symptoms or complications after dental procedures were examined by the department of oral and maxillofacial surgery. Those without BRONJ but with concerning symptoms were referred for clinical evaluation, including imaging. Among the group who received maxillofacial imaging, there were 10 patients identified with stage 0 disease and abnormal radiographic features.
Results: There were a total of 30 patients without exposed bone but with concerning symptoms who received maxillofacial imaging which consisted of panoramic radiography, cone beam CT or medical grade CT. Among these 30 patients, 10 had stage 0 disease with similar radiographic features of regional or diffuse osteosclerosis in clinically symptomatic areas, most with extension beyond the involved site. Other findings in these 10 patients included density confluence of cortical and cancellous bone, prominence of the inferior alveolar nerve canal, markedly thickened and sclerotic lamina dura, uniform periradicular radiolucencies, cortical disruption, lack of bone fill after extraction, and a persisting alveolar socket. Seven of the ten patients had had a prior extraction in the area of pain anywhere from 7 to 37 months prior to the imaging was completed. None had exposed bone develop during one-year follow-up. The remaining 20 patients had normal or localized radiographic findings consistent with odontogenic pathology.

Conclusion: In 10 of 30 symptomatic patients referred for clinical evaluation and imaging, a consistent finding was conspicuous osteosclerosis in clinically symptomatic areas characteristic of stage 0 disease. These data support the need to better understand radiographic features associated with bisphosphonate exposure and to determine whether osteosclerosis is a specific finding indicative of the risk for progression to BRONJ. Due to a lack of a true control group there is no way to determine causality, but data may allow clinicians of symptomatic patients to identify a diagnosis for their disease and take measures to prevent progression of BRONJ.

Roseanna Noordhoek DDS, 4th year OMFS Resident
VCU Medical Center

**Clinical concepts of Dry Socket**
**Cardoso, C.L.; Rodrigues, M.T.; Junior, O.F.; Garlet, G. P.; de Carvalho, P. S.**
**Journal of Oral and Maxillofacial Surgery 68(8): 1922-1932, 2010**

Dry socket is the most common complication after tooth extraction. This article serves as a review of the definition, pathophysiology, etiology, preventive methods and treatment of dry socket. This article also gives current recommendations for prevention and treatment. All areas of discussion are supported with data from clinical research. This specific review was performed by the oral surgery department at the University of Sao Paulo Bauru School of Dentistry.

Alveolar osteitis, or dry socket, has been encountered for many years and several definitions have been suggested. There is great variability when defining alveolar osteitis. Currently, many investigators suggest the following definition for dry socket: postoperative pain surrounding the alveolus that increases in severity for some period from one and three days after extraction, followed by partial or total clot loss in the interior of the alveolus, with or without halitosis.

The exact etiology of dry socket has not yet been defined. However several local and systemic factors play a role and have been described in published studies. The principal factor in the etiology of dry socket has been described as increased local fibrinolytic activity in the extraction socket. This increased fibrinolytic activity is thought to be due to the presence of varying amounts of plasmin locally. Local plasmin contributes to lysis of the formed clot and also contributes to the formation of kinins. These kinins activate the afferent nerve termination and have been linked to the characteristic pain associated with dry socket. Excessive plasmin is thought to be caused by excessive local trauma and bacterial invasion. Trauma from the hand piece, aggressive curettage, bony fragments in the socket, poor oral hygiene and preexisting pericoronitis were listed as contributing factors. Interestingly, the experience of the surgeon plays a role in the incidence of dry socket. This is thought to be attributed to surgery time and amount of tissue damage. The bacteria associated with fibrinolytic activity in the socket were mostly anaerobic and antibiotic therapy aimed at prevention and treatment should be chosen accordingly. Patient factors that influence incidence of dry socket include age, oral contraceptive use, smoking, deep impactions, poor oral hygiene, pericoronitis, active disease of the tooth, ulcerative gingivitis, and immunocompromised status.

Preventive measures based on this evidence include several methods: the use of aseptic technique, copious irrigation of any surgical site, use of antifibrinolytic or antibacterial mouth rinses pre- and post-surgery, use of collagen or gelatin plug, and systemic antibiotics. However, the use of postoperative antibiotics does not seem to play a role in the prevention of dry socket.

Each clinician may use this reported evidence, clinical judgment, and experience to provide their patients with the best care possible. Prevention of dry socket can have significant emotional and economical impacts on dental practice.

Matthew Maxfield, DDS, 2nd Year OMFS Resident
VCU Medical Center

# PathologyPuzzler

## with Dr. John Svirsky

For this issue's Pathology Puzzler, I am going to show some cases that have an unusual radiographic presentation.

Case 1 (figures 1-6) is in a 59 year-old black male who presented for routine dental care and the lesions were found on radiographs. The patient had no symptoms and the medical history obtained from the patient was non-contributory.

What is your clinical impression of the pathologic process?

The next three radiographs (figures 7-9) (Cases 2-4) were sent in for consultation in three different patients as incidental findings.

What is your clinical impression?

Case 5 (figure 10) was submitted for consultation in a 15 year-old white female with a non-contributory medical history. The patient just returned from a vacation with her family in Jamaica.

What do you think?

*Continued from page 37*

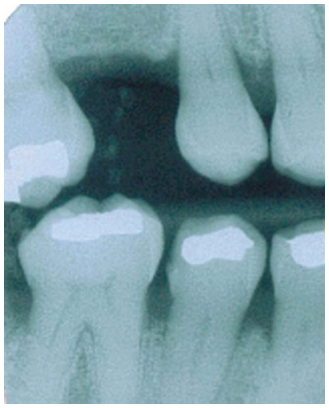
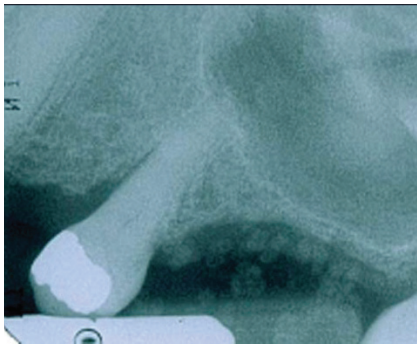


Figure 1



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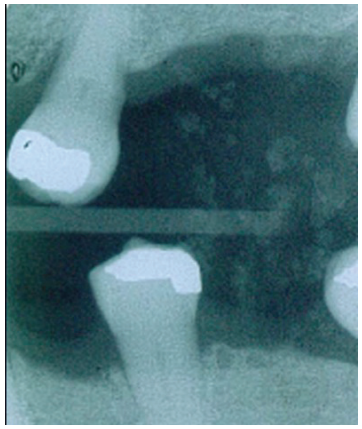


Figure 3

Figure 4

Figure 5

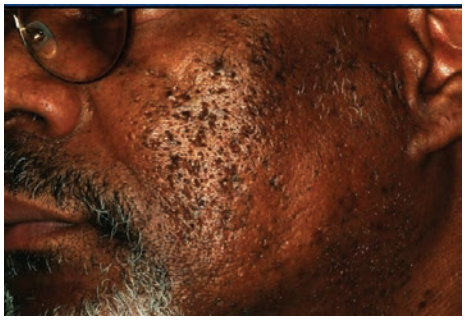


Figure 6

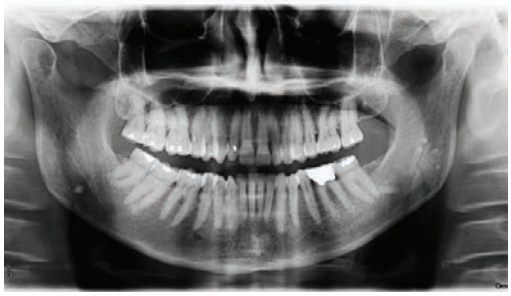
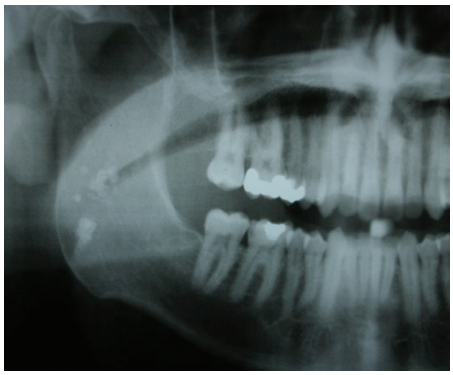


Figure 7



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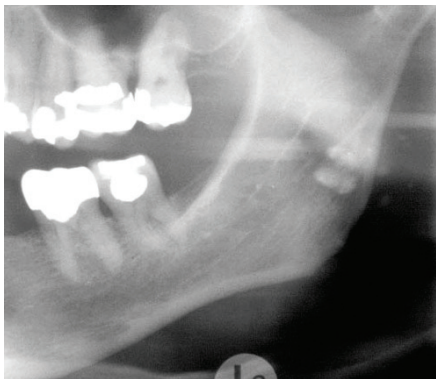

Figure 9

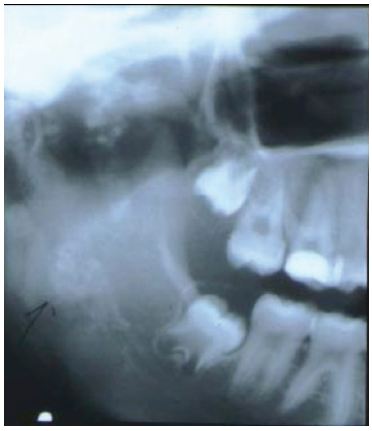

Figure 10

# Accuracy Rate of Clinical Diagnosis for Malignant Oral Lesions

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**ABSTRACT:** Secondary in importance only to prevention is the early detection of oral cancer. Early detection is dependent upon frequent thorough head and neck examinations and the diagnostic acumen of the examiner. This article documents a 74.6% accuracy rate when clinical examination suspected the presence of an oral malignancy as compared to the ultimate microscopic malignant diagnosis. Conversely, the accuracy rate of microscopically diagnosed oral cancers having a suspected malignant clinic impression submitted with the biopsy specimen was 67.5%. The most common misdiagnoses are tabulated and discussed.

