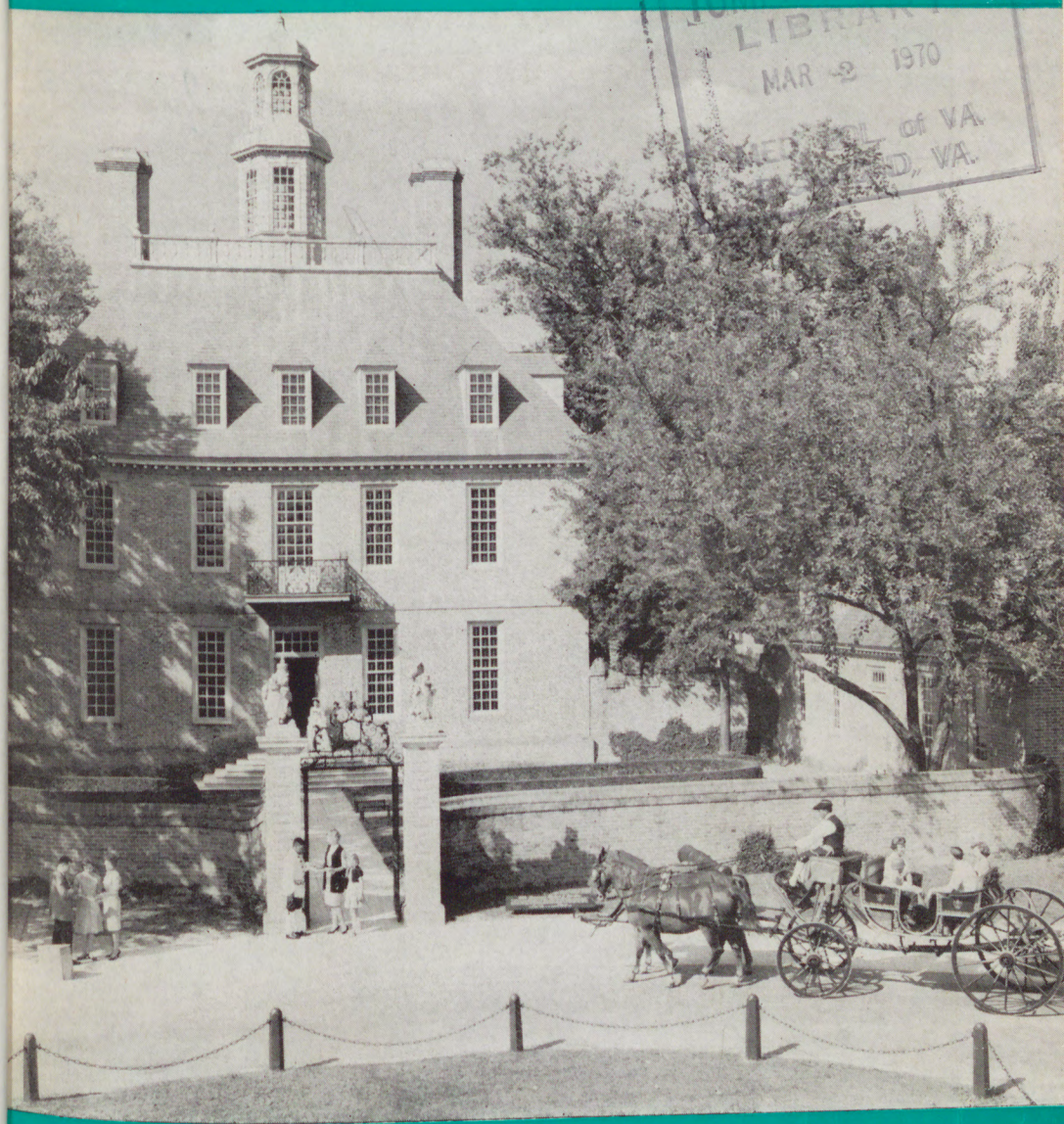
Virginia Dental Journal



ADA Meeting Report
Dental Legal Problems
VDSP Report

Volume XLVII February, 1970 Number 1

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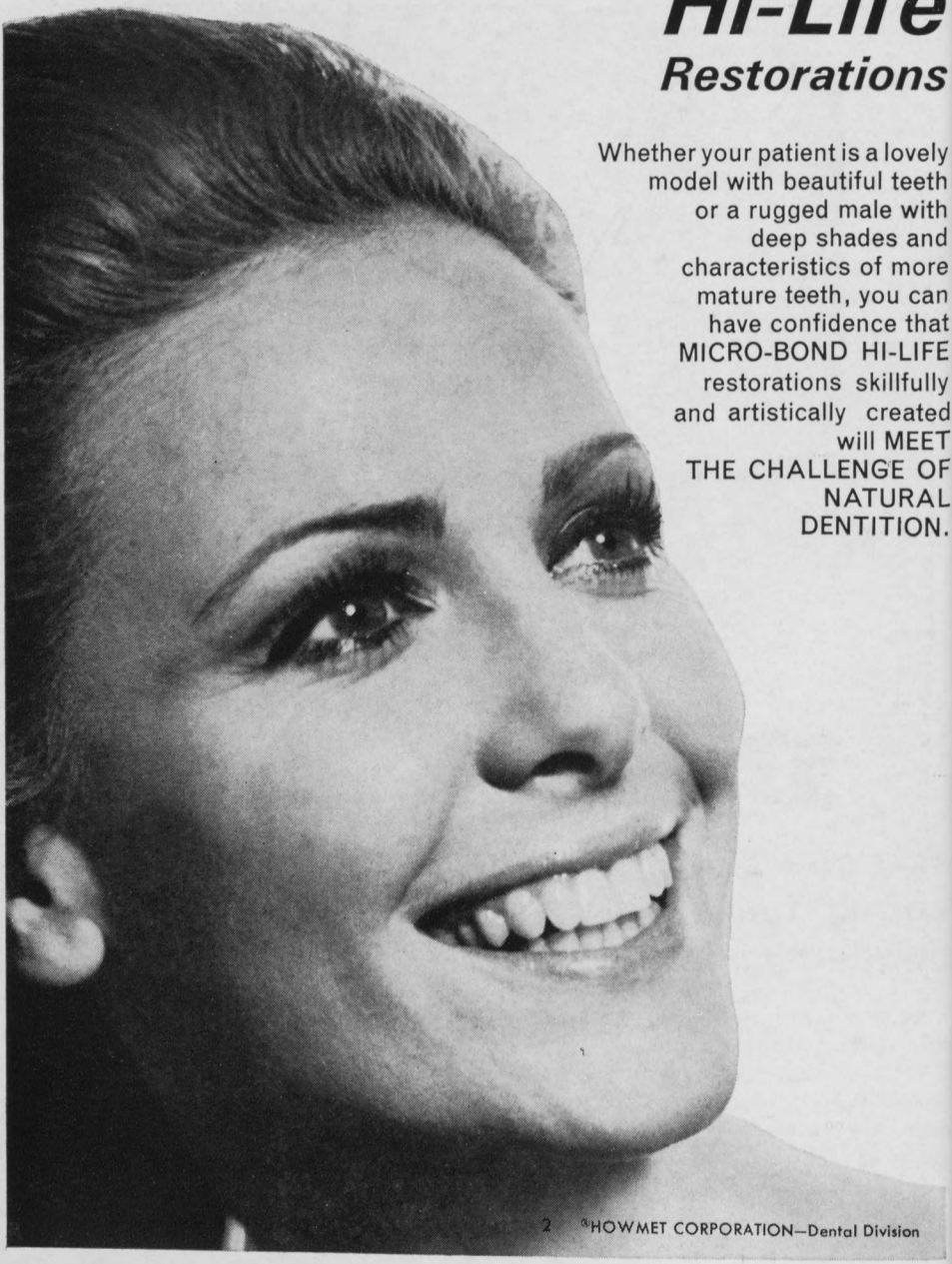

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CALENDAR OF EVENTS

MARCH 1970

4, 5 **Southwest Virginia Dental Society Meeting** (in cooperation with Bristol Dental Society, March 4th meeting - Dr. Harold Kilpatrick, clinician) Bristol YMCA, Bristol

11 **Southside Dental Society Meeting** (Cpt. Jerry A. Mahalick, clinician) Swift Creek Mill Playhouse, Colonial Heights

19 **Richmond Dental Society Meeting** (Dr. Ray W. Alcox, clinician) Holiday Inn, Robin Hood Road, Richmond

25 **Northern Virginia Dental Society Meeting** (Dr. Paul H. Keyes, clinician) Sheraton-Fredericksburg Motor Inn, Fredericksburg

APRIL 1970

10, 11 **"Telling Our Story to the Public" - Workshop on Speakers Bureaus** sponsored by the Virginia State Dental Association, the Women's Auxiliary to the VSDA, the Virginia Dental Assistants Association and the Virginia Dental Hygienists Association

16 **Richmond Dental Society Meeting** (Dr. Fred Spencer, clinician) Holiday Inn, Robin Hood Rd., Richmond

17 **Shenandoah Valley Dental Association Meeting** Hotel Monticello, Charlottesville

MAY 1970

16 **Continuing Education Workshop** - VSDA Dental Education Committee and other committees, VSDA Central Office, Richmond

15 **Northern Virginia Dental Society Meeting** Elks Lodge, Fairfax

21 **Richmond Dental Society Meeting** (Robert P. Levoy) Holiday Inn, Robin Hood Rd., Richmond

22, 23 **James River Study Club** (Dr. Robert F. Barkley, clinician — Preventive Dentistry) Holiday Inn, Hampton

JUNE 1970

13 **V.S.D.A. EXECUTIVE COUNCIL MEETING** Boar's Head Inn, Charlottesville

FUTURE EVENTS

Meetings of the Virginia State Dental Association

101st Annual Meeting—Sept. 20-22, 1970 . . . . . Hotel Roanoke, Roanoke

102nd Annual Meeting—Sept. 26-28, 1971 . . . . Golden Triangle Motor Hotel, Norfolk

103rd Annual Meeting—Oct. 8-10, 1972 . . . . . John Marshall Hotel, Richmond

Meetings of the American Dental Association

111th Annual Session . . . . . November 8-12, 1970 . . . . . Las Vegas, Nevada

112th Annual Session . . . . . October 10-14, 1971 . . . . . Atlantic City, N. J.

113th Annual Session . . . . . October 29—Nov. 2, 1972 . . San Francisco, Calif.

Virginia Dental Journal

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COVER: Governor's Palace at Williamsburg. A reminder of the Speakers Bureau Workshop "Telling Our Story to the Public" to be held at Cascades Meeting Center in Williamsburg, April 10-11, 1970. (See page 41)

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IN MEMORIAM

DR. DAN O. VIA, Charlottesville, Virginia, died January 17, 1970 at the age of 73. He was a Life Member of the VSDA and ADA through the Shenandoah Valley Dental Association. He was born in Charlottesville, Virginia and was graduated from the University of Maryland in 1918, when he began general practice. He served as President of his component society as well as President of the Virginia State Dental Association in 1942. He was a veteran of World War I.

DR. CHARLES BRUCE HARLOE, Winchester, Virginia, died December 1, 1969 at the age of 83. He was a member of the VSDA through the Shenandoah Valley Dental Association. He was born in Highview, West Virginia and was graduated from the MCV School of Dentistry with a DDS Degree at which time he began general practice. He served on the State Executive Committee and also as President of his component society. During World War I, he served in the Medical Enlist Reserve Corp of the U. S. Army.

DR. GUY ROSS HARRISON, Richmond, Virginia, died December 22, 1969 at the age of 80. He was a member of the VSDA through the Richmond Dental Society. He was born in Sussex County, Virginia and graduated from the MCV School of Dentistry in 1912 when he began practice of Maxillofacial Surgery in Richmond. During World War II, he served as a Major in the Dental Corp. In addition to serving on various committees on the local and state level, he also served as President of his component society, and as the first dental member of the State Board of Health.

MRS. IDA REID, ("Miss Ida") of Roanoke, Virginia, beloved secretary for many years under past VSDA Secretary-Treasurers Dr. James E. John, Dr. William T. McAfee, and Dr. Myron E. Henderson, passed away November 25, 1969. Mrs. Reid had helped with the registration desk each year at Annual Meeting, even after the establishment of the VSDA Central Office in 1964. She was elected to honorary membership in the Virginia State Dental Association in 1966.

EDITORIAL

A STITCH IN TIME

Some of us solve problems only when we are forced to. This allows no real progress. Certainly plugging holes in a dike is necessary, but it is far better to strengthen and extend it. Plugging is only crisis work. Strengthening and extension are progress.

Fortunately, those who care enough to work for organized dentistry lead us less in crisis than most professions. We are in the fringes of a crisis right now. There is still time before the crisis forces a solution that is less than the best. It can happen here.

"Crisis? What crisis?" you ask. It is third-party or prepayment in dentistry.

Third party payment grows by leaps and bounds. If dentistry controls the programs, it and the public will benefit. If we allow outsiders, who don't know dentistry, to control the programs, both dentists and the public will suffer.

The outsiders will dictate quality and quantity of treatment. Dentistry will suffer in conscience and finance. The public will suffer from low-grade treatment and poorer health.

It is rare to be able to serve yourself and others at the same time. You now have such an opportunity: Join the Virginia Dental Service Plan. Give yourself a break.

We recommend your reading the Virginia Dental Service Plan report on page 6.

J. S. S.

"What's With The Virginia Dental Service Plan ?"

by

Byron M. John, D.D.S.,
Executive Director

Recently at a dental meeting I was asked why the Virginia Dental Service Plan had not kept its members better informed. I feel that this is a just complaint and will try to answer some of the most often asked questions. They are: *What programs are administered by the Plan? Why should I be a member? What are the advantages? Why not use commercial insurance carriers or a non-profit organization such as Blue Cross - Blue Shield? What are other states doing? How does Virginia compare?*

PROGRAMS BEING ADMINISTERED BY THE VDSP

First of all, the programs being serviced by the Virginia Dental Service Plan are: (1) Summer Headstart Program for Buchanan-Dickenson Rural Development Corporation, funded for $28,000. (2) Mountain Community Action Program, Full Year Headstart, funded for $6,200. (3) Mountain Community Action Program, Summer Headstart, Wytheville, funded for $9,900. (4) Blue Ridge Job Corps, Marion, funded for $18,000. (5) Roanoke TAP Agency, funded for $34,000. (6) Richmond Headstart Program, funded for $18,000. (7) New River Community Action Program, Summer Headstart, funded for $7,800. (8) New River Full Year Program, funded for $3,600. (9) Roanoke County School Dental Accident Program. (10) The first commercial program, Thompson Raymo Woolridge Corporation, of Falls Church and Washington, D. C. These are the programs started since last February. One sees how rapidly the dentists of Virginia are involved in prepayment programs.

The government programs involve all dentists who want to participate, regardless of their membership in the Virginia Dental Service Plan. These federally funded programs have been the major administrative responsibility of our Plan.

The picture is changing, by the addition of the Roanoke School Dental Accident Program and other commercial contracts.

WHY BELONG TO THE VIRGINIA DENTAL SERVICE PLAN?

This brings us to the second question - Why belong to the Virginia Dental Service Plan? The Virginia Dental Service Plan has already become involved, together with the Virginia State Dental Association and the Old Dominion Dental Society,

in stopping outside efforts to take over the private practice of dentistry in our state. These efforts represented only a small area of dental responsibility, but the intent and the precedent were there. We spent many apprehensive hours working to maintain our private identity. The next reason for belonging to the Virginia Dental Service Plan is financial. It has an effect upon all of our pocketbooks. The Plan pays usual and customary fees in private contracts to member dentists, while nonmember dentists are paid on a table of allowances. Nonmember dentists are not entitled to be paid directly. I am sure in some cases patients will be paid directly, so the nonmember dentist will have to collect his own accounts. There are other reasons for belonging to the Plan, but in my own mind these are sufficient.

WHY NOT USE COMMERCIAL INSURANCE CARRIERS?

Commercial insurance carriers in the past have shunned dental coverage. It is only since the birth of dental service plans that any real effort has been made to write any substantial dental policies. Only token coverage was available before this. Commercial programs are completely out of our control, and the fact that by 1980 eighty per cent of dental practice will be prepaid makes this matter of control very important. In my opinion, the physician-controlled Blue Cross - Blue Shield is by far the most dangerous. Blue Cross - Blue Shield appeals to certain oral surgeons who have close alliance with physicians in some areas. The dental profession as a whole should not sell out because of this, thus "taking a giant step" back to being a "stepchild" of medicine. We are capable professionally and statistically to do our own job. Only the dentists will decide our fate.

HOW DOES VIRGINIA COMPARE?

Where does Virginia stand in comparison with other states in development of dental plans? Virginia has moved slowly and soundly. We have had professional, economic, social and other disharmony in working out our plan, but I can point with pride to men who have helped to solve these problems. At this point I can justlv say that Virginia leads in the Eastern United States. The dentists of Virginia owe a great debt to our Board, especially to *Dr. A. G. Orphanidys* of Newport News, our President; *Dr. L. Ray Shields* of Charlottesville, our past Secretary-Treasurer; *Dr. Francis M. Foster* of Richmond; *Dr. W. Yates League* of Richmond; *Dr. Walker P. Sydnor* of Lynchburg; *Dr. Henderson P. Graham* of Marion; *Dr. Thomas C. Bradshaw* of Blackstone; *Dr. L. O. Clark, Jr.* of Virginia Beach, our present Secretary-Treasurer; and 'The General", *Dr. Byrnal M. Haley* of Warrenton.

Most states assess all dental society members from $300 to $600 each to support their dental plans.

In Virginia we asked only $25 from each participating dentist, and have no dental society assessment. The Virginia State Dental Association lent the Corporation $2,500 for which we are grateful. This was paid back in late December 1969. Five per cent on all commercial contracts in Virginia will be deducted to build a reserve. This is the same as credit card accounts now charge and will be discontinued as soon as possible.

Yes, you do have an active dental service plan! Support it! The Plan now has over 600 members. We want to add more in the membership drive in 1970. *Stand up and be counted for private practice!*

707 Building
Roanoke, Virginia

Annual Meeting

of the

Southeastern Academy

of

Prosthodontics

April 23 thru 25, 1970

Hotel John Marshall

Richmond, Virginia

Theme: "Preventive Prosthodontics"

Members & their Guests

MAXILLOFACIAL PROSTHODONTIC SERVICE AT THE SCHOOL OF DENTISTRY

by

* Charles M. Heartwell, D.D.S.
** Paul E. Peters, Jr., D.D.S.

INTRODUCTION

Experience teaches us that disagreements in words contribute to confusion, misunderstanding, and at times, arguments. This is particularly true in the health sciences. Two factors that contribute to semantic confusion are (1) the use of unscientific terms, and (2) the coining of terms and phrases to satisfy one's own concepts. It is for this reason that the definitions and terminology associated with maxillofacial prosthodontics are presented. When we understand these terms, intelligent communication can exist between the prosthodontist and the general practitioner.

The general practitioner of dentistry does not, as a rule, provide maxillofacial prosthodontic service. However, general practitioners may find that their familiarity with this service will be of value to their patients who need such treatment.

* *Professor, Department of Prosthodontics, Health Sciences Division, Virginia Commonwealth University, School of Dentistry, Consultant to the Departments of Oncology and Radiation Therapy, Health Sciences Division, Virginia Commonwealth University Hospital.*

** *Instructor, Department of Prosthodontics, Health Sciences Division, Virginia Commonwealth University, School of Dentistry.*

DEFINITIONS AND TERMINOLOGY

Maxillofacial Prosthodontics: That branch of dentistry which attempts to protect tissue under certain conditions of therapy and directly or indirectly to restore parts of the body which are congenitally missing, or lost as a result of surgery, accident, or war injury. The prosthesis restores more than missing teeth and the adjacent associated alveolar ridges.

A surgical prosthesis: A temporary or provisory appliance. That is, the prosthesis is used primarily before, during, and immediately following surgery.

A Maxillofacial or oral facial prosthesis: The definitive or restorative appliance, a substitute for the missing part or parts. This is not a permanent prosthesis. The use of the word "permanent" should be avoided. The use of the term "permanent" can be misleading to a patient, as he will expect the prosthesis to last for a lifetime. The appliance may last, but tissue changes and the changes will require remaking or altering the prosthesis.

BRIEF HISTORY

A prosthesis which restores missing or lost parts of the body is not new.

There are very few new methods or technics in medicine or dentistry. The techniques have been refined, and new materials and medicaments have been developed. The restorative materials are far from being ideal and additional research is needed in this area.

The ancient Egyptians used pieces of gold to correct palatal and cranial defects. Artificial ears, eyes, and noses were found on Egyptian mummies.

Early in the sixteenth century the literature contained information about restoration of lost parts. Petronious and Pare successfully practiced rehabilitation by the use of ingenious appliances. The Chinese used waxes and resins to construct noses and ears. Individuals over the ages have practiced a "do it yourself" type of maxillofacial service using such crude materials as wads of cloth, pieces of leather, paper, wax, and tree bark.

We may assume that as long as there have been people on the earth there has been a need for maxillofacial service. Accident, war, the increase in life expectancy, and ravages of disease continue taking their toll of parts of the body.

DISCUSSION

Maxillofacial prosthodontics offers an excellent opportunity for close cooperation in the health sciences. Patient rehabilitation requires a team approach, with diagnosis. The members of the team must be acquainted with the different disciplines if the patient is to be returned satisfactorily to society.

Although this article deals primarily with artificial replacements, it must be understood that an artificial substitute is *not* the treatment of choice if living tissue can be satisfactorily used.

A maxillofacial prosthesis attempts to protect tissue under certain conditions, primarily radiation therapy. It may be a shield protecting an adjacent area or an area which is in line with the direction of radiation. It may act as a carrier to maintain the source of radiation in the most suitable therapeutic site. (Fig. 1)

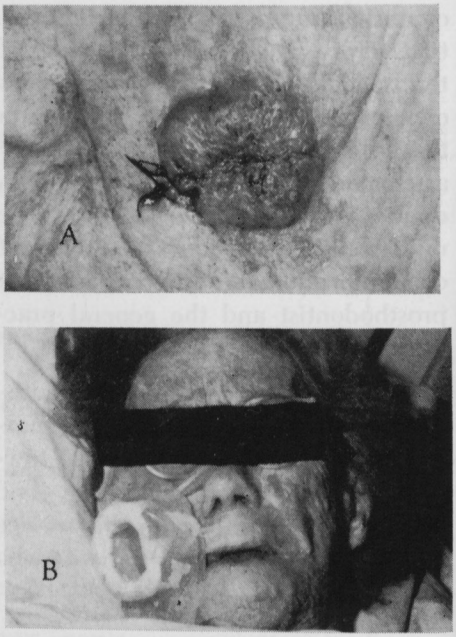

Fig. 1. A prosthesis was fabricated to maintain the source of radiation in a definite relation to the tumor. (A) Tumor mass (B) Prosthesis in place.

A *stent* holds a skin or mucous membrane graft in place. This is not to be confused with a splint, which holds a broken bone in place to keep a part of the body in a fixed

position or maintain an orifice or tubular opening. A stent is constructed from a moldable mass called "Stent's composition." This mass is molded at the site of the graft and allowed to harden. Dr. Stent, an English dentist, developed the technic and the moldable material. From these descriptions one should see that the word stent should refer to a definite material and technic. The term "splint" can refer to many different materials and many technics to keep a part of the body in a fixed position.