**INTRODUCTION:** In 2009, cancer of the oral cavity and pharynx made up 2.4% of the total distribution of malignancies in the U.S.[1] An estimated 28,500 new cases of cancer of the oral cavity and oropharynx will occur each year with an estimated 6,100 deaths.[1] The mortality, morbidity and related treatment costs are abysmal. According to Alfano and Horowitz, "…oral cancer kills more Americans each year than either melanoma or cervical cancer."[2] Moreover, the morbidity following radiotherapy and/or surgery with radical neck dissection for late stage disease can significantly reduce the quality of life for those that do survive. Surviving patients may have to contend with "reduction of tongue mobility, caries and loss of dentition, xerostomia, muscle trismus, diminished taste and mastication, risk of osteoradionecrosis, and anesthesia of the oral cavity".[3]

Prevention and early detection of oral cancer should be of paramount importance to health care professionals. Dentists reportedly perform double the number of oral cancer examinations as do physicians even though they see approximately the same number of patients per week.[4] This degree of patient exposure places dentists in an ideal position for prevention and early detection. There are commonly known risk factors that include exposure to tobacco products, alcohol and sunlight. These common, and often self-inflicted, risk factors account for approximately 80% of all oral, oropharyngeal, and laryngeal cancers.[5] Exposure of the oral cavity's epithelium to these carcinogens may account for the observation that squamous cell carcinoma is the most frequent histologic type of oral cancer, representing approximately 95% of the total oral malignancies.[6]

Despite advances in a variety of cancer therapies, the five-year survival rate for oral cancer has not significantly improved over the past 40 years.[7] A significant reason for this disappointing fact is that oral cancer continues to be diagnosed at a late stage. Even though the vast majority of oral cancers are readily visible to the patient or health care professional, only 35% are initially detected in the small, localized Stage I, while the remaining are larger with local or even distant metastases.[8] Initial detection at the local, regional or distant spread stages affects the 5-year survival rate of 82%, 53%, and 28% respectively.[1] The stage at diagnosis also affects racial statistics: 38% of whites are diagnosed at Stages I and II (localized) compared to only 18% of blacks.[6] These figures translate into differences in the five-year survival rate: 58% for whites and 34% for blacks.[6] At the heart of these statistics as well as the failure in improvement of the five-year survival rate over the last several decades is a lack of public and professional education with respect to prevention and/or early detection of oral cancer. Research estimates the overall average five-year survival rate of 52% could be increased to 81% with earlier detection.[9] Early detection is essential to provide for better survival rates and improved quality of life.

Educating the public with respect to prevention and early detection needs to include the avoidance of known carcinogens (tobacco products, alcohol, and sunlight) as well as the necessity to seek out and obtain a thorough head and neck examination on a routine basis, at least annually. The latter necessitates that the patient voluntarily makes an appointment with a health care professional (physician, dentist, dental hygienist). Unfortunately, neither of these activities is adequately carried out in America today. Although the American Cancer Society recommends annual oral cancer examination for adults over 40 years of age or with high risk habits (smoking, dipping, alcohol consumption, excessive UV light exposure), the data shows only 15% of the adult population reported EVER having undergone an oral cancer examination,[10] while only 7% had the examination in the most recent twelve months.[11] Therefore, there is not only a need to increase public awareness but also a need for better professional education.

An article in the *Journal of the American Dental Association* documented that Maryland dentists felt there were four major themes explaining a lack of success in prevention and/or early detection of oral cancer. These were "inaccurate professional knowledge about oral cancer, inconsistency in oral cancer examination procedures, lack of confidence in when and how to palpate for abnormalities, and lack of time to routinely provide oral cancer examinations".[10] Thus, a combination of public and professional education, coupled with increased awareness, may hold a positive promise for the future with respect to the death, disability, debilitation, and disfigurement caused by oral cancer. Future success will depend on four factors:

1. Increasing the number of patients visiting health care offices for oral examinations.
2. Increasing the number of health care providers performing systematic and thorough oral examinations.
3. Increasing the diagnostic skills of health care providers in recognizing premalignant and malignant lesions of the oral cavity.
4. Increasing the use of diagnostic techniques (cytology, biopsy) for early detection.

It is the purpose of this study to determine the current diagnostic acumen of dentists with respect to recognizing squamous cell carcinoma of the oral cavity by comparing the clinical impressions submitted with biopsy specimens sent to the oral pathologist with the actual histologic diagnosis that was made after microscopic examination.

**MATERIALS AND METHODS:** The records of the biopsy accessions at the Department of Oral Pathology, School of Dentistry, Virginia Commonwealth University from 1952 -2000 were reviewed. There were 90,954 specimens submitted for histologic evaluation.

For each of these specimens the diagnosis made by the clinician and the histologic diagnosis were documented, tabulated and compared. In each instance, the final diagnosis was made after microscopic evaluation by a board-certified oral pathologist (Drs. L. Abbey, J. Burns, R. Elzay, G. Kaugars, D. Page, J. Svirsky, and J. Salley).

Three questions were addressed:

1.) What percentage of the time when presented with an oral cancer did the clinician correctly recognize the lesion as malignant? (Table 1)
2.) What percentage of the time when a clinician believed a lesion was malignant did it turn out to have a malignant histologic diagnosis? (Table 2)
3.) What were the most common misdiagnoses?

**RESULTS:** Of the total 90,954 submitted specimens, comparisons were made between the clinical impression of the submitting dentist and the ultimate histologic diagnosis made by the oral pathologist. There were 2,155 specimens submitted with a malignant clinical impression (Table 2) of which 67.52% were clinically diagnosed correctly. Of the 90,954 submissions 1,455 were histologically diagnosed as an epithelial malignancy (Table 1). Of these, only 1,086 were submitted with a malignant clinical impression by the contributor and correctly diagnosed (74.6% correct). Of the remaining 25.4%, the top four most common clinical misdiagnoses were hyperkeraosis/leukoplakia, chronic ulcer, pyogenic granuloma, and erosive lichen planus.

**DISCUSSION:** The most common clinical "look-a-likes" that were misdiagnosed as a malignancy are listed in Table 1. Leukoplakia, defined as an intraoral white plaque that can not be rubbed off, is at the top of the list. Clinically, Leukoplakia is very common, with an incidence as high as 3% among adults.[12] Histologically, Leukoplakia can run the gamut from hyperkeratosis to dysplasia to carcinoma. However, about 80% of the clinical Leukoplakias represent hyperkeratosis, hyperparakeratosis, or hyperorthokeratosis. Leukoplakia has an estimated lifetime risk of malignant transformation of approximately 4%.[12] In this study, Leukoplakia/hyperkeratosis represented the most common misdiagnosis for oral squamous cell carcinoma, representing 4.19% and 6.91%, respectively (Tables 1 and 2). Fibrous hyperplasia (4.08%), chronic glossitis (1.67%), pyogenic granuloma (1.65%) and erosive lichen planus (1.17%) make up the four most common misdiagnoses after Leukoplakia/hyperkeratosis (4.19% and 6.91%) and ulcer (3.92% and 5.85%).

Although in this study the submitting dentists diagnosed over two-thirds of the lesions that they suspected of being a malignancy correctly, the remainder were submitted with an inaccurate clinical impression. Cognizant of the limitations of clinical visualization and palpation and, since these cases were biopsied and submitted for histologic diagnosis, this is not a serious error on their part. However, it emphasizes two points. First, one should not rely solely on a clinical impression because the lesion may be more serious than expected and second, any tissue removed should not be discarded, but rather it should be sent for microscopic examination.

There are very few instances that the clinical findings with a lesion in the oral cavity are so pathognomonic that other entities should not be considered in the differential diagnosis. This is particularly true in the early, formative phase of any lesion's natural development. However, with respect to oral cancer, it is exactly this early, formative phase in which clinicians need a heightened degree of suspicion and must exercise accurate diagnostic acumen in order to maximally benefit their patients.

**SUMMARY:** Dentists are fairly accurate in identifying oral cancer utilizing their clinical skills of visualization and palpation. However, additional public and professional education could help to significantly reduce the morbidity and mortality associated with this dreaded disease. Factors putting patients at risk of developing oral cancer should be addressed on fronts extending from mass advertising and prevention campaigns to smoking/drinking cessation projects. If an oral cancer cannot be prevented, then the next best thing is to detect the tumor while it is small, prior to metastasis, and treatable. Early and accurate identification of oral cancer has a dramatic positive impact on mortality and morbidity.

While the clinician's accuracy in diagnosing malignant lesions of the oral cavity was shown to be good (74.6% correct), it is meaningless if an adequate head and neck examination is not performed at appropriate intervals. The importance of a professionally performed head and neck examination or a thorough self-examination cannot be overstated. By increasing the quantity and quality of these examinations, oral cancer statistics can be improved.