SURGICAL PROSTHESES

Some of the conditions aided by the use of a surgical prosthesis are skin and mucous membrane grafts, rhinoplasty, fractures, osteotomy, and oncotomy.

In fractures of the facial bones, a splint is used when intermaxillary and intra-maxillary wiring cannot or should not be used, as in the following situations: *(1) Edentulous or almost edentulous jaws, (2) certain maxillary fractures with extensive displacement, (3) where edema prevents or impairs breathing with the jaws wired, (4) where nasal obstruction prevents nose breathing, (5) where nausea either from medication or mode of transportation exists, and (6) in children whose teeth have poor contour from wiring.*

Prostheses used for patients undergoing surgery for tumors of the head and neck (Fig. 2) are advantageous. (1) They support displaced tissues, (2) allow the patient to swallow

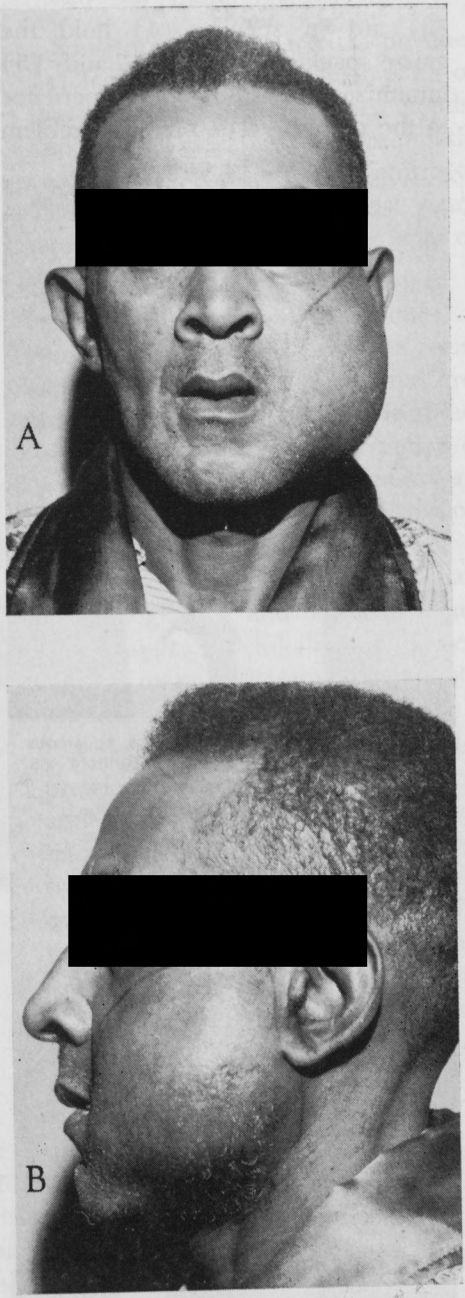

Fig. II. A rhabdomyosaroma (A) Lateral view (B) Frontal view. A prosthesis will be fabricated and it will be inserted at the time of surgery.

without spillage from the nasares, (3) aid in speech, (4) hold the gauze packings in place, and (5) minimize the traumatic experience to the patient. The nursing problem

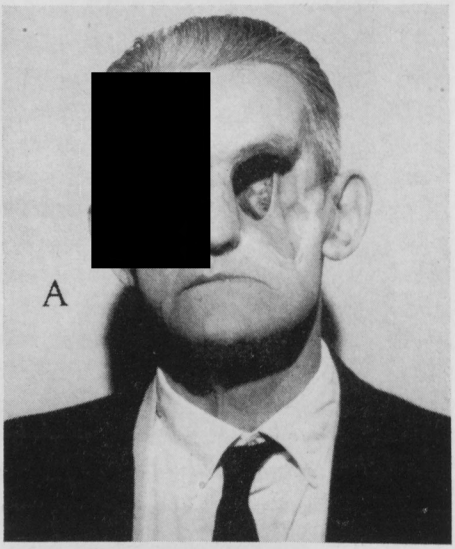

Fig. III. (A) This patient had a squamous cell carcinoma of the right maxillary antrum that was treated surgically.

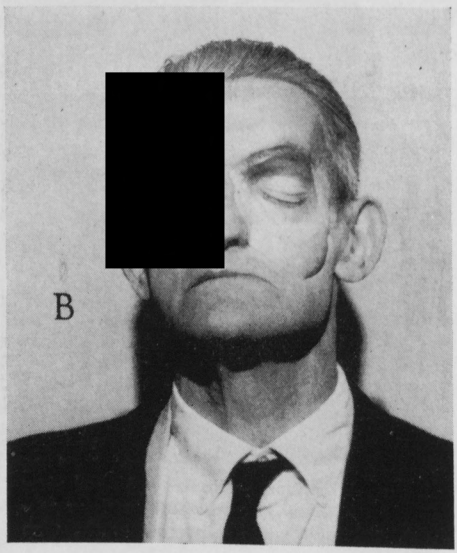

Fig. III. (B) A closed eye maxillofacial prosthesis and complete dentures are in place.

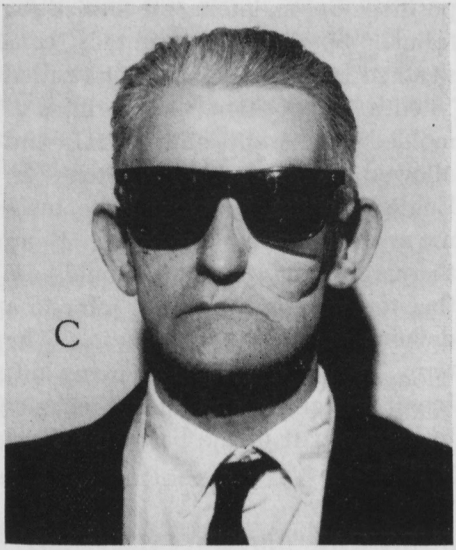

Fig. III. (C) The dark glasses are not attached to the prosthesis. The prosthesis is retained by using attracting magnets in the complete maxillary prosthesis and in the facial prosthesis. The glasses give a better esthetic result.

is magnified when a patient cannot speak or swallow. One must realize that some patients cannot communicate if they cannot speak, for they cannot write. Mental trauma is magnified when the patient knows that his loved ones cannot understand him.

To complete the discussion of maxillofacial prosthodontics, we must consider the more definitive phase of replacing that which is congenitally missing or that which has been lost. (Fig. 3)

For further clarification of terms, this discussion can be divided into (1) oral facial (maxillofacial) — a prosthesis which involves the oral cavity and jaws or (2) somatoprosthesis, a prosthesis which replaces missing or lost parts of the body not involving the oral cavity.

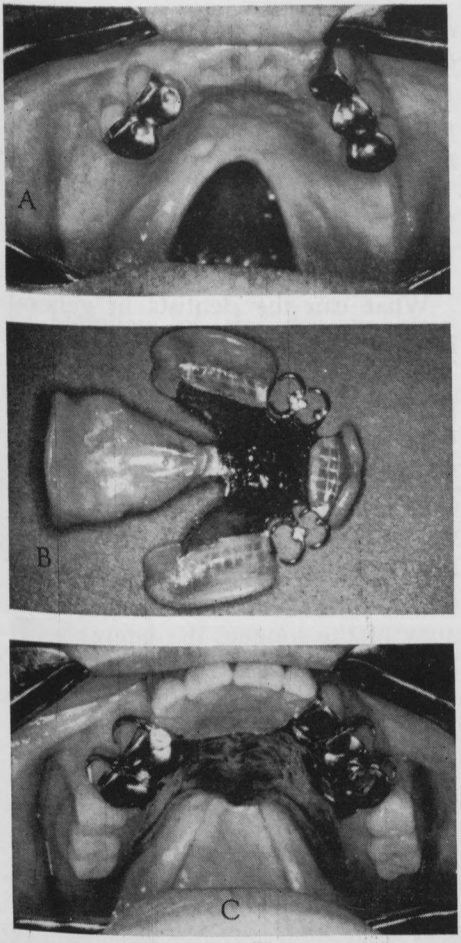

Fig. IV. Congenital Cleft palate
(A) This patient needs treatment for her congenital cleft.
(B) The obturator and speech bulb are attached to the maxillary removable partial denture.
(C) The obdurator and speech bulb make it possible for clearer speech and swallowing without spillage through the nose.

The most prevalent congenital defect involving the mouth is the palate and cleft lip. (Fig. 4) These defects are greatly involved in swallowing and speech. In some situations the lack of sufficient soft palate affects speech so much that the patient becomes a recluse. Surgical procedures and/or a prosthesis frequently return these patients to society.

Somatoprosthesis (b o d y prosthesis) includes replacement of parts of the skull, nose, ears, fingers, hands, and feet. These parts are frequently congenitally missing or deformed. These parts are frequently lost, damaged beyond repair in accident, or surgically removed.

Of great importance, in times of war, is the damage and loss from shrapnel and explosions of hand grenades, and "booby traps". In times of war and peace, the destruction of parts of the head and neck as a result of malignant or benign tumors is also important. The increase in life expectancy, the increase in cancer recognition and detection, and the changes in rehabilitation techniques make this an ever greater problem.

Artistic skill, the knowledge of impression and restorative materials, and training in anatomy, physiology, and psychology are involved in rehabilitation. These factors are all part of prosthetic dentistry. The dentist should meet the challenge and become an active member of the team responsible for this treatment. When parts of the head and neck are missing or must be removed, a problem far greater than with most parts of the body is present. To rehabilitate these patients to look like human beings, speaking and eating and acceptable to society, is a challenge. It is a challenge which we can meet in many situations. It is not a financially rewarding specialty. This is one of the reasons why few dentists

undertake maxillofacial treatment — an understandable situation not to be criticized. The financial aspect is why most of this service is performed in government institutions. This situation will be remedied when the proper people become more informed and educated in the treatment procedures. More financial aid will be available and more dentists will perform this service.

The Dental School prosthodontic department of the Health Sciences Division of the Virginia Commonwealth University now provides some of this service. The Chairman of the Department of Oncology of the Health Sciences Division and the Dean of the Dental School have made this service possible.

A member of the prosthodontic department is available for the following: *(1) to attend the clinical evaluation and treatment planning conferences, (2) to make preoperative impressions and casts of the maxilla and mandible and/or face, (3) to perform a comprehensive oral examination and complete all pre-irradition or presurgical prosthesis, (4) to construct immediate and treatment obturators, (5) to conduct postoperative conferences and treatments, (6) to act as consultant to the State Rehabilitation Center for patients with congenital defects, (These are primarily young adults with speech defects), (7) to assist the department of Oral Surgery by fabricating a surgical prosthesis, (8) to give lectures and demonstrations to the senior dental students (this is a part of the program that is conducted by Richard P. Elzay, D.D.S., coordinator of Cancer Teaching for the School of Dentistry) at the Dental School, and finally (9) to construct and maintain the definitive prosthesis.*

THE GENERAL PRACTITIONER'S ROLE

What can the dentists in general practice do to aid in this service? They can include in their diagnostic procedures a thorough visual and digital examination of the lips and soft tissues of the oral cavity. They can:—examine lateral margins of the tongue, the junction of the tongue and mucous membrane of the floor of the mouth in the region of the apex of the tongue, the lateral walls of the throat, and the soft palate; biopsy red and white lesions that persist over seven days after their inception or after the removal of the suspected cause; use cytology procedures in diagnosis even though they don't always reveal a malignant tumor; make casts of the maxillary and mandibular arches for patients prior to surgery of the head and neck involving the oral cavity. In some situations the prosthodontist does not see the patient in the preoperative procedures. He will not have casts unless the patient's dentist can furnish them. The preoperative casts are very valuable to the prosthodontist during the restorative procedures.

SUMMARY

1) Efforts to use artificial materials to replace lost or missing parts of the head and neck are not

new. The need for this service is becoming increasingly more necessary. In the last century members of the dental profession have been interested in developing maxillofacial prosthodontics to a more specialized science.

2) Members of the departments of Prosthodontics, Oral Pathology and Oral Surgery actively participate as a part of the team in the rehabilitation of tumor patients at the Virginia Commonwealth University School of Dentistry.

3) The general practitioner can be of invaluable assistance in the early detection of malignant lesions and take steps to aid in the rehabilitation of these patients.

Goodwill Ambassadors and Instructors: Under sponsorship of the American Prosthodontic Society, these dentists helped to promote better dentistry throughout the world by "teaching teachers" in foreign dental schools. Dr. A. L. Martone of Norfolk pictured (3rd from right) with the group, went to Japan.

RESEARCH NEWS

MEASURE DISINTEGRATION OF DENTAL CEMENTS IN MOUTH

Investigators supported by the National Institute of Dental Research have devised an appliance worn in the mouth that provides for comparison-testing of the disintegration of three dental cements.

It is a partial denture of cast gold with two large grooves or windows in which test cements are placed. Each cement remains in the mouth at least 30 days, and the dentures are weighed before, at intervals during, and at the close of the test to establish amount and rates of loss. Also, changes in the surface area are measured by a planimeter. The denture is removed only for cleaning.

Silicate cements absorb water and gain weight for several days after insertion. They are therefore weighed daily until they stabilize, and the test is run for the following 30 days. After each cement is tested, it is removed and replaced with another until the test series is finished. This way it is possible to learn the range of the individual differences and to make valid comparisons between cements under the same clinical conditions.

Distilled water and dilute acids have been used for laboratory tests of solubility and disintegration of dental cements, but hitherto no precise method of testing these factors in clinical situations has been available.

Investigators at Indiana University tested zinc phosphate, silicate, and zinc oxide-eugenol (ZOE) cements. They found considerable individual variation among patients in the rate and amount of loss of each cement. Two people lost less than five milligrams per square centimeter of exposed surface area of zinc phosphate in 30 days, whereas another person lost about 45 mg/sq cm in the same time. The other subjects fell in between these two extremes. Individual variation was even greater for ZOE and much less for silicate cements.

However, disintegration rates in the mouth had no direct relation to previous laboratory tests with either water or dilute acid. ZOE is much less soluble than the other two cements in the laboratory, yet disintegrates appreciably faster in the mouth. Much of this loss comes from abrasion. ZOE wears away 35 times faster with brushing, whereas zinc phosphate abrades only about five times as fast as silicate cement.

The research was conducted by R. D. Norman, M. L. Swartz, R. W. Phillips, and R. Virmani, who think that measures of both solubility and abrasion in the mouth are necessary for predicting the wearing quality of cements, and are of more value than laboratory tests.

NEW PLASTIC DECAY-PREVENTIVE TO BE TESTED

A new plastic paint to prevent decay on a tooth's grinding surface will be tested under a grant from the

National Institute of Dental Research.

Dr. Michael Buonocore of the Eastman Dental Center in Rochester, New York, who will conduct the study, already has shown the practicability of this approach. With another resin he obtained on 86 per cent reduction in decay after one year even though that material was more difficult to apply and in some cases became dislodged.

The new thin material, however, is quite easy to use, requires no drilling, and in preliminary tests has remained adherent for more than one year. It is painted on much like nail polish, but does not harden until an ultra-violet (UV) lamp is shined on it. Long-wave UV rays activate an agent in the resin that makes the plastic set immediately.

The dentist or hygienist paints the teeth that are to be protected from decay and then shines a gun-shaped UV flashlight on them. This changes the colorless liquid adhesive to a hard, smooth, nearly-invisible film.

If its effectiveness is confirmed, this easily applied therapeutic agent could be made available to large numbers of children, save countless man-hours of already overburdened dentists, and free much of their time for diagnosis and treatment of more difficult problems in many other patients. It also could be a boon to the handicapped who cannot brush their teeth or submit to long operative procedures, to military personnel, and to people living in areas where there is a scarcity of dentists.

The tooth's biting surfaces frequently decay despite fluoride's protective effects. Enamel in these areas is often thin or absent, and the pits and fissures normally found in these surfaces trap and shelter decay-causing microbes. Once decay begins in the pits, it can spread quickly throughout the tooth.

Under a grant of $47,600 for the first year of a study approved for three years, Dr. Buonocore will also test the adhesive on the surfaces between teeth. These surfaces will be coated before the adjacent tooth erupts.

In addition, he will try to anchor orthodontic wires with the adhesive and fill small cavities or line larger ones with it. An adhesive liner might seal metal, plastic, or cement fillings and stop decay-causing debris from creeping in between the filling and the tooth. Still other potential uses are to cover unattractive, poorly calcified, or stained teeth and to repair broken edges on front teeth.

ANIMALS CONTRACEPTIVES STUDY INDICATES CARIES INCREASE

Chicago — Animal experiments have indicated that the use of synthetic steroid contraceptives may increase the incidence of caries, according to a University of Missouri dental scientist.

Although findings obtained from these experiments cannot be applied directly to humans, they point up the need for further investigation, said Dr. Frank T. Y. Liu of Kansas City, Mo.

Writing in the December edition of *Dental Abstracts* published by the American Dental Association, he pointed out that the experiments were conducted at weaning or pubertal age in female rats.

The caries increase was in proportion to the dose level and frequency of administration of the two contraceptives used in the test. There was a synergistic or at least an additive effect between these two hormones in causing caries.

The hormones also caused a significant retardation of salivary gland development and general body growth, he said.

The increased caries incidence in the rats treated with hormones was probably not from the decreased food intake, body weight gain and thyroxine secretion, or from the increased secretion of estrogens and adrenocorticosteroids, he explained.

The decreased submandibular and parotid weights, as well as in the number and diameter of submandibular granular tubules in the hormone-treated rats, might have interfered with the physiologic functions of the salivary glands and consequently facilitated the carious lesion formations, he said.

These steroids also might have affected the chemical and physical characteristics and maturation of nutrition of the molars, increasing the susceptibility of molars to caries formation, Dr. Liu stated.

Dr. Liu is associated with the University of Missouri at Kansas City School of Dentistry. The article originally appeared in the *Journal of Dental Research.*

STROKES AND THE MOUTH

Persons who have suffered a stroke display a reduced ability to perceive objects in the mouth, according to a Temple University dental scientist.

Dr. Albert P. Solomon of Philadelphia said deficiencies in certain regions of the brain due to some type of injury cause demonstrable disorders including the failure to discriminate orally between different shapes.

Writing in the November edition of *Dental Abstracts*, Dr. Solomon noted that some of the problems of the deficiencies can be inability to wear dentures, irregular masticatory function and speech problems.

All three problems are directly related to the poor showing by stroke patients in the oral stereognosis testing procedures. He described oral stereognosis as the faculty of perceiving the three-dimensional shape of objects examined orally and identifying them.

Patients in an experimental group had suffered some type of stroke or cerebral vascular accident while those in a control group had no history of stroke, he said.

All persons were asked to identify 10 different geometric shapes which were placed in their mouths. The shapes were cut from thin plastic sheets.

With a total of 100 possible answers, the control group gave a cor-

(Continued on page 28)

Dental Legal Problems

by

F. W. Clement, M. D.

(Reprinted by permission from *Anesthesia*,
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Of recent years, there has been a marked increase in the number and nature of malpractice suits brought against physicians and dentists. Settlement out of court may tend to encourage such suits. Many a disgruntled patient has been known to threaten suit in order to avoid payment of a fee. The increased incidence of malpractice litigation has doubtless been encouraged by the (seemingly) large or excessive monetary awards determined by the court or jury. As a result, the cost of malpractice insurance has soared. To protect himself, the dentist will be inclined to refer his major or high risk patients to hospital for treatment. In such cases, the patients' pre and postoperative care becomes the responsibility of the hospital and anesthesiologist. This, of course, increases the cost of both medical and dental care to the patient.

Historically:

The current hazard of malpractice suits in the practice of medicine and dentistry is by no means of recent origin; in fact, it dates back to 1850, which marked the first medical malpractice suit of legal record. Professional liability insurance did not exist at that time. During the next fifty years, only ten malpractice suits are recorded. Dentistry, as a profession, started in this period. Josiah Flagg, a former major in the U.S. Army, started as an itinerant dentist in 1782. The first dental malpractice suit of record was in 1850. In this case, the dentist had guaranteed for one year, satisfaction with a set of teeth—or money refunded. Thus, for the first time, dentists were warned never to guarantee anything.

With the increase in travel, education and methods of communication, each succeeding decade showed a marked increase in malpractice litigation. This, in turn, led to the formation of companies, staffed by legal experts, to provide specialized legal protection and defense to both the medical and dental professions. Every field of specialty in dentistry presents hazards which may lead to litigation. Every dentist, whether he be in general practice or in a specialty is subject to the possibility of a law suit—merited or otherwise.

Oral Surgery, Exodontia and Anesthesia are all related fields in dentistry and are very frequently the source of malpractice suits based up-

on professional services. The claims associated with these fields are many and varied. Some of these claims alleging negligence or incompetence on the part of the operator are:

In Exodontia and Oral Surgery, removal of the wrong teeth or of more teeth than authorized; damage to crowns or bridges; failure to remove roots; forcing roots into the antrum; laceration of or injury to the lips, tongue or soft parts of the mouth and throat; infection due to unsterile instruments; nerve injuries; fracture or dislocation of the mandible; shock or tissue burns from x-ray or other electrical equipment; inhalation or swallowing of foreign bodies; hypodermic needles or dental burs broken off and fragments left in the tissues; etc.

In Anesthesia: Under local anesthesia—liabilities involve systematic reaction (convulsions, etc.) from intravascular injection of the local analgesia solution; nerve injuries resulting in loss of function—partial facial paralysis; paresthesias; intraoral infection; broken needles, etc. Under general anesthesia — various postoperative unfavorable systemic reactions; inhalation of a foreign body; injuries to the patient caused by restraint during the anesthesia; death from overdose of anesthetic agent; and hallucinations about supposed undue familiarity by the dentist during the anesthetic. (This reaction makes it imperative that a third party (preferably a female) be present during general anesthesia.)

Consent Forms:

While consent forms are of value in the dental office, it is certainly not expected that a patient sign a form for each and every treatment given. The fact that the patient came to the office for treatment and accepted that treatment is in itself a form of consent.

It must be remembered, however, that later on a patient may refuse or deny a written consent claiming that he did not understand or realize what he was signing. Also he may claim that he was under the influence of preoperative medication at the time and so was not responsible for his actions. In such cases, the consent may be worthless. A signed consent, however, does have both legal and psychological value. Knowing that he had willingly given written consent to treatment could cause the patient to hesitate about instituting any sort of legal action.

The need for signed consent will vary with the doctor-patient relationship. One reason given for the increase in filing of malpractice suits is due to the loss of the old fashioned doctor-patient relationship. Specialization could be partly to blame for this. The dentist who develops a real personal interest in his patient conveys to that patient that his interest is genuine and that he is not just another "case". Any proposed treatment or operation should be discussed in detail so that the patient has a clear understanding as to what is going on, what is expected of him and what the doctor hopes to accomplish. Further, complications and difficulties that may occur during the treatment should be outlined. A patient whose confidence

and cooperation has thus been secured will be very reluctant to file a malpractice action at a later date.

In the practice of both dentistry and medicine, it is impossible to stress too much the importance of good public relations with the patient.