Table 1: **Comparison of 1,455 Malignant "Histological Diagnoses" To Their Original "Clinical Impression"**

| **"Clinical Impression" rendered by clinician:** | **Total Number** | **Percent** |
|---|---|---|
| Malignancy (includes Cancer, Carcinoma, Verrucous Carcinoma, Squamous Cell Carcinoma, Carcinoma-in-situ) | 1,086 | 74.64 (correct) |
| Hyperkeratosis / Leukoplakia | 61 | 4.19 |
| Ulcer | 57 | 3.92 |
| Pyogenic Granuloma | 24 | 1.65 |
| Erosive Lichen Planus | 17 | 1.17 |
| Granulation Tissue | 15 | 1.03 |
| Solar Keratosis | 12 | .82 |
| Papilloma | 12 | .82 |
| Fibroma | 11 | .76 |
| Basal Cell Carcinoma | 10 | .69 |
| Keratoacanthosis | 10 | .69 |
| Epithelial Hyperplasia | 9 | .62 |
| Miscellaneous (individual responses had total number less than seven) | 131 | 9.00 |
| **TOTAL** | **1,455** | **100** |

Table 2: **Comparison of 2,155 Malignant "Clinical Impressions" to Their Ultimate "Histologic Diagnoses"**

| "Histologic Diagnosis" Rendered by Pathologist | Total Number | Percent |
|---|---|---|
| Malignancy (Verrucous Carcinoma, Squamous Cell Carcinoma, Carcinoma-in-situ) | 1,455 | 67.52 (correct) |
| Hyperkeratoses | 149 | 6.91 |
| Non-specific Ulcer | 126 | 5.85 |
| Fibrous Hyperplasia | 88 | 4.08 |
| Chronic Glossitis | 36 | 1.67 |
| Solar Keratosis | 28 | 1.30 |
| Miscellaneous (individual responses had total number less than seven) | 273 | 12.67 |
| **TOTAL** | **2,155** | **100** |


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*Dr. France Nielson is a 2010 graduate of Virginia Commonwealth University School of Dentistry


# PathologyPuzzler

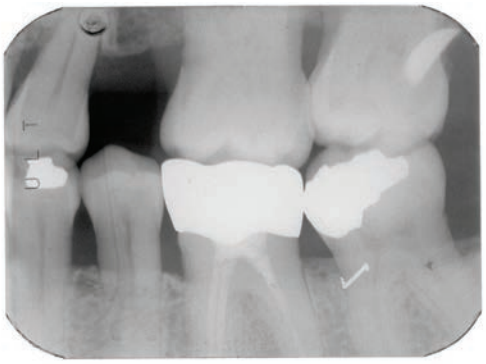
## with Dr. John Svirsky


*Continued from page 33*


Case 1 involves multiple scattered calcifications of low density that showed up on bite wing and periapical radiographs (figure 1-4). The clinical finding of facial scarring acne in an adult confirms the diagnosis of multiple miliary osteomas. These lesions, in addition to being associated with deep acne scars, are also seen in neurotic/factitial excoriation and following dermabrasion.

Case 2-4 were presentations with the same density found in a more posterior location than Case 1. The findings in these cases are compatible with tonsilloliths and are usually found in enlarged tonsils with large crypts that entrap debris that eventually calcify.

Case 5 is a presentation in a young girl who retuned from Jamaica (this was a clue) and had her hair braided. The "lesions" appearing to be calcifications are the bits of foil placed in the beads to keep them in place.



### A final radiograph of interest:

Incidental finding on radiograph of 67 y. o. w. m. Patient states "a piece of a hammer head flew into my cheek" about ten years prior. He also states "they decided to leave it alone." Note crescent-shaped object on distal aspect of #15

# VDA Services Announces the Endorsement of HandCraft Linen Services

VDA Services is pleased to announce the most recent addition to the endorsed vendors program: HandCraft Linen Services. Upon a thorough review by the VDSC Board of Directors, HandCraft was chosen to be the only uniform and linen service company to be recommended by VDA Services.

Headquartered in Richmond, HandCraft Linen Services takes great pride in being health care's largest uniform and linen supplier in the Mid-Atlantic Region. With processing facilities in Richmond, Salem and Salisbury, MD, and over 25 years of experience in the healthcare linen field, HandCraft is well positioned to provide great service to all members of the Virginia Dental Association.

HandCraft Linen Services provides dental offices, physician offices, ambulatory surgery centers, hospitals and long-term care facilities with quality linen and medical uniforms at very competitive prices. In addition to already great pricing, VDA Members will also receive an additional 10% off as an added member benefit.

The reusable linen programs and personalized uniform services remove the hassle from managing inventory, controlling variable costs and regulating compliance. With the rising concerns of blood borne pathogens and infectious diseases, HandCraft follows OSHA compliance regulations taking the liability away from you and your staff members. Whether you are currently using a linen service, buying your own uniforms and linens or doing it yourself; the biggest benefit is the savings of both time and money that you will receive when you switch to HandCraft. Each account is handled with quality care to ensure all individual needs are met, supported by our unique billing structure, consultative set-up process and attentive customer service. HandCraft treats every customer like they are the only customer.

To find out more about the new program with HandCraft Linen Service please call 804-358-8671 (Account Representatives – Jessica Kraegel and Brian Raugh) or visit www.handcraftservices.com. For more information on all of the VDA Services vendors please visit www.vadental.org or contact Elise at the VDA (804-288-5750).

VDA Services – Peer Reviewed, Members Only Benefits, Supporting the VDA

# Keeping It Simple-
# Petersburg firm finds savings, satisfaction with Dental Direct

By: Richard F. Roadcap, D.D.S., Editor

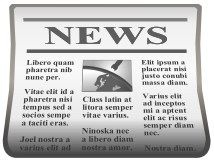
Operations Manager Aaron Gay is busy. With 550 employees nationwide and multiple projects underway at all times, he doesn't have time in his job at Quality Plus Services to compare premium rates, decipher insurance jargon, and listen to employees complain they "can't find a dentist who takes our insurance". Petersburg-based QPS provides start-to-finish engineering and construction services for industrial Fortune 500 companies throughout the US. Since 1997 it has provided dental benefits for its employees with Dental Direct Reimbursement, previously known as DR, with no increase in premiums.

The ease of administration – "It's simple math on one sheet", says Mr. Gay – makes it an asset for employers. Dental Direct also is a boon for companies with employees in far-flung locations. He said dentist participation has never been a problem, making access to dental care much easier wherever employees find themselves. QPS employees receive 100% reimbursement of the first $100 of dental care, and have an annual maximum of $500 in benefits. Dependents also have a $500 maximum, so a family of four could receive up to $2000 in benefits per year, with no fee schedules, exclusions, or predeterminations. Patients pay at the time of service, and are reimbursed by the employer according to plan requirements. Employees can also establish a "flex" (FSA) account, and use the accompanying Visa® card to pay for dental care with pre-tax dollars. Another bonus for the employer, according to Mr. Gay, is the unused funds that remain with the company, instead of being spent on insurance premiums.

Mr. Gay admitted insurance agents have tried to steer him away from Dental Direct. When they hear the savings that accrue "they back off", he says, knowing they can't compete. He said owners and human resources departments are often too busy to compare the cost with traditional third-party insurance. "I can't believe there aren't more people involved", he said, when asked about the savings to employers. He credits Cork Coyner of Benefits Administration, Inc., with alerting him to Dental Direct's simplicity and low cost. QPS has been the recipient of many state and national awards for workplace safety. Maybe not having to parse competing insurance bids every year allows the company to focus on matters of greater concern.

**Need more information? Go to the Dential Direct website at www.vadentaldirect.com or contact Elise Rupinski at the VDA Central Office - 804-288-5750 - rupinski@vadental.org**

DENTAL DIRECT




# EPA Will Propose Rule to Protect Waterways by Reducing Mercury from Dental Offices / Existing technology is available to capture dental mercury

Release date: 09/27/2010

Contact Information: Jalil Isa, isa.jalil@epa.gov, 202-564-3226, 202-564-4355

WASHINGTON – The U.S. Environmental Protection Agency (EPA) today announced it intends to propose a rule to reduce mercury waste from dental offices. Dental amalgams, or fillings containing mercury, account for 3.7 tons of mercury discharged from dental offices each year. The mercury waste results when old mercury fillings are replaced with new ones. The mercury in dental fillings is flushed into chair-side drains and enters the wastewater systems, making its way into the environment through discharges to rivers and lakes, incineration or land application of sewage sludge. Mercury released through amalgam discharges can be easily managed and prevented.

EPA expects to propose a rule next year and finalize it in 2012. Dental offices will be able to use existing technology to meet the proposed requirements. Amalgam separators can separate out 95 percent of the mercury normally discharged to the local waste treatment plant. The separator captures the mercury, which is then recycled and reused.

Until the rule is final, EPA encourages dental offices to voluntarily install amalgam separators. Twelve states and several municipalities already require the installation of amalgam separators in dental offices.

Approximately 50 percent of mercury entering local waste treatment plants comes from dental amalgam waste. Once deposited, certain microorganisms can change elemental mercury into methylmercury, a highly toxic form that builds up in fish, shellfish and animals that eat fish.

Fish and shellfish are the main sources of methylmercury exposure to humans. Methylmercury can damage children's developing brains and nervous systems even before they are born.