Records:

The keeping of proper records in the dental office is most important. Various types of record cards are employed. This information will be useful if and when the patient returns to the office at a later date for treatment and will be invaluable in case of a malpractice suit. When the doctor is in legal trouble, there is something more important than his own office or hospital records. Such records should be legibly written and all unnecessary details or opinions omitted. The essential information should include the preoperative examination and evaluation of the surgical risk; the preoperative sedation, if any; duration of the anesthesia with remarks about any unusual reactions on the part of the patient; postoperative recovery time, etc. If the dentist should visit or treat a patient in the home or hospital, the details of all such calls should be entered on the patient's record card. Also, records should be made of any unusual or important telephone calls concerning a patient. The above records will thus be invaluable to refresh the doctor's memory, should the necessity arise at some future date.

The importance of keeping proper records and of maintaining the proper public relations with the patient is stressed in the following letter:[1]

"We realize the doctor can get bogged down in the detail of record keeping, but there is nothing any more important from the standpoint of defense when the doctor is in trouble than his own office records and hospital records. Legible handwriting should be stressed. Sloppy use of abbreviations should be deplored. Statements of opinion in records which are not necessary to the case can be most dangerous. Although facts do not change a doctor's impression or opinion concerning a certain fact, situations can change. In most areas there is a time lag between the rendering of the professional service and the filing of the malpractice action. This time lag is roughly two years. This further emphasizes the importance of records made at the time of the operation or treatment."

The following excerpts are from an excellent article by Harvey Sarner, L.L.B. which appeared in the April 1965 issue of the *Journal of the American Dental Society of Anesthesiology*.[2]

"The Standard of Care— The New and the Old

There is no controverting the statement that dentistry practiced 30 and 40 years ago was of a lower standard than modern dentistry. The level of dental care received by the general population has increased as has the level of care received by individual patients. What was acceptable dental practice in 1930 may not be ac-

ceptable in 1965, and what is acceptable in 1965, may not be acceptable in 1970. As the standard of dental care increases, the level of care required by the courts in considering malpractice claims also increases. What may not have been malpractice in 1930, may be malpractice in 1965, and what may not be malpractice in 1965, may be malpractice in 1970.

The legal standard of care required of the dentist is increasing as the actual standard of care increases. This is because the general legal principle remains the same at the same time the science and art of dentistry moves on. To understand this point, we must consider the legal standard of care.

A dentist is not legally liable for all injuries that result in his dental office. It is incumbent upon the patient to demonstrate that his injury was caused by some negligent act on the part of the dentist. Under the usual conditions, the patient cannot recover in court against the dentist unless he proves this negligence, even though he can show that he has suffered an injury. The patient proves negligence by illustrating that the dentist did not exercise the required standard of care. The standard of care required of the dentist in any given situation is that of the reasonably prudent dentist: that is, did the dentist in question act in the same reasonable manner as the reasonably prudent dentist would have under the same or similar circumstances? All the law requests of the dentist is that he will have acted in a reasonable manner under the circumstances. One of the circumstances is time. Using a procedure in 1930 may have been reasonable, but using the same procedure in 1965 could be considered unreasonable.

In determining the standard of care and the reasonable dentist test, expert witnesses are called to testify as to established practices in the community and to the state of the art and science of dentistry. They will testify as to the current level of dental care, and it will be no defense for the dentist to argue that he is using the procedure that he learned in dental school 30 years ago.

The purpose of this article is to explore the growth of the standard of care and its potential effect upon the administration of anesthetics. The following are admittedly speculative comments on what the courts may require of the dentist in the future; 'in the future', could mean 1970, 1969 or the next time an injury results from the administration of an anesthetic.

This statement could be interpreted to mean that progress places an increasing burden upon the dentist, and perhaps this is true. This burden is tolerable when it is considered in light of the fact that all the law asks of the dentist is that he act up to the standard of care of the reasonable prudent dentist.

Oxygen in the Dental Office

No reported lawsuit has been found in which the action was predicated upon the dentist's failure to have oxygen in his dental office. If

some dentists have oxygen, and some do not, then the law would probably find that it is not negligence not to have oxygen because some reasonable dentists do not have it. As more and more dentists have oxygen available in their dental offices, however, it becomes more a question of the reasonable dentists having oxygen and the unreasonable not having it. When it is only the unreasonable who do not have it, then the courts can quickly find that the dentist was negligent in not having oxygen. In this case, if it can be shown that the patient's injury would not have resulted or would have been less severe if the doctor had oxygen, the dentist will be found to have been guilty of malpractice.

The prevalence of oxygen in the dental office is a prime example of how the dental profession increases its own standards of care and makes the marginal practitioner conform to increased standards. It is submitted that this is a desirable and professional approach.

Aspiration Before Injection

A combination of increased usage and recommendations from recognized authorities could have the effect of raising the standard of care. The best example of this is the use of an aspirating syringe.

It is clear that, back in 1930, there was no malpractice in failing to use an aspirating syringe. And this was probably true in 1960. In 1970? In 1965? When the situation exists in which the reasonably prudent dentist uses an aspirating syringe and the unreasonable does not, then the mere failure to use one will probably constitute malpractice and make the dentist liable for any resulting injury. *Accepted Dental Remedies* contains at least two recommendations that the dentist use an aspirating syringe. *ADR* says, 'Care should be taken to utilize a syringe which permits aspiration before injection, to minimize the danger of intravascular injection', and 'Clinical evidence has shown that the untoward reactions of local anesthetic solutions can be minimized by the following preparations: (1) Prevent intravascular injection by attempting to aspirate blood before injection.'

Perhaps it would be argued that only the extra prudent dentist takes the precautions as outlined in *ADR*. When the *ADR* recommendations are viewed in conjunction with the recommendations of the accepted experts in the field, however, there is every indication that some day a court may find the mere failure to aspirate before making an injection to constitute negligence.

The Disposable Needle

The same comments made about oxygen in the dental office and aspiration before injection are applicable to the use of the disposable needle. The use of the disposable needle may become so widespread in the future that a court could find the dentist was negligent by not using a disposable needle. According to one industry source, presterilized disposable needles are present-

ly being used by 60 per cent of the practitioners most of the time.

At one time, the needle presented the most common subject for dental malpractice lawsuits. The lawsuits fell into two general categories. First, there were the nonsterilized needle cases, which the patient inevitably won. If the patient was able to demonstrate that the injury was caused by using an unsterilized needle, the patient usually won the lawsuit since the dentist could not argue that the reasonably prudent dentist would use an unsterilized needle. This precedent has been so firmly established that it is rare that this sort of case ever comes to trial.

The second category involves the broken needle. The dentist who broke a needle and removed the tip, or referred the patient to someone capable of removing the tip, usually was protected by the courts. The courts have been saying that the needle tip can be broken even when used by the reasonable prudent dentist. But, if the patient was able to demonstrate that the reason the needle broke was because the dentist attempted to use the same needle too often, the patient might show negligence on the part of the dentist. The dentist who broke off the needle and did not remove it or inform the patient, usually lost the malpractice suit on the grounds that he was negligent in failing to remove the tip or inform the patient and not on the grounds that he broke the tip.

To date, no case is known in which failure to use a disposable needle by itself constituted negligence. This may be so in the future. But, if the use of disposable needles becomes so widespread that only the unreasonable dentist sterilizes his own needles, the court may find that any time the dentist breaks off the needle tip, he was negligent because he failed to act like the reasonably prudent dentist and use the disposable needle.

The essential point of this article is that, as the level of dental care increases, the law requires more of the reasonable dentist. This is progress and professionalism at its best."

Cardiac Arrest:

The responsibility of the dentist for the treatment of cardiac arrest occurring in his office during anesthesia or otherwise, has not been definitely established and varies in different states. Certainly the dentist would not be expected to perform the open chest procedure; however he should be familiar with the closed method of resuscitation and continue with such while awaiting other medical or surgical assistance. Years ago little was known about the causes or treatment of cardiac arrest. Now, however, whether it occurs in the operating room, in the dental office or clinics, on the street or in the home, a definite routine has been established to deal with this emergency. All medical and paramedical personnel are expected to be familiar with a method of dealing with this emergency.

Legal Fees for Services:

Every dentist will, at one time or another, have trouble in collecting

his fee from a patient who professes dissatisfaction with the treatment rendered. At times, a patient, in order to avoid payment may threaten to file a malpractice suit. In such cases, should he so desire, the dentist may waive or reduce his fee without prejudicial effect even though he was later charged with malpractice. His reason for so doing would be, of course, to avoid a possible threatened lawsuit. Should the dentist reduce or cancel his fee, he should explain to the patient that he is so doing for two reasons, one being because of the patient's dissatisfaction and the other the wish to maintain a good doctor-patient relationship. Further, he should point out to the patient that the above action in no way constitiutes any reflection on the quality of the services rendered.

Though collection agencies are commonly employed to effect payment of delinquent accounts, the dentist should exercise restraint and decide with care, which accounts should be given for collection, rather than having delinquent accounts automatically referred to the agency. There may be some very good reasons why an account has not paid, such as wrong address, vacations or death in the family, etc. Collection agency tactics may serve to antagonize such patients and the dentist is the loser.

Should the dentist consider his treatment of the patient has been proper and without negligence and that the patient has the ability to pay, he must decide whether or not it is economically worthwhile to take legal action to enforce payment. Should he file suit, the patient, through his lawyer, may file counter suit. Frequently he may find that preparation for the trial will entail much of his time, with perhaps several appearances in the courtroom, plus the unfavorable publicity, so he decides the time lost from his practice is excessive and he becomes willing to settle out of court in the smallest amount he can.

On the other hand, the dentist may decide that for reasons other than financial, legal steps should be taken to enforce payment. Such a decision may be influenced by the fact that it is now possible to secure insurance which will reimburse the doctor while absent from his office, up to 200 or more dollars per day.

To summarize:

1. A waiver or fee reduction is not an admission on the part of the dentist of an inadequate or poor treatment.

2. Should the result be questionable, suit for collection should be avoided. A waiver or reduction of fee may avoid legal trouble.

3. Even if the treatment were proper and negligence denied, legal action to enforce payment may not be economically profitable.

Malpractice Insurance:

In 1965, the assets of the companies handling all kinds of liability insurance quintupled since 1944, to more than 33 billion. In 1964, Americans

paid more than $4 billion in liability insurance premiums to finance payments to injured people, 11 times what they paid 20 years before. It is estimated that 9 to 10,000 malpractice actions are filed each year and court judgments plus settlement costs out of court amount to 50 million dollars per year. Awards range from a few thousand dollars to well over a million. In one instance, a 2 million dollar award was against an airline and airplane manufacturer for the death of a passenger killed in an air crash.

No medical or dental doctor should think of practicing his profession these days without adequate malpractice insurance protection. This protection should be sought through a company which specializes in this field. Such a company offers lawyers and investigators who work full time on malpractice cases. They are familiar with medical and dental terminology, know what questions to ask, what records are important and all legal details pertinent to such procedures. Doctors should employ only the insurance companies approved by their societies and stay away from those companies which write malpractice insurance only occasionally.

How much protection should a doctor carry? Many years ago, a policy for 5 to 15,000 dollars was quite adequate. Today, the picture has vastly changed. Because of the ever increasing frequency of liability litigation, plus awards up to and exceeding a million dollars, the amount of dollar protection considered adequate and the premium costs have soared accordingly.

Minimum protection should be in the amounts of $100,000 to $300,000. For a relatively small extra fee, the applicant may secure the added protection of what is known as the 'Million Dollar Umbrella Coverage'. This umbrella policy will cover all the awards and settlements that exceed the other liability policies, up to one million dollars. In addition to this professional protection, it covers personal liability relating to incidents other than professional. The protection and ease of mind provided by this type of policy makes its cost well worthwhile.

Many doctors feel that because it is generally accepted that all doctors carry ample liability insurance, that this fact tends to influence jurors in the size of the awards to the patient. Also that the contingency fee system influences the size of the awards.

In this respect, an article in *Medical Economics*,[3] relates:

"Question: Landau — 'The fact that plaintiff's attorneys get a percentage of the recovery, they feel encourages unrealistically high demands.'

Answer: Hassard — 'Our experience in polling jurors routinely after all malpractice trials indicates quite strongly that many jurors assume the plaintiff's attorney will take one third of any award. They therefore, increase the size of the award to make sure the plaintiff gets the amount they intend for him.'

Answerback: 'I think the contingency fee is a source of a great deal of mis-

understanding between doctors and lawyers. It is unethical for a physician or dentist to have a contingent interest in his own case; his compensation, obviously, must not depend on the outcome of his treatment. Many doctors are so accustomed to this professional ethic that they have difficulty understanding that the attorney is in a different professional situation. The attorney is an advocate, the doctor is not. The contingency fee system encourages attorneys to reject a case because the prognosis is poor. Finally, the contingency system is the only way a poor man can afford legal help in pressing a just claim.'

Morris: 'Certainly there are very strong arguments in favor of contingency fees. But that doesn't mean they shouldn't be regulated. I see no reason why a lawyer should take 50% of a million dollar recovery. He can't possibly do that much work on a case.'

Answerback: 'Lawyers who charge 50% are few and far between and judges who permit that high a fee are fewer still. In New York, judges have called 50% unconscionably high; 33⅓% is usual for negligence cases.' "

Malpractice Prevention:

To avoid or minimize the chances of legal trouble in your practice, become familiar with the following important points:

1. Keep accurate records permanently. Suits sometimes arise scores of years after the rendering of services.

2. Keep up with the average standards of your field of practice in your locality. This the law requires you to observe.

3. Avoid criticism of the work of other doctors. To do otherwise not only invites censure, but also weakens your own defense.

4. Avoid admissions against your own interest on services you have rendered or anyone else has rendered in your behalf.

5. Learn and observe your legal responsibility to the patient.

6. Use the x-ray as a diagnostic or confirmatory aid where that is established practice.

7. Guarantee no results. Such guarantees are unethical.

8. Cooperate with the patient in securing the aid of consultants. These strengthen defenses.

9. Give proper notice of termination of services so as to avoid charges of abandonment.

10. Keep professional confidences of your patient strictly privileged.

11. Avoid divulging that you have professional liability coverage.

12. Refrain from unapproved or experimental procedures.

13. Be courteous and tactful in relations with patient.

14. Advise patient of any absence from practice and recommend or make available a competent substitute.

15. Make certain that proper instructions are given with prescriptions or in the care of patient.

16. Have, whenever possible, unprejudiced witness of your relations with the patient, especially in the case of female patients.

17. Establish a clear understanding relative to fees before services are rendered, specially if such fees are of sizable amounts.

18. Postpone, whenever possible, any suit for fees until after the statute of limitations on malpractice suits has expired.

19. Secure legal advice before attending a coroner's inquest as a witness.

20. Secure legal advice on how to make your personal assets less vulnerable to damage suit attacks.

21. Avoid telephonic prescriptions without proper verification.

22. Keep all equipment in proper working order.

23. Avoid fields in which you are not properly qualified.

24. Keep all promised appointments.

25. Give proper instructions to assistants and make certain that they are observed.

26. Keep up with manufacturers' warnings of possible adverse drug reactions.

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Footnote: The author wishes to thank the legal staff of the Medical Protective Company of Fort Wayne, Indiana, for their interest and cooperation in the preparation of this paper.

STROKES AND THE MOUTH

(Continued from page 18)

rect response in 90 per cent of the choices while the study group gave a correct answer in 57 per cent of choices, Dr. Solomon stated.

In a second test the percentages were 96 per cent and 49 per cent. The results show a definite inability on the part of the stroke victim to identify simple shapes in their mouths. In both tests the control group consistently had more correct responses for each shape than the study group.

Difficulty of perception of shape in the mouth increases as the similarity between shapes is more pronounced and decreases as the shapes are distinctly different from each other, he added.

Dr. Solomon is associated with Temple University dental school. The article originally appeared in the *Temple Dental Review.*

Dental Building II

by

Felix E. Shepard, D.D.S.

Fundamental changes during the past year have affected the basic structure of the Medical College of Virginia. In July of 1968, Virginia Commonwealth University was established. The Medical College of Virginia became the Health Sciences Division and Richmond Professional Institute became the Academic Division of the new University. The component divisions have progressed well since inception of the program.

Dental Building II marks a significant expansion of dental education in Virginia. The Wood Memorial Building, the previous center of the dental education program, opened in 1954. Classes of fifty-four students were accomodated in laboratory, classroom and clinical instruction. Over the years, the increasing needs were met by the expansion of existing facilities to accomodate instruction to a level of seventy-five, then eighty students per class. The last increase exhausted all potential expansion of physical facilities. The rising population indicated a demand for more dentists. Moreover, the need for trained and efficient auxiliary personnel was apparent. Dental Building II, ultramodern, five levels building, was planned and developed to meet this challenge. The first class of one hundred freshmen students was admitted in September 1969. At the same time, the first class in dental hygiene training began with six students.

The quality of any educational system depends on the new ideas incorporated in the physical plant and their adaptability to the education of the student. Teaching techniques and learning improve in an environment helpful to learning. This environment should challenge both faculty and students and help them to keep abreast of the advances in dental education. This presentation is concerned with the physical plant of Dental Building II and related areas most significant to updating of dental education.

PHYSICAL PLANT

Dental Building II faces 12th Street on the site previously occupied by the Buildings and Grounds Office and Post Office. Directly behind and connected to it is the Wood Memorial Building. Clinical, laboratory and office space for certain departments will be expanded and changed to meet the needs of those concerned.

The long, rising glass panels on the front of the new building (Fig. 1) accentuate the modern design. Beyond the entrance, the general layout welcomes you to one of the most progressive educational plants in the country.

Fig. 1 Front view of Dental Building II.

RECEPTION AREA

One enters the building through a granite-paneled foyer. Elevators to the right go to the upper floors. Directly beyond the foyer, an escalator takes patients to the second floor reception room. The return escalator is opposite.

The reception room (Fig. 2) is in the wing between the buildings. Accessible to all the clinic areas, this spacious, carpeted room provides a comfortable, relaxed atmosphere.

An electronic panel at the reception desk monitors the paging, intercom system throughout the two buildings.

CONSULTATION ROOMS AND CLINICS

From the reception room, patients may go to the consultation rooms, orthodontic and oral surgery clinics on the south wing. The main operative clinic is in the north wing.

Three consultation rooms are adjacent to the reception area. Unlike an open clinic, the rooms allow the student a chance to appoint patients and arrange consultations with various departments. This encourages the student to become more self-reliant and relaxed as he applies what he has learned.

The clinics have the newest equipment. Individual oral surgery cubi-

Fig. 2 A view of the reception room in Dental Building II.

cles have central suction, oxygen and air outlets as well as ceiling-hung lights and mobile units. Provisions are made in the clinic for a shielded x-ray cubicle. There is also a large centralized sterilization alcove.

The east wing of the operative clinic is set up for the Dental Assistant Utilization Program (Fig. 3). Larger cubicles and wider aisles afford a less crowded, more efficient working arrangement. Contoured lounges, high velocity suction, individual mobile cabinets, etc. make instruction in "Four-Handed Dentistry" easier. This program has been updated considerably to orient the student to his role in team responsibility.

UNIT LABORATORIES

The first and third floors accommodate the student unit laboratories (Fig. 4) and study halls. Five laboratories for each class are equipped for twenty students each. At each entrance, separated from the main working area, is the "dirty room", where all investing, casting, pouring or models, etc. is performed. There are television receivers throughout the laboratories for viewing tapes and live demonstrations. An intercom system at each work bench connects the student with the central T. V. control room for questions and answers.

Rather than a crowded, disorderly place, the laboratory becomes a learning area. Students are averse to noise and crowded conditions. In the past the student was hindered, rather than helped, to use the laboratory experience as a time of learning. Limiting the number of students per laboratory provides for more individual comfort and a larger area of operation. It also encourages a better student-instructor ratio. Personal instruction and less tension prepare a student to face the clinical and practical years ahead.

A study hall is associated with each group of laboratories. This en-

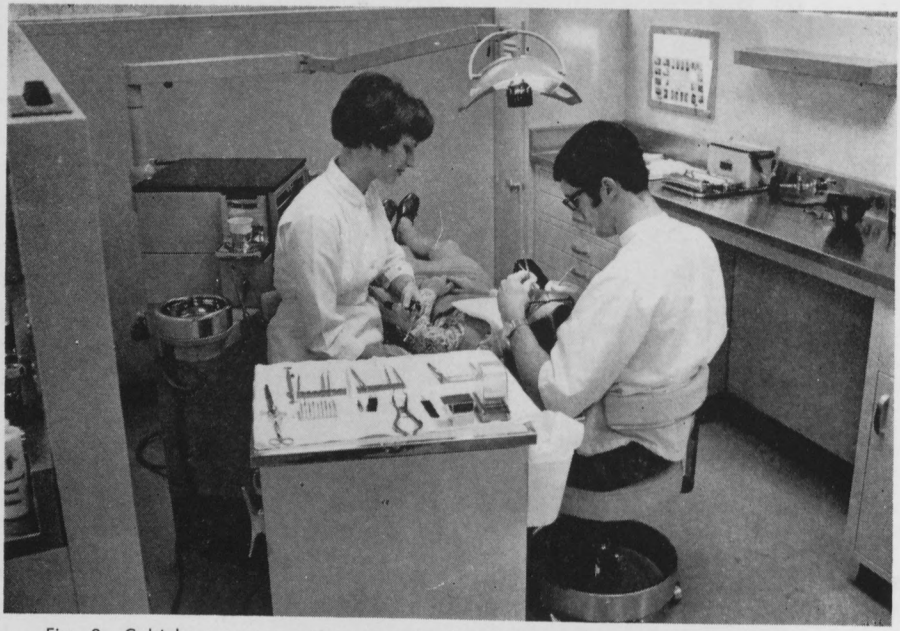


Fig. 3 Cubicle arrangement as seen in the Dental Assistant Utilization clinic. An example of cubicles in the other clinical areas.

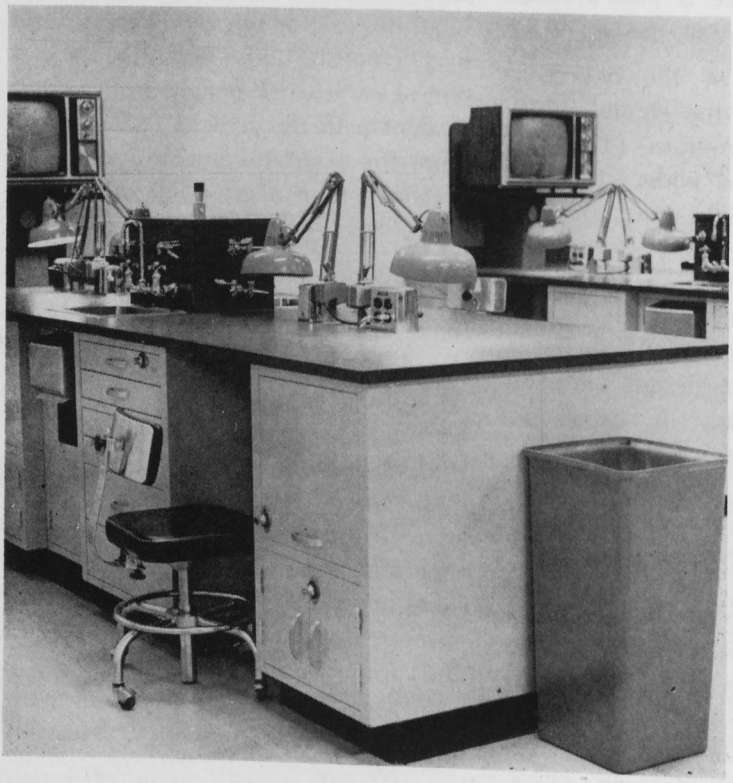


Fig. 4 An example of student working area in the laboratory.

courages the student to be better prepared, more self-reliant and willing to progress on his own.