More information on mercury from dental offices: water.epa.gov/scitech/wastetech/guide/dental/index.cfm

More information on mercury and the environment: www.epa.gov/mercury/index.html

# Stocks vs. Bonds: Opportunity vs. Safety

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

"Stocks are risky, and bonds are safe." "Stocks present great opportunity for gain, and bonds just piddle along." We often hear such comments in our discussions with clients about investments. But the truth is both stocks and bonds have risks. Both stocks and bonds provide opportunity for gain. The real question is: Which type of investment is appropriate for you and why?

First, understand what a share of stock represents. When you purchase a share of stock, you become an owner in the company. While your one share of stock may not represent significant money or ownership, you have acquired all of the rights that go with that share of stock, including casting your vote on certain corporate issues and being a beneficiary of the company's growth - - or decline - - in value.

Companies vary in size from "small-cap" to "mid-cap" to "large-cap", depending upon the capitalization of the company. Typically, large-cap companies have more stable stock prices than small caps, so there may be less risk. However, small caps may have higher growth potential - - and risk. Stocks can vary also by style: growth or value. A growth stock generally represents a company that is expanding at an above-average rate. Gain could be significant; however, so can risk, especially if growth slows. A value stock tends to be slower and steadier, because investors may think that the worth of the business is not yet reflected in the value of the stock. (CNN Money.com, 7-9-10). But what if the investor is wrong, and the value of the business slides, rather than grows? The most basic risk with any stock investment is the variability of the stock market. The markets can, will, and have gone up. They also can, will, and have gone down.

Although there are other various categories of stocks and types of risks with stocks, the point is that stocks have risk. There's always a risk-reward continuum that must be considered in investing. The question then becomes: How much risk are you willing to take for the potential gain that you believe can occur in a company. That's a question that only you can answer from your knowledge of yourself, your past experiences with investing, your understanding of market activities, your research, your tolerance for risk, your time horizon for needing your money, and the quality of advice and communications you have with your financial advisor.

O.K., so are bonds good investments? First, be reminded that a bond represents a loan to a company. Generally, the payback is the original investment plus interest. So the answer depends upon what one means by "good investments". While many folks think that bonds are not risky or are less risky than stocks, the facts show otherwise. Bonds just have different types of risks. For example, an investor should consider the following with bonds:

•Reinvestment Risk - The risk that the proceeds from a bond will be reinvested at a lower rate than that of the original bond.

•Call Risk - The risk that the bond will be called by its issuer. If a bond has a call provision, when interest rates fall often the issuer can retire the debt and issue a lower interest-rate bond.

•Default Risk - The risk that the bond's issuer will be unable to pay the contractual interest or principal in a timely manner - - or at all!

•Inflation Risk - The risk that the rate of return on the bond does not keep up with the pricing structures of the general economy; i.e., your money loses buying power.

Whenever one invests in the stock markets, there is a risk-reward continuum to consider. The previous discussion is very simplified and does not contain everything one should know about investing. However, the most simplified truths are: stocks and bonds both have risks, and they both also can have rewards. The ultimate decision about which type of investment - - stocks, bonds, others investments, or combinations- - is appropriate for you should depend upon your risk tolerance, your time horizon, and your investor profile. Do you know yours?

# Management of Amalgam Waste from a Dental Practice

By: Al Dube', SolmeteX® Dental

Dental offices have a variety of dental wastes which need proper disposal for environmental and liability reasons. The American Dental Association offered the first version of Best Management Practices (BMPs) in 2003 which provided guidelines and suggestions on how to manage amalgam wastes. The BMP document has been amended in recent years to include the installation and use of amalgam separators, solids collection devices on the vacuum line of dental offices. This article is focused on the management of amalgam, reasons for concern, and some clarification related to amalgam separators.

Amalgam is predominantly composed of mercury, 50% in most cases, with the other components varying in amounts based on individual formulas for silver, copper, tin etc. Amalgam is stable in its solid form; however, because of the mercury in its composition, as a waste it is regulated as a hazardous material. With regulation, responsibility and liability issues for waste generators arrive. The responsibility is to properly manage the amalgam waste on premises and properly recycle or dispose of the amalgam waste from your practice. Your liability is derived from being the generator of the waste. The generator is legally and financially liable for the proper disposal of the waste. This is commonly referred to as "Cradle to Grave" specifically the generator's grave not the material's grave.

How real is the liability? Last year dentists in the New England area used a local waste hauling company to manage the waste generated from their practices. The amalgam from dental offices, along with other regulated wastes, was collected and stored at this facility. The facility proceeded to dump excess liquids from some of the collected amalgam waste down the drain which triggered an investigation by state and local authorities as a large spike in mercury concentrations was noticed at the local sewage treatment plant. Through the investigative process, the source of the mercury spike was traced to the local waste handling company. Regulators descended on the facility finding extensive mismanagement of the stored and transported waste. The facility was immediately closed and the owner arrested on environmental negligence charges. The owner was indicted on fifteen counts, and a major cleanup of the waste facility is being undertaken. The owner of the waste facility is unable to finance the cleanup of the site. The cost of the cleanup will be collected in the form of fines to his customers, mostly dental offices. In a similar case (in Connecticut) fines to several dentists were nearly $10,000 each. The generator of the waste, the dentist, is liable for the waste and cannot transfer the liability to another party. The "chain of custody" is a paper trail which leads back to the generator. The waste generator (i.e., the dentist) is released from liability when the amalgam is recycled.

What are the amalgam wastes within the dental office? Contact and non-contact amalgam are commonly used terms and in the past were required to be collected separately. This is no longer the case. Sources of amalgam waste such as scraps of amalgam from restorative procedures, scraps collected in the chair-side traps of the dental chair and vacuum pump filters should be collected and sent for recycling. Expended capsules from restorative procedures have residual mercury within them and should be collected to adhere to the ADA's BMP program. With the ADA amending BMPs in 2007 to include the recommendation of installing an amalgam separator to vacuum lines, the collection containers are added to the list of amalgam wastes. All amalgam wastes are required to be properly processed. Recycle certificates are issued providing documentation which releases dentists from liability.

In recent years regulations requiring amalgam separators for dental offices have surfaced with ten states and numerous municipalities around the county now mandating them. The Environmental Protection Agency (EPA) is currently investigating the option of a national regulation requiring the use of BMPs to include installation of amalgam separators. An announcement regarding EPA's intentions is expected this fall.

Amalgam separators are mistakenly referred to as mercury collection devices. In reality amalgam separators are solids collection devices which capture mercury by default. Each amalgam separator on the market is required to be certified under the International Standards Organization (ISO) 11143 certification. The certification validates the performance of the amalgam separators capturing greater than 95% of the solid particles introduced into the system by weight. The ISO standard does not measure mercury capture efficiency. Amalgam separators capture not only amalgam but all the other solid materials which pass through the vacuum system. The amalgam separator collection container along with other amalgam waste is considered hazardous waste requiring proper disposal.

Dental offices are considered Conditionally Exempt Small Quantity Generators (CESQG). This designation exempts dentists from some regulatory requirements; however, proper disposal is required. Certificates of recycling or disposal are required to be maintained by dental facilities as validation of proper waste management. All scraps from restorative procedures, chair-side traps, and vacuum pump filters should be collected and placed in scrap buckets. Amalgam separator collection containers, along with the scrap buckets, fall under the CESQG status for dental offices and provide the opportunity for common carriers (UPS, FedEx) to ship the waste amalgam from dental offices directly to recycling facilities. Shipping services are available through your local dental dealer.

Managing your amalgam waste is important for environmental reasons and good business practices. Properly managing amalgam waste minimizes liability for dental practitioners. Installation of amalgam separators (currently not required in Virginia) could be required nationally in the near future.

# Extraoral

*By: Dr. Elizabeth M. Wilson*

## Open: An Autobiography

By: Andre Agassi

ISBN-13: 9780307268198, $28.95
Publisher: Knopf Doubleday Publishing, 2009

To finish off the summer, I offer a bit of light fare for your consideration: *Open: An Autobiography*, by tennis legend Andre Agassi. Now, as I write this article, the US Open is around the corner, so why not escape into the world of tennis?

When I was a youngster, my Mom barely ever watched TV. If she was watching, tennis was most likely on. And if she was standing and watching, tennis was definitely on. Probably a Bjorn Borg match – her favorite player. Sometimes she would clap very loudly with a "very good" attached; sometimes she would squeal at an error; also she screamed. Probably a Johnny Mac match – her all time least favorite player. She loves tennis and still plays. At any rate, I learned to appreciate tennis from sitting beside my Mom. Today, it is me in front of the TV, still watching and screaming.

When, in 2006, Agassi announced his retirement to the world and played his final US Open match, I knew an era was ending. My heroes while was growing up were now, basically, done: Courier, Sampras, and Agassi. Done, done, and done. Reading Agassi's book consequently was like a welcome walk down memory lane.

The crazy hair, the "Image Is Everything" ads, Barbra Streisand, then Brooke, were all familiar to me. What wasn't familiar was Agassi's brutally honest reflection on his life. (Also, some pretty startling revelations about hair pieces and crystal meth.) This champion in the world of tennis dedicated his book to his young children, and says in it he is really writing to them. This claim rings true. When he learns a life lesion he tries to tell it straight. He does not embrace the media's traditional Agassi narrative of "the rebel turns into hardworking tennis ambassador", which would have been easy for him. Instead, he methodically tells the story of his life as remembers, flaws and all, with great humor as well.