Laboratories on the first floor will be available for training of dental technicians in the future.

LECTURE ROOMS

The fourth floor lecture rooms (Fig. 5) are designed for presentations. Rows of cushioned seats are elevated from the front to the rear of the room. Students enter from the rear of the room than from the front. This prevents disturbing the speaker or other students while a class is in session. The lecture works from a platform provided with a lectern, blackboard, microphone and projection screen. A telephone on the wall is connected with the T.V. control room. This telephone is used to tell the studio director when to start, stop or repeat T.V. tapes at any part of the presentation.

Television receivers are suspended from the ceiling. The projection area is in the rear of the room. The lighting is adjusted for proper illumination of the room at all times.

AUDIOVISUAL

Probably the most updated part of the program is the audiovisual facility of Dental Building II. The success of many phases of dental education depends more and more upon these media.

Fig. 5 Lecture room

Fig. 6 A view of the TV Control Room and one of the demonstration rooms in Dental Building II.

The fourth floor T.V. studio (Fig. 6) consists of a control room and two demonstration rooms. Tapes and live demonstrations are monitored here and channeled to the lecture rooms or unit laboratories for student viewing. There is a connecting cable to the Oral Surgery Clinic. Programs may be presented directly from the clinic for instant viewing or taping.

It will be the responsibility of the faculty to make and provide video tapes for future use. The student is encouraged to review these tapes periodically in his preparation for lectures, laboratory procedures, examinations and clinical operations. During certain evening hours tapes may be viewed.

The Audiovisual Department of MCV designed and operates these systems.

In the past, it was impossible to foresee the changes in the concepts of dental education that we have today. Likewise, it is still difficult to project what the future may bring. Even though the dental facilities at VCU seem complete, there may be more demands. In this event, dental education in Virginia will be expanded and changed to meet the needs of the student, the profession and society.

COMPREHENSIVE HEALTH PLANNING

by

Henderson P. Graham, D.D.S.

I'm sure that all of us remember the old saying, "Where there is life, there is hope", and I'm equally sure that the 89th Congress took this into consideration when they passed Public Law 89-749, a Comprehensive Health Planning legislation. This law was enacted as a result of a crisis in our health care system where health services, facilities and manpower resources have fallen far short of the needs of health consumers. It is designed to strengthen planning at all levels, and in particular, encourage development of comprehensive, rather than *categorical* health services at the community level. Health planning per se is not a new concept, however, *comprehensive health planning* is a new approach, and is exerting real influence in the shaping of our health care system that must be responsive to health demands being generated throughout the United States.

Our health policy of today requires a system of comprehensive health that is accessible and available to all of our citizens on a continual basis. It is essential that the system encompass all major components including *preventive, diagnostic, therapeutic* and *rehabilitation services.* Involved in the process are the pooling of public, private and voluntary health agency resources, with planning and decision-making responsibilities shared at all levels by both providers and consumers of health services.

The basic objective of P. L. 89-749, popularly known as the "Partnership for Health Act", is to *coordinate*, (and this is a *key word* that is repeated all through this legislation), the e n t i r e gamut of community health resources, including health personnel, health facilities, and health services, for the purpose of providing the finest health care possible without expensive duplication.

Pressures are developing in problem areas to provide additional health manpower in literally all health categories; licensing of health manpower; more hospital beds; more nursing home beds; and more extended care facilities. And this is of key importance to all of us to provide these, within a price range that we, the taxpayer, can afford to pay.

We must recognize that Virginia is widely divergent in character, and that community needs vary to a major degree, throughout its geographical boundaries. In essence, this is why local, regional and state planning groups, committees, councils and commissions are mandatory. The health and medical care segment

must join forces with the consumer group who certainly possess, by virtue of their community involvement, the local "know-how", and who recognize their health needs.

It should be recognized that knowledgeable consumers can make contributions which will result in improving our health care system.

What are the major health problems confronting health officials today in America? Certainly in all parts of our country they include the following:

(1) maldistribution of health services (accessibility and availability); (2) spiraling costs of medical care; (3) severe shortages of medical care facilities; (4) severe shortages of health manpower; (5) fragmentation of health services; (6) quality care; and (7) transportation to health care.

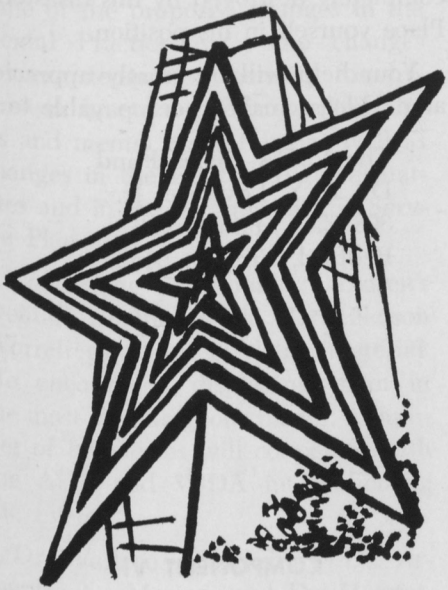
It is ironic indeed that despite tremendous advances in the medical science field and our national annual investment in health of more than $56 billion, literally millions of our citizens are denied access to quality health care. By and large, these are our citizens who reside in high population density areas, and our ghettos and in rural pockets of America.

Costs of medical care are of increasing concern. The rapid and continuous rise is partly due to the development and implementation of new and costly diagnostic and treatment techniques; and an upward (and well deserved) surge in hospital wages as these employees become more and more competitive with industry. Since wages comprise 75 per cent to 80 per cent of overall hospital operations, it is impossible to reduce costs if we limit our approach to this area. A far more practical approach might be an analysis of the average hospital stay per patient which this past year averaged 8.4 days. If this average stay could be reduced merely by one day per patient stay throughout America, more than $1.7 *billion* would be saved. We should not complacently accept hospital stays of so many days, but we must be extremely careful not to adversely affect the quality of needed care for each individual patient but conscientiously, we should launch a vigorous effort to ensure that each day of hospitalization is necessary. This decision, of course, must in the main, be decided by our personal physician and the hospital industry.

If we hope to surmount these problems, it is imperative that we develop a sound planning approach. Comprehensive health planning is a road map that, if properly used, will make it possible to congregate health services, which will provide preventive, acute, and rehabilitative care, in accessible locations, and through a reasonably organized health care system, at a cost our people can afford. This is our task — this is our challenge.

210 Center Building
Marion, Virginia

COMPONENT NEWS



COMPONENT V

W. C. Williams
Associate Editor

On November 14 and 15 the Piedmont Dental Society and guests met at the Homestead for the 54th session. The meeting was conducted by President *Curtis Woodford* and featured an address by *Dr. Myron Henderson*, President of the Virginia State Dental Association. The clinician, *Dr. Donald K. Pokorny*, chairman, Fixed Prosthodontics Section, University of Detroit lectured.

Dr. Pokorny, speaking on successive days, divided his material into two parts: I. the Specific Interrelationship between Operative Dentistry and the Periodontium; II. Current Concepts of Occlusion. He stressed the importance of clinical diagnosis, basic concepts of occlusion, and periodontal evaluation in full mouth rehabilitation. He stated, "The problems occurring after restorative dentistry could usually be prevented by following the basic concepts of good dentistry." When the general dentist encounters a case where he feels his skill is limited, he should not hesitate to refer. In fact, it is his

Dr. Curtis R. Woodford, immediate past president and Dr. John S. Young, president of Piedmont Dental Society.

grave responsibility to the patient to do so.

The meeting was concluded with a business session at which time Dr. H. Marvin Midkiff of Martinsville was named President-Elect.

Let's all remember the severe physical and financial hardship imposed on a fellow dentist, Dr. Rudolph J. Radick of Buena Vista, by the flood of Hurricane Camille. Dr. Radick's dental office and equipment were completely destroyed by this disaster. Place yourself in his position.

Your help will be greatly appreciated. Please make check payable to:

The VSDA Relief Fund
Dr. E. Y. Lovelace, Jr.
308 East Main Street
Bedford, Virginia 24523

COMPONENT VI

Howard B. Stanton, Jr.
Associate Editor

The Southwest Virginia Dental Society celebrated its biennial General Assembly Day in Abingdon on December 4, at the Martha Washington Inn. Area Congressmen and State Legislators attended the social hour and dinner as guests of the society.

Two senators and seven delegates came with their wives. They heard the views of the dentists about bills upcoming in the 1970 General Assembly. Each lawmaker spoke briefly.

At the business meeting, Dr. Dan Reasor urged the recruiting and training of dental technicians in the community college system. He said we have emphasized the assistants and hygienists programs, but the number of dental technicians is declining. It is urgent that more be trained.

Dr. Howard Stanton presented a change in the Component Constitution and Bylaws concerning the term of the Executive Councilor, to be

voted on at the March meeting.

Dr. Henderson Graham presented some of the proposed changes in the Dental Practice Act. The changes concern temporary permits for hygienists in state public health clinics and mental institutions as well as changes in the Dental Hygiene Statutes and in the Virginia Dental Service Plan.

Concerning National Children's Dental Health Week, Dr. Nelson Worrell gave out publicity material. He encouraged displaying them in the most advantageous places. A number of businesses will cooperate with the ADA and VSDA in publicizing the event.

Dr. Wallace - Blacksburg, Dr. Armentrout - Marion, and Dr. Hofstetter - Bristol were elected to membership.

Dr. John T. Kelly, Chairman of the State Public Information Committee announced that the slide and tape presentation "Careers in Dentistry" developed by the Dental Education Committee is now available from the Central Office and each component has a copy. These are used in high schools as recruiting aids.

Doctors Jack D. Cole, president-elect, Keith D. Speer, president and Henderson Graham at Component 6 Business Session.

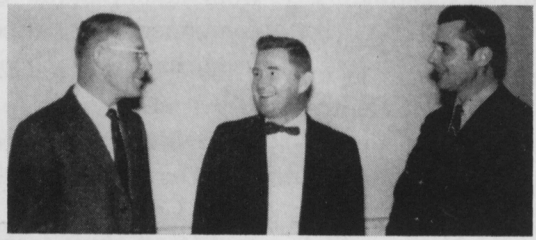
Dr. Kelly announced that the Bristol Dental Society, in conjunction with Component 6 is sponsoring a registered clinic featuring Dr. Harold C. Kilpatrick. The all day clinic is open to both dentists and staff. It will be at Bristol's new Y.M.C.A. building on March 4, 1970. He requested that registrations be made as far in advance as possible and opened the invitation to the rest of the state. This clinic precedes the next meeting of the component on March 5.

Dr. French Moore, Sr., reported that the International Relations Committee will use its $300 appropriation in other ways than in the past, to aid in sending instruments and literature overseas.

Dr. Peyton Rowlett of Tazewell was commended for donating 47 years of the *ADA Journal* to the Emory and Henry Library.

Dr. Keith Speer introduced Dr. Carlton Gregory, President-elect of the VSDA. Dr. Gregory asked all members to help solve dentistry's problems. "We need to solve our internal problems first, such as education and participation, and then our external problems such as public relations, government programs and prepaid plans," observed Dr. Gregory.

Dr. J. Barnes Sanders, Life Member of the ADA, deplored the VSDA's action in increasing the age require-



Dr. R. F. Jackson (l) and Dr. Keith D. Speer (R.) discuss the program with Dr. J. Marvin Reynolds, clinician.

ment for VSDA life membership. He said, "Virginia is the only state that has such stringent requirements. If we are that broke, we ought to go out of business."

Dr. French Moore, Jr., Vice Chairman of the State Executive Council, read a plea from the Living Endowment Fund. He said that the Council requests that no dentist sign agreements with the State Health Department or any other organization which is not approved by the Virginia Dental Service Plan.

Dr. Robert F. Jackson introduced the clinician, Dr. J. Marvin Reynolds, Professor of Crown and Bridge Prosthodontics at MCV. Dr. Reynolds presented some of the newer ideas in fixed prosthodontics.

"Don't go any closer to the tissue than conditions force you to. Look at the tissue. Don't the restorations cause gingival retraction and inflammation no matter how smooth they are? If at all possible, keep margins away from the tissue," he said.

These same criteria should be observed with amalgam. The margins should be kept away from tissue and in *cleansable* areas.

Dr. Reynolds advocated the designing of restorations from the dynamics of mandibular movement as well as the static relation of centric. Since the mandible moves more than it is at rest, we must provide for these movements both in the restoration and the preparation. We must consider where the opposing cusps are in centric, but more importantly, we must consider where they go in chewing and idling.

"In designing the preparation and the restoration, satisfy the demands of the case and then quit," Dr. Reynolds summarized.

Following the business and scientific sessions, the members joined legislators and other guests for the social hour and banquet.

JOIN THE VIRGINIA DENTAL SERVICE PLAN: IT'S GOOD BUSINESS!

Mr. Willmore B. "Cy" Hastings
Charlotte, North Carolina

"Telling Our Story To The Public"

WORKSHOP ON SPEAKERS BUREAUS

APRIL 10-11, 1970

Cascades Meeting Center
Williamsburg, Virginia

Sponsored by:

Virginia State Dental Association, Women's Auxiliary to the VSDA, Virginia Dental Assistants Association and Virginia Dental Hygienists Association

Send In Your Reservations

FRIDAY NIGHT: Meeting and reception

SATURDAY: Group meals and meetings, individual workshop sessions in the afternoon, closing with evening banquet

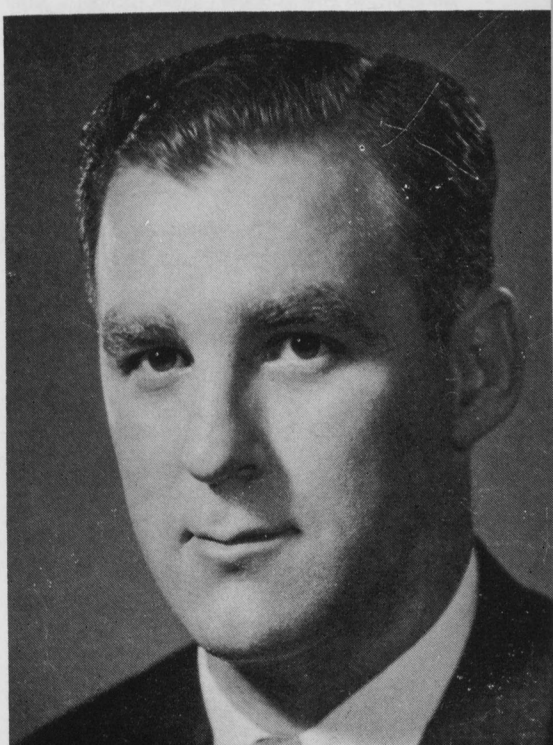
SPEAKERS AND CONSULTANTS:

Mr. W. B. Hastings
Charlotte, North Carolina

Mr. Peter C. Goulding
ADA, Chicago, Illinois

Professor Raymond Hodges
Faculty, VCU, Richmond, Virginia

Mr. Peter C. Goulding, Assistant Executive Director, Public Information, American Dental Association, Chicago, Illinois



"I See By the Paper . . ."

MOBILE DENTAL UNIT IN USE AT RUSSELL SCHOOLS

RICHLANDS NEWS-PRESS

Richlands, Va., Nov. 26, 1969

Through the combined efforts of the State Department of Education, the Russell Area Development Corporation and the Russell County School Board (Elementary and Secondary Education Act) have been able to secure a mobile dental trailer for use in the Russell County Elementary Schools.

The dental trailer is equipped with two chairs. An aide has been employed to assist Dr. D. E. McDaniels. Elementary and Secondary Education Act Funds have made possible the employment of an aide.

The services of the school dentist are available only to indigent children in grades two and seven and children attending the Head Start Program.

The dental unit is currently located at the Copper Creek Elementary School and will serve the Grassy Creek and Oak Grove Schools in addition to the Copper Creek School. After completing work at these schools, the unit will serve the following schools during the 1969-70 term: Castlewood Elementary, Lebanon Elementary and Cleveland Elementary.

ORAL CANCER CLINIC SCHEDULED FOR DEC. 10

TIDEWATER NEWS

Franklin, Va., Nov. 13, 1969

An oral cancer screening sponsored by the Southside Dental Society, Southampton Temple 15 Pythian Sisters and the Southampton Unit of the American Cancer Society is scheduled for Wednesday, Dec. 10 in Franklin.

Jack L. Russell, information officer for the State Department's Division of General Health planned the clinic.

The clinic will be held from 2 to 6 p.m. in the offices of Drs. Edwards, Dodson and Rawlings, 516 N. Main St.

The examination for adults over 21 is painless. Oral or mouth cancer can be cured when detected early.

The eight dentists that will work the clinic are Dr. Barham Dodson, Dr. Hubert Rawlings, Dr. Robert T. Edwards, and Dr. Darden W. Jones, of Franklin, Dr. Winston Brown, Boykins; Dr. J. R. Hager, Zuni; Dr. Earl Strickland, Ivor. Dr. Steven Bissell, Petersburg, will be the oral surgeon.

Fifteen ladies from the participating organizations will assist the dentists.

Recent clippings from Virginia newspapers about dentistry and members of the Association

CANCER SOCIETY PLANS DENTISTS' EXAMINATIONS

VIRGINIA GAZETTE

Williamsburg, Va., Oct. 24, 1969

On Sunday (Oct. 26) Williamsburg area residents will be able to visit the dentist free of charge and without pain.

Under co-sponsorship of the local Health Department, Cancer Society and Dental Society, all persons over 21 years old can be examined by a dentist for possible early signs of cancer of the mouth.

The clinic is scheduled from 1 p.m. until 5 p.m. at the Public Health Center behind the Williamsburg Community Hospital on Mount Vernon Avenue.

It is the seventh Mouth Cancer Detection Sunday in Virginia, and the first in the Peninsula area. More than 300 dentists, assistants and volunteers will be taking part in the statewide effort.

The attending dentists will examine the patient's face, jaws and soft tissue inside the mouth. The examination is quick, painless and free.

The American Cancer Society reports that the chance for recovery of mouth cancer is eight to one if the cancer is found before it has spread to other vital areas.

Other clinics in the area will be at Riverside Hospital, Langley Air Force Base Dental Clinic, Hampton Health Department, Fort Eustis Dental Clinic.

OWENS TO SEEK HALL'S VACANT SEAT

VIRGINIAN-PILOT

Norfolk, Va., Nov. 14, 1969

CHESAPEAKE — Dr. Hugo A. Owens, who announced Monday as a candidate in the June councilmanic election, said Thursday he will seek election to the seat made vacant Wednesday by the death of Councilman Colon L. Hall.

A special election to choose a replacement must be held within 60 days of council notification to Corporation Court that a vacancy exists.

The judge of Corporation Court and Circuit Court are also required to choose an interim replacement until a special election is held. The election date has not been set.

Owens is the only announced candidate for the June election in which all nine council seats are at stake. Hall's term of office runs until Sept. 1, 1970.

Owens, 53, is a dentist, a member of the Democratic City Committee, and a member of the City Highway Safety Commission. He is an honor graduate of Howard University's College of Dentistry.

Fifth District ADA Caucus Breakfast. Standing (L. to R.) — Doctors Jason R. Lewis, T. Roy Jarrett, Jr., and L. Ray Shields. Seated (clockwise) Doctors Carlton E. Gregory, L. O. Clark, Jr., W. H. Traynham, Jr., Byrnal M. Haley, Myron E. Henderson, Mrs. L. L. Bailey, Executive Secretary and Doctors Thomas T. Upshur, Thomas C. Bradshaw and Alexander L. Martone. — Virginia Delegation.

ADA Meeting - New York 1969

Final registration at the 110th Annual Session of the American Dental Association reached 27,946 persons, one of the largest attendance totals ever. Of those registered, 11,033 were ADA members, 2,413 dentists from abroad, 863 students, 1,441 dental assistants, 951 dental hygienists, 377 dental laboratory technicians, 3,253 exhibitors, 764 dental dealers, 682 foreign guests and 6,209 guests.

Dr. John M. Deines of Seattle, Washington was chosen president-elect in competition with Dr. Kenneth F. Ryan of Flint, Michigan. Dr. Harry M. Klenda of Wichita, Kansas was installed as the 106th president of the ADA at the closing session of the House of Delegates. Dr. Hugo M. Kulstad of Bakersfield, California was elected first vice-president, Dr. Frank A. Farrell of Chicago, Illinois was elected second vice-president and Dr. Jerry Adelson of New York, N. Y. was elected third vice-president. Dr. Carlton H. Williams of San Diego, California was unanimously re-elected for his fourth term as Speaker of the House of Delegates.

VIRGINIANS PARTICIPATE IN COMPREHENSIVE SCIENTIFIC SESSION

The four-day scientific session was one of the largest ever presented by the American Dental Association. Virginians who took part in the program were:

Motion Pictures: Dr. Philip B. Peters and Dr. Charles M. Heartwell, Jr. of Richmond - "Surgical and Prosthodontic Management of the Atrophied Edentulous Mandible"; Dr. Anthony J. Viscido, Springfield and Dr. A. E. Edelman, New Jersey - "Fixed Prosthesis for Edentulous Mandibles Utilizing Endosseous Implants". (Also presented as a table clinic by Dr. Viscido.)

Table Clinics: Miss Louise Lloyd, Dental Assistants, Mechanicsville - "Your Society and Dental Health Week"; Northern Virginia Gnathological Research Group: Dr. Roy E. Stanford, Jr. McLean, Coordinator, "Pantographic Tracings" - Doctors Robert W. Clements, Falls Church, Raymond Ernest and Louis R. Savarie of Arlington, Dr. Roy E. Stanford, Jr., McLean; "Determinants of Occlusion" - Drs. Raymond T. Bond and Bernard T. Carr of Alexandria; and "Cusp-Fossa Waxing Technic" - Dr. Richard S. Cantwell, Falls Church and Dr. Ralph Gibson, Jr., Fairfax.

Honors: Dr. Alexander L. Martone was appointed to another term on the Council on Dental Laboratory Relations of the American Dental Association. Dr. W. C. Henderson of Richmond and Dr. Herbert R. Boyd, Jr. of Petersburg were elected as Fellows in the American College of Dentists. Dr. C. David Richardson, Jr. of Richmond was elected president of the American Academy of Dental Radiology. Dr. Thomas C. Bradshaw of Blackstone was elected third vice-president of the American Association of Dental Examiners. Dr. S. Elmer Bear of Richmond was elected president of the American Society of Oral Surgeons. Dr. Hugo Owens of Portsmouth was elected to the Board of Directors of the American Society for Preventive Dentistry and heads the Steering Committee that will organize and publish the new society's newsletter and journal.

ACTIONS OF ADA HOUSE OF DELEGATES

(At the direction of the Executive Council, the