It is an entertaining read, especially for a tennis fan. But, it is more – the old fashioned "coming of age" story we've seen so many times, yet through the insecure eyes of tennis prodigy. He finds success and failure, on and off the court (I guess Huge success and Huge failure would be appropriate), and comes to terms that one cannot exist with the other. As my Dad says, don't aim for perfection – rarely do we achieve that. Aim instead for excellence.

Agassi's journey contains a valuable lesson for us as dentists. It is frustrating to strive for perfection, so consistently try for excellence (it makes much more sense). Give *Open* a read and see if you agree.

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

As highlighted in Q3 2010 edition of the VDA Members with Anthem health insurance are eligible for Value Added Benefits through the Association Program. Below, please find more detailed information on one of these great added benefits – travel assistance services.

For more information on health coverage through Anthem or the Value Added Benefits Program, please contact B&B Insurance Associates at 877-832-9113. B&B Insurance is a full service, independent, licensed insurance agency that has been recommended by the Virginia Dental Services Corporation since 2000.

# Travel assistance

**Extending coverage no matter where life takes you**

Anthem Life

## Providing comfort when you're far from home

- You are automatically enrolled in Travel Assistance when you elect term life and AD&D insurance from Anthem Life.
- Travel assistance benefits are available to you and your family 24 hours a day, seven days a week.

## Security wherever you go

**Anthem Life Insurance Company knows the importance of feeling safe and secure when you are away from home.**

What would happen if you got sick in another city or country? Who would you call if you couldn't speak the language? Anthem Life has teamed up with Europ Assistance USA to provide important travel assistance services when you or your family are 100 miles or more from home, including personal and business travel.

### A helping hand in medical emergencies

You can feel secure knowing that Travel Assistance benefits are available 24 hours a day. If you have an emergency medical situation while traveling, simply call the toll-free number to:

- Coordinate and pay for medical evacuation to the nearest appropriate treatment facility or back home, when medically necessary, up to $100,000
- Send your dependent children home if they are left unattended due to your emergency, up to $5,000
- Send your traveling companion home, up to $5,000
- Arrange a bedside visit for a family member or friend if you are hospitalized for more than seven days, or if you are in critical condition, up to $5,000
- Arrange and pay for repatriation services, up to $10,000

### Your travel companion

In addition to helping out during medical emergencies, your coverage also provides the following personal services:

- Receive and transmit emergency messages
- Emergency cash advances, up to $500*
- Emergency medical payments, up to $10,000*
- Legal assistance/bail, up to $5,000*

* You must reimburse Europ Assistance USA for these expenses.

### Easy access to travel information

Europ Assistance USA can provide valuable information before you travel, including immunization and passport requirements, foreign exchange rates, travel advisories and weather conditions.

You can obtain information by calling Europ Assistance USA:
From the U.S. and Canada: 866-295-4890
From other countries (call collect): 202-296-7482.

You can also obtain information online at europassistance-usa.com. For a complete description of covered services, as well as detailed contact information for inquiries, go to europassistance-usa.com and click on the GO button. Log in with the following information:

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*Valid only for eligible members*

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|---|---|
| **US and Canada:** | 866-295-4890 |
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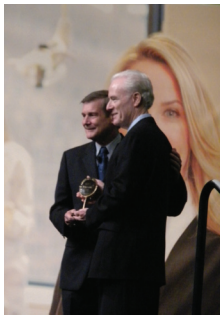
or or send an e-mail to ops@europassistance-usa.com.

# Awards & Recognition



## VDA Executive Director receives 2010 ADA Humanitarian Award

October 9, 2010 - Orlando, FL: Dr. Terry Dickinson was honored at the 2010 ADA Opening General Session. He was present the ADA Humanitarian Award by Dr. Ron Tankersley (ADA President and VDA Member) for his work on the M.O.M. Projects.

## The VDA is awarded the prestigious 2010 ADA Golden Apple Award!

Our entries, "Virginia Dental Association Foundation" in the category of Excellence in Access to Dental Care Programs, and "VDA Non-Covered Services Legislation" in the category of Legislative Achievement in the ADA's Annual Program were two of a small number to be selected for this prestigious dental society award. Congratulations to the VDA staff and members who work hard everyday to make a positive impact on professional dentistry and our community!

The ADA has announce the official results in a Convention Daily issue of the ADA News (published at the Annual Session).

## Awards Presented at the 2010 VDA Governance Meeting:

| | |
|---|---|
| Emanuel W. Michaels Distinguished Dentist Award: | Dr. Anne C. Adams |
| Community Service Award: | Dr. Harold J. Neal, Jr. and Jamie Neal |
| Special Service Award: | Jerry Prentice |
| Leadership (going off the Board of Directors): | Drs. Ralph L. Howell, Jr. and James E. Krochmal |
| Presidential Citations: | Dr. Bruce R. Hutchison, Dr. Audrey Gamulo and Cathy Griffanti |
| Honorary Membership: | Karen Kraus |


*Karen Kraus, Dr. Alonzo Bell*

# Linda Miles Speaks at Mentorship Meeting

By: Dr. Dennis Cleckner

The initial Mentorship Meeting on August 21, sponsored by the VDA with the support of VCU, was very well attended by all levels of dental students… yes, there was one D-1 there! Several years ago, when Dr. Gus Vlahos was VDA President, he took steps to coordinate a mentor-mentee program between the VDA and the VCU School of Dentistry. Now that his daughter is a D-2, it is more important to him than ever. VDA leaders, like Dr. Bruce Hutchison, have lent their shoulders to make it happen.

Dr. Kirk Norbo, as Committee Chairman, secured Linda Miles as a speaker at the school. She spent that Saturday talking to students about different models of practice to consider upon graduation. I'd like to thank Melissa Reitano, the pre-dental student who worked in my office this summer, for

arranging for her dad to ask Linda to provide the lecture at no cost to any of the participants.

Of course, not much happens in organized dentistry in Virginia without VDA Executive Director Dr. Terry Dickinson pitching in. And not much happens at the dental school without the support of Dr. Fred Certosimo and Dr. David Sarrett. We had a pretty full lecture room and from my seat on the side, I did not see one student dozing off. Dr. Certosimo's alma mater has a successful mentoring program, and he hopes to make this one as successful.

Dr. E. James Reitano, a very successful Virginia Beach dentist, introduced Ms. Miles and shared how much her mentorship had meant to his practice and success. He is obviously doing something right, as all three of his children would like to go to dental school. Linda shared facts and numbers normally offered to dentists only, and answered questions any of the students raised. She not only provided free copies of her most recent book, but also took time to autograph them for all the students.

After the lecture, there was ample time to retreat to the Crockett Lounge, and spend time meeting the doctors present and find mentors with common interests. At this point the specifics are not well-defined, and the VCU Curriculum Committee has not approved the program. There is not an established mentor-mentee ratio, the mentors do not have to be approved as Adjunct Faculty, any time away from the clinic still requires the use of personal leave, and going to the mentor's office is not a sanctioned activity of a VCU student…(such activity is not insured).

University Connections

## Balancing Act

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

One Thursday afternoon, during clinic, I was anxiously trying to finish a composite restoration. Realizing that it was 5:10 p.m., I still had to write up my SOAP note, take my patient to see the Patient Account Coordinator, rush back to clean up and somehow leave by 5:20 p.m. to pick up my daughter from daycare. Thankfully, two second year students were nearby, understood my dilemma, and were gracious enough to help (I promised to make cookies in return for their kindness). After getting home and making dinner for my daughter and myself, I snuggled up on the couch to watch "Nick, Jr.®", and attempted to catch up on three chapters of reading that I had to comprehend for my exam the next morning. Soon, my two-year-old demanded that I "stop reading". I simply told her that "I wish I could" and that "Mommy has to study for a test tomorrow." That day and many other moments are constant reminders that I am both a dental student and a Mommy, a continuous balancing act.

I equate being a mother and dental student to having three full-time jobs: as a parent, as a student, and as a clinician/lab tech. Thankfully, two of my jobs overlap a bit! There are days when I may not get as much sleep as I would like, or feel unprepared for an exam. There are also days when I must do lab work or treatment planning, and miss out on time with my daughter. Sometimes, I choose to put off reading or studying in order to put together a puzzle or play a game. I must make a choice, and I often feel that I am not perfect at either being a dental student or emulating Martha Stewart.

The rigors of dental school have changed over the decades, but the many hours in class, in lab, and late-night studying for exams have not. We put ourselves through this difficult season, knowing that when we graduate life will be better. We will have more time, have a "regular" schedule that allows us to enjoy our career, and spend time with our family as well. The road to become a professional requires sacrifice, but the greatest sacrifice we make to be a dentist and a professional is our time. A large portion of our twenties (or thirties) is consumed with our path to a degree. This is also the time when most are starting or adding to their family.

In past decades, women were going to college and pursuing careers, which meant family planning was often delayed. In today's age of instant gratification, many women want families and careers, simultaneously. Dentistry is an appealing field because it offers the best of both worlds. Dentists can choose to see patients from 8:00 to 5:00, often working four days a week. That leaves plenty of time to make dinner, do homework, attend games, and spend quality time with your children and spouse. Family life and career must be balanced after graduation, but it is during the educational process that it is most challenging. Despite the difficulty of being a student and a mother, currently six women at VCU School of Dentistry succeed at both.

I find encouragement and inspiration from the other five amazing women who balance family and school so gracefully. I recognize that parenthood is an added obstacle to the demands of dental school, but I would not trade the joy that my child and husband bring for an easier education. Ultimately it is my love for both the profession which I will soon enter, and my family, that gives me strength and drive to succeed in all my school endeavors.

# Virginia Dental Association
## *Governance Meeting*
## September 24-26, 2010
## Roanoke, VA

*Inducted into the VDA Fellows for 2010: (L-R) Drs. Timothy Golian,J. Patrick Baker, Randy Norbo, Frank Farrington, Paul Patterson, Wm. Graham Gardner, and David Black*

*Dr. Michael Abbott, 2010-2011 VDA President Addressed the membership.*

**Sponsored by:**

COTA
VIRGINIA TECH'S CENTER FOR ORGANIZATIONAL AND TECHNOLOGICAL ADVANCEMENT

## Board of Directors - Actions in Brief
## September 24-26, 2010

The following is reported as information only:

1. Approved: A resolution to provide the VDA Board of Directors a maximum of $10,000.00 to obtain an independent assessment of reconstruction cost of the VDA building.

2. Approved: The following appointments for 2010-2011.

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

3. Approved: The following members of the VDSC Board of Directors for 2009-2010:
Lanny R. Levenson, President; Kirk Norbo, Vice President, Rodney J. Klima, Secretary/Treasurer; Fred A. Coots, Jr., Frank C. Crist, Jr.; Wallace L. Huff; Bruce R. Hutchison; Jeffrey Levin; Robert A. Levine; Harvey H. Shiflet III; Leslie S. Webb, Jr.; Edward J. Weisberg; Roger E. Wood; Andrew J. Zimmer; J. Ted Sherwin, liaison.

4. Appointed: The following to serve as the 2011 Awards Subcommittee: Scott Miller, (Chair), Mike Link and Anthony Peluso.

# Minutes of the 141st Annual Business Meeting
# Saturday, September 25, 2010, 1:30pm
# Hotel Roanoke & Conference Center, Roanoke, VA

1. **President Alonzo M. Bell called the meeting to order.**

2. **The flag pledge was recited.**

3. **The following deceased members were remembered:**
Component 1: James A. Boyd, Tommy J. Hellems, Arthur Siegel, Emmette C. Skinner, Jr. Component 2: George H. Barnett, Martin W. Damsky, Herbert R. Kolb, Acree S. Link, Melvin R. Morrison. Component 3: Herbert Tobias, Lawrence G. Mathews. Component 4: Nathan B. Evens, Llewellyn T. Flippen, Ralph B. Holmes, Emory R. Thomas. Component 5: Robert R. Blake, Jr., Robert F. Jackson. Component 7: Alden S. Anderson, Jr., Thomas E. Burke, Ernest Diaz, Claude A. Harper. Component 8: John F. Armstrong, Jr., George R. Aylor, Jr., James O. Hodgkin III, Khanh U. Le, James T. Planicka, Gerald J. Rose, James M. Schultz.

4. **The following were inducted into the VDA Fellows in 2010:**

Component 1: J. Patrick Baker, Carl P. Roy, Richard K. Quigg. Component 3: David L. Ellis, Frank H. Farrington. Component 4: Steven G. Forte, Wm. Graham Gardner, Christopher R. Richardson. Component 5: David E. Black, Randy J. Norbo. Component 8: Timothy Golian, Paul H. Patterson.

5. **The following received Life Member Certificates in 2010:**

Component 1: Frederick T. Birsch, Arthur L. Halstead, Robert H. Loving, Jr., Glenwood E. Morris, Warren E. Sachs, Ned D. Taylor. Component 2: Albert F. Creal, Jr., Thomas E. Witty, Jr. Component 3: Joseph W. Browder, Harold J. Neal, Jr. Component 4:
Robert F. Barnes, Jr., Sam E. English II, Robert A. Johnson, Edmund E. Mullins, W. B. Perkinson, Jr., Joseph Tregaskes, Harry E. Savage, Jr., Thomas H. Trow, Odie A. Whitlow, Roger E. Wood. Component 5: Michael P. Adams, Fred A. Coots, Jr.,
Frank C. Crist, Jr., William A. Deyerle, Richard A. Lynch, Malcolm J. Mallery, Alexander Ramsey, C. F. Smith, Fremont A. Vess, Jr., Jesse R. Wall, John H. Walrod, John R. Wheless II, Barry Wolfe, Michael L. Woods. Component 6: Perry D. J. Mowbray,
Paul T. Umstott, Harry R. White, Jr., Glenn A. Young. Component 7: Richard M. Miller,
Berkley Pemberton. Component 8: Joel R. Braunfeld, Edward Casillas, Joseph Catanzano, Robert E. Divalentin, Harold H. Fagan, Melvin J. Felber, Charles M. Ferrara, Raymond J. Haston, Joel R. Kessler, Robin S. Kim, Timothy Kirkpatrick
Kie D. Lee, Paul E. Levine, Jonathan F. Lillard, Eddie S. Longman, John A. Marino, Arthur J. Novick, Raymond Obertone, Richard A. Peyser, Gerald Rothman, William B. Sherman, Richard A. Spagna, W. J. Steffan.

6. **The following received 50 Year Certificates in 2010:**

Component 1: Thomas U. Hopkins, Matthew J. Howell, Bruce I. Longman, William C. March, Bobby M. Martin, Roger L. Visser, Erwin R. Whiteside. Component 2: Elmer O. Fisher, Thomas G. Luckam. Component 4: Robert G. Evans, Richard K. Green, John H. Harding, Jr. Stanley B. Jones, James R. Knight, Jr., Frank R. Richardson. Component 5: B. K. Haley, Jr. Component 6: Jack D. Cole, Walter R. Dillow, Jr., John R. Kiser, Sr., French H. Moore, Jr. Component 7: Michael F. Kivlighan, Raleigh H. Watson, Jr. Component 8: Jeremiah J. Kelliher, Sr., Peter P. Kunec, N.J. Nassif, Paul C. Quinn, Louis R. Savarie, David R. Sipes, Harold P. Wittman, George B. Zacko.

7. **The following received 60 Year Certificates in 2010:**

Component 1: E. Todd Clark. Component 4: Major D. Gayle, Jr., Norman W. Littleton, Cornelius H. Ramsey, Claude D. Richardson, Jr. Component 5: Edwin A. Gendron, Sr. Component 6: William E. Cline. Component 8: Ashur G. Chavoor, Dwight W. Newman, Jr., Harding L. Thomas.

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

Category A – Small Component Membership

| | |
|---|---|
| Percentage of members who contributed to VADPAC | Component 6 |
| Percentage of Commonwealth Club Members | Component 2 |

Category B – Large Component Membership

| | |
|---|---|
| Percentage of members who contributed to VADPAC | Component 8 |
| Percentage of Commonwealth Club Members | Component 8 |

The Governor's and Apollonia Club members were recognized.

9. **President Bell announced the following election results:**

President-Elect – Roger E. Wood
ADA Delegates – Richard D. Barnes, Ralph L. Howell, Jr., Edward J. Weisberg. (All will serve three year terms.)
ADA Alternate Delegates – David C. Anderson, Alfred J. Certosimo, Bruce R. Hutchison, Michael J. Link, Elizabeth C. Reynolds. (All will serve two year terms.)

**10.** **The out-going component presidents were recognized.**

**11.** **Ron Tankersley, ADA President, installed the newly elected VDA officers, ADA delegation members and component presidents.**

**12.** **Alonzo Bell presented in-coming VDA President, Michael A. Abbott, with the president's pin.**

**13.** **Michael Abbott presented Alonzo Bell with the past president's pin, the VDA Torch Bearer Award and the ADA Constituent President's Plaque.**

**14.** **The meeting was adjourned.**



## 39th HOUSE OF DELEGATES - ACTIONS IN BRIEF
## SEPTEMBER 24 – 26, 2010

1. Adopted: Bylaws amendment adding two advisory members to the Board of Directors. The Bylaws will read as follows:

ARTICLE VI, Section 1 (Board of Directors)
Advisory (nonvoting) members of the Board of Directors shall be the Parliamentarian, the ecutive Director, the Journal Editor, the Dean of the VCU School of Dentistry, a student representative from the VCU School of Dentistry, and a liaison from the Old Dominion Dental Society.

2. Adopted: Bylaws amendment increasing the percentage used to calculate the number of VDA Fellowships. The Bylaws will read as follows:

ARTICLE I, Section 2.E - The last sentence will read: The number of Fellows shall be limited to seven percent (7%) of the active members of the Association, except that those Fellows who are life or retired members or who are no longer members of the Association shall not be included in this calculation.

3 Adopted: The VDA supports a one year extension to the two year pilot program allowing public health dental hygienists to perform preventive services under remote supervision in three public health district districts (Southside, Cumberland Plateau and Lenowisko). This will include a reporting requirement to the Virginia Secretary of Health. (Policy)

4. Adopted: A one and a half day Governance Meeting schedule that will go into effect in 2011. (Policy)

5. Adopted: A Bylaws amendment listing the duties of the Mentoring Committee:

ARTICLE VII; Section 6
11. Mentoring Committee

b. Duties: It shall be the duty of this Committee: (1) to serve as an introduction to organized dentistry; (2) to share practice experience; (3) to support the continuance of the dental profession by helping our colleagues.

6. Adopted: A Bylaws amendment to Article II, Section 1. The Bylaws will read as follows:

ARTICLE II – Meetings

Section 1. Annual Governance/Membership Meeting: The Annual Governance/ Membership Meeting shall be held each year as approved by the Board of Directors. It is suggested that the meeting shall rotate to different areas of the state which shall include Northern Virginia, Eastern Virginia, Central Virginia, and Western Virginia if there are no extenuating circumstances. It shall be the purpose of this Meeting to foster the ideals of the Association as set forth in ARTICLE II of the CONSTITUTION of this Association.

7. Adopted: Policy for Use of VDA Email Addresses

The VDA will not sell, lease, or in any way make the VDA email database available to any third party, including study clubs or commercial entities, with the exception of the eight VDA components. In order to facilitate communication, individual VDA components may request the VDA central office to distribute specified email-attached documents to other selected components.

The policy shall consist of the following:

1. All outgoing emails shall have the "To:" line/field to consist of the (originating) component's email address (i.e.: sending the email "to" the sender).

2. The (desired) email directory of email addresses shall ONLY be placed/listed within the "BCC:" line/field of the email(s). This is to restrict and protect the visibility/security of each members' email address. It shall be a violation of this policy if the desired directory of email addresses is placed/listed in either the "To:" or the "CC:" lines/fields.

3. The VDA will redirect an email from VDA members, VCU dental students, the VCU School of Dentistry and the VDA components, provided the email meets the screening requirements of the VDA.

4. Any third party will not be permitted to broadcast an email to the VDA membership by using the VDA membership database without the express consent of the Board of Directors of the VDA. The Board of Directors will establish any appropriate fees.

5. Guidelines for emails to be approved by the appropriate VDA staff and/or component for transmission to VDA members shall be as follows:

   a. emails and their attachment(s) must be under a total size of 8 MB. File size may be updated at the discretion of the Board of Directors.
   b. emails must be either for the promotion of the profession of dentistry, or for the benefit of the dental health of the public of Virginia.
   c. emails must originate from an individual or institution whose primary mission is in the field of dentistry, or with the express consent of the Board of Directors of the VDA.
   d. emails cannot contain any profanity.
   e. emails cannot contain any discriminatory reference to sex, race, or religion.
   f. Should the appropriate staff of the VDA be unable to determine approval or disapproval for an email based on the above parameters, the email will be referred to the Executive Director of the VDA, and/or to the Board of Directors of the VDA, for approval or rejection.
   g. The Board of Directors will establish any appropriate transmission fees.

6. As established by the Board of Directors of the VDA, any payment for emails will be received prior to the broadcast of the email to the VDA members. Mode of payment and an application form for presenting an email for broadcast to the VDA will be created and determined by the financial director of the VDA.

7. Nothing in this protocol is intended in any way to restrict the free use of the VDA email database by the VDA, or its associated foundations or subsidiaries, for the purpose of conducting VDA business or maintaining communications with and between the various VDA committees, or in communicating with the members of the VDA.

8. Adopted: Recombine The Virginia Meeting and the Governance Meeting as soon as practical. It is recommended that the joint meeting be held in September.

9. Adopted: The House of Delegates authorizes the VDA Board of Directors to proceed with the investigation to rebuild and/or purchase an office building for the VDA Central Office in the Greater Richmond area.

10. Adopted: The 2011 budget as amended.

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Reported as information only:

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

   Anthony R. Peluso Component 1
   Benita A. Miller Component 4

2. Dr. David C. Anderson was re-elected Speaker of the House.

3. The following received Life Membership in 2010:

   Component 1: Frederick T. Birsch, Arthur L. Halstead, Robert H. Loving, Jr., Glenwood E. Morris, Warren E. Sachs, Ned D. Taylor. Component 2: Albert F. Creal, Jr., Thomas E. Witty, Jr. Component 3: Joseph W. Browder, Harold J. Neal, Jr. Component 4: Robert F. Barnes, Jr., Sam E. English II, Robert A. Johnson, Edmund E. Mullins, W. B. Perkinson, Jr., Joseph Tregaskes, Harry E. Savage, Jr., Thomas H. Trow, Odie A. Whitlow, Roger E. Wood. Component 5: Michael P. Adams, Fred A. Coots, Jr., Frank C. Crist, Jr., William A. Deyerle, Richard A. Lynch, Malcolm J. Mallery, Alexander Ramsey, C. F. Smith, Fremont A. Vess, Jr., Jesse R. Wall, John H. Walrod, John R. Wheless II, Barry Wolfe, Michael L. Woods. Component 6: Perry D. J. Mowbray, Paul T. Umstott, Harry R. White, Jr., Glenn A. Young. Component 7: Richard M. Miller, Berkley Pemberton. Component 8: Joel R. Braunfeld, Edward Casillas, Joseph Catanzano, Robert E. Divalentin, Harold H. Fagan, Melvin J. Felber, Charles M. Ferrara, Raymond J. Haston, Joel R. Kessler, Robin S. Kim, Timothy Kirkpatrick
   Kie D. Lee, Paul E. Levine, Jonathan F. Lillard, Eddie S. Longman, John A. Marino, Arthur J. Novick, Raymond Obertone, Richard A. Peyser, Gerald Rothman, William B. Sherman, Richard A. Spagna, W. J. Steffan.

4. Karen Kraus was given VDA Honorary Membership.

# Welcome New Members!

## *September 2010*

### Northern Virginia Dental Society

Dr. Ana Arango graduated from Autonoma University, located in Colombia, South America, in 1996. She then continued to complete her general practice residency at the University of Miami Jackson Memorial Hospital in 2009. Dr. Arango is currently practicing in Alexandria.

Dr. Gerald Awadzi graduated from the University of Pennsylvania in 2001. He is currently practicing in Manassas.

Dr. Celeste Balino graduated from Howard University in May of this year. She is currently practicing in an Associateship in Alexandria.

Dr. Emoke Basa received her AEGD in 2002. Dr. Basa is practicing in Springfield.

Dr. Poonum Bharal graduated from the VCU School of Dentistry in May of this year

Dr. Fawzia Bhavnagri recently graduated from the VCU School of Dentistry in May of this year.

Dr. Pierre Cartier graduated from the University of Kentucky in 2005. He then continued to receive his Advanced Education in General Dentistry Certificate in 2006. Dr. Cartier is currently practicing with the Arlington Cosmetic Dental Group in Arlington.

Dr. Richard Gallagher graduated from the University of Pennsylvania and received his certificate in Periodontics. Dr. Gallagher will be practicing in Fairfax.

Dr. Meredith Gardner graduated from the Medical College of GA in 2008. Dr. Gardner is currently practicing in Alexandria.

Dr. Matthew Gerald graduated from the University of Maryland, Baltimore College of Dental Surgery in 2010. Dr. Gerald is currently practicing with Dr. Glenn Gerald in Vienna.

Dr. Matthew Gialanella graduated from the New Jersey Dental School in 2009. He received his General Practice Residency Certificate in June of this year. Dr. Gialanella is currently practicing with the Virginia Center for Cosmetic and General Dentistry in Arlington.

Dr. Syed Hussaini graduated from Virginia Commonwealth University in 2007. He then continued to Columbia University, where he completed his specialization in orthodontics and dentofacial orthopedics in June of this year. Dr. Hussaini is currently practicing in an associateship in Fredericksburg.

Dr. Samer Jarwa graduated from University of Southern California in 2003. Dr. Jarwa is currently practicing in Fairfax.

Dr. Deepak Kakar graduated from the VCU School of Dentistry in 2002. He then completed his specialization in Pediatric Dentistry in 2004. Dr. Kakar is currently practicing in Fredericksburg.

Dr. Sandy Lin graduated with her AEGD in 2006 from Boston University. Dr. Lin is currently practicing in the Northern VA area.

Dr. Hung Quoc Lu graduated from VCU School of Dentistry in 2008. He completed his MSd, Orthodontics Certificate in 2010. Dr. Lu is currently practicing in Burke.

Dr. Robert Moffitt graduated from VCU School of Dentistry in 1982. Dr. Moffitt is practicing in Lorton.

Dr. Justin Norbo graduated from the VCU School of Dentistry in May of this year. He is currently practicing in an Associateship with Dr. Kirk Norbo in Purcellville.

Eunseok Oh graduated from New York University in 2005. He then attended Stony Brook University where he received his Certificate in Periodontics in 2010. Dr. Oh is currently practicing in Vienna.

Dr. Mimi Park graduated from the VCU School of Dentistry in May of this year.

Dr. Cana Pasierb graduated from the VCU School of Dentistry in May of this year. He is currently practicing in an Associateship in Woodbridge.

Dr. Nathalie Phaeton graduated from the Howard University College of Dentistry in 2006. She then continued to complete her pediatric dentistry specialization in 2008. Dr. Phaeton is currently practicing in Falls Church.

Dr. Jennifer Pham graduated from Temple University School of Dentistry in 2010. Dr. Pham is currently practicing in the Northern VA area.

Dr. Laura Pierce graduated from Loma Linda School of Dentistry in 2006. Dr. Pierce comes to us from Nashville, TN, and is currently practicing in the Northern VA area.

Dr. Chetana Ramisetty received her GPR in June of 2010. Dr. Ramisetty will be practicing in the Northern VA area.

Dr. Kathryn Smith graduated from the Medical University of South Carolina in May of this year. She is currently practicing in an associateship with Dr. Raymond Niles, Jr. in Woodbridge.

Dr. Linda White graduated from the Medical College of Virginia in 1983. She then continued to complete her General Practice Residency in Hospital Dentistry from UMDB in 1985. Dr. White is currently practicing in Manassas.

### Peninsula Dental Society

Dr. Ann Greeley graduated from Boston University in 2006. She is currently practicing with United States Army in Ft. Eustis.

Dr. Yugal Behl received his Certificate in Orthodontics from Boston University in 2010. Dr. Behl is practicing in Yorktown.

### Piedmont Dental Society

Dr. Rajdeep Guraya graduated from UMKC School of Dentistry in 1995. He then received his degree in Oral Maxillofacial Surgery in 2001. Dr. Guraya is currently practicing in Lynchburg

Dr. Javeria Mirza graduated from New Jersey Dental School in 2009. She then completed her GPR in 2010. Dr. Mirza is currently practicing in Martinsville with Dr. George Stermer.

Dr. Rudolph Wolf graduated from the VCU School of Dentistry in May of this year. He is currently practicing with Anthony D. Bailey DDS, Inc. in Bedford.

### Richmond Dental Society

Dr. Ana Paula Benedetti graduated from the University of Florida in 2006. She then continued to complete her specialization in orthodontics and dentofacial orthopedics in 2008. Dr. Benedetti is currently practicing in an Associateship with Dr. Richard Byrd in Richmond.

Dr. Sonny Duong graduated from the VCU School of Dentistry in May of this year.

Dr. Robert Laughlin received his DDS from Columbia University in 2008. Dr. Laughlin received his Certificate in Pediatric Dentistry in 2010 and is currently practicing in Richmond.

Dr. Donald Murry, III, graduated from Case Western Reserve University in May, 2010. He is currently practicing with Dr. Donald Murry, Jr. in Powhatan.

Dr. Sejal Patel graduated from Virginia Commonwealth University in 2008. She then completed her Advanced Education in General Dentistry Certificate in 2009. Dr. Patel is currently looking to practice in a group practice, Associateship, clinic, or federal dental service.

Dr. David Pemberton graduated from Meharry Medical College in 1979. Dr. Pemberton is practicing in Richmond, VA.

Dr. Kathleen Seiler graduated from VCU School of Dentistry in 2002. She then received her AEGD at Ft. Bragg in 2004. Dr. Seiler is currently practicing at Buckingham Family Dentistry in Dillwyn.

Dr. Michael Whitecar graduated from the VCU School of Dentistry in May of this year.

### Shenandoah Valley Dental Association

Dr. Katherine Southwell graduated from the Audie Murphy VA Hospital with her AEGD in San Antonio in July 2010. Dr. Southwell is practicing in Charlottesville, with the Charlottesville & Crozet Blue Ridge Dental Group.

### Tidewater Dental Association

Dr. Darren Dorfman graduated from the VCU School of Dentistry in May of this year. Dr. Dorfman is currently practicing in a General Practice Residency, which he will complete in 2011.

Dr. Davis Gardner graduated from the VCU School of Dentistry in May of this year. He is currently practicing in an Associateship with Dr. Harold Demsko in Windsor.

Dr. Robin Langston graduated from Howard University in 1989. She is currently practicing in Portsmouth.

Dr. Suganthi McNeill graduated from Temple University School of Dentistry in 2009. Dr. McNeil is currently practicing in Smithfield.

Dr. Clayton Miller graduated from the VCU School of Dentistry in May of this year. He will complete his Navy Advanced Education in General Dentistry Certificate in 2011.

Dr. Jillian Reynolds graduated from Virginia Commonwealth University in 2008 and has completed her specialization in pediatric dentistry this year. Dr. Reynolds is currently working in an associateship with Lefcoe ,Weinstein, Sachs ,& Schiff in Norfolk.

# In Memory Of...

| Name | Component | City | Date |
|---|---|---|---|
| Dr. Acree Link | 2 | Newport News | June 15, 2010 |
| Dr. Ernest Diaz | 7 | New Market | July 2, 2010 |
| Dr. Ralph Holmes | 8 | Vienna | April 29, 2010 |
| Dr. Thomas Burke | 7 | Strasburg | September 15, 2010 |
| Dr. Khanh U Le | 8 | Falls Church | September 5, 2010 |

## New Dentist Conference

By: Dr. Krista Woodlock

It was another stellar year for the ADA's 24th New Dentist Conference on June 24-26, 2010 held in beautiful San Diego, California. Every year I am impressed with the level of informative speakers, accommodations and camaraderie. The Catamaran Resort Hotel and Spa was an incredible setting for this event. This conference provides many new dentists with the opportunity to network and share ideas with their colleagues, while earning their requisite CE credits. If you are a dentist who has been practicing for less than ten years, make plans now to attend this meeting next year. This year fun was had by all!

The opening day of the conference focused on developing leadership skills in your personal and professional life with the very entertaining keynote speaker, Cynthia DíAmour. There was an interactive discussion where many dentists shared their personal experiences and challenges as new dentists. An overview of ADA resources were made available to new dentists through the New Dentist Network Committee. A very important theme of this session was to encourage new dentists' involvement in organized dentistry. Everyone in attendance was able to meet and mingle with the ADA Board of Trustees at the opening reception that evening.

Friday's keynote address by Mr. Brian Blasko gave everyone new ideas on how to maximize their potential in life. Everyone was able to gain some "fue"î for their internal gas tank. On both Friday and Saturday the conference provided many informative and valuable CE courses. There were courses on practice management including "Recession Proof Strategies" by Ms. Lisa Philp, and "The Grand Slam - Early Years of Private Practice" by Dr. Mark Hyman. We were honored to attend the course presented by the renowned Dr. Gordon Christensen discussing "Ongoing Changes in Dentistry".

An awesome Friday Night Luau was generously sponsored by the American Dental Political Action Committee (ADPAC). This excellent networking opportunity took place on the picturesque beach at the beautiful Catamaran Resort. The performers were fabulously entertaining, with their awesome costumes, dancing and flame throwing exhibition. It was quite an event!

Congratulations are in order for the 2010 Golden Apple recipients: Dr. Thomas R. Smyth of Minnesota, winner of the New Dentist Leadership Award; Dr. Christopher D. Morgan of Michigan, winner of the New Dentist Legislative Leadership Award; and Dr. Brett Kessler of Colorado, winner of the Outstanding Leadership in Mentoring Award. The San Antonio District Dental Society New Dentist Committee received the New Dentist Committee Outstanding Program Award of Excellence for its program, "CND Continuum for Excellence". Award recipients were recognized at the luncheon on Saturday.

Once again, this great event left me looking forward to next year's conference in the big city of Chicago. In the words of Frank Sinatra, "it's my kinda town!" Hope to see you all there in June of 2011 for another weekend of networking, continuing education and camaraderie!

# Classifieds

## Job Opportunities

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We have many satisfied clients with associates in your area that we have helped to either buy-in, buy-out or conduct a delayed sale with the current associate. Without a quality valuation and plan up front these transactions normally fail. Call or email us to arrange a FREE CONSULTATION to find out if you are a candidate for this service. The result is higher income and a higher practice value for the seller and a clear financially positive path for the associate. THE MCNOR GROUP, 888-273-1014 X 103 or johnf@mcnorgroup.com, www.mcnorgroup.com.

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Fairfax County, VA - Hot Area! "Hybrid practice startup", 4ops - 2.5 days/wk, refers endo, ortho, pedo, os - 1600 s/f leased space. Asking $350K - Donna Costa, 800.988.5674. www.snydergroup.net<http://www.snydergroup.net/>.

South Hill, VA Practice Ownership Opportunity!! The Affordable Dentures practice in South Hill, VA is for sale. The transition of this practice will not require the buyer to borrow from a bank. For detailed information please call: Brian Whitley at (800) 313-3863, ext. 2290 fax: (252) 208-7090

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PRACTICE FOR SALE- Northern Virginia. Prince William County/Manassas. Established modern practice with great staff in place 4 operatories. Grossing over $600K on short week. POLCARI ASSOCIATES, LTD. (800)544-1297 www.polcariassociates.com

## Miscellaneous

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**FOR SALE – EQUIPMENT FOR SALE** - Twilite Machine, Waterlase, **GENERAL PRACTICES: Falls Church** - Asking $285,000, P/T - 20 hours/week, 4 operatories - 3 equipped, **Woodbridge** - Turnkey (No Patients) - G.P. or Specialist - 3 operatories, 900 square feet, **Manassas** - Turnkey (No Patients) - G.P. or Specialist - 7 operatories, **Woodbridge** - 7 operatories, F/S and PPOs, **Richmond Area** - Revenue: $217,000, 2 operatories, **Falls Church** – Revenue: $550,000, 7 operatories - 3 equipped, **La Crosse** - Revenue: $200,000, 4 operatories. Specialists Only - **Fort Belvoir** –Turnkey (no records), 4 ORs - fully equipped, 1,500 square feet, **Fairfax County** - Endodontist and/or Orthodontist Wanted - to work in 2 established G.P. offices in Fairfax County. Also have turnkey dental office available for lease in Belvoir area (no prosthodontists). **PRACTICE SALES & TRANSITIONS**, (877) 539-8800, www.dentalsales.org.

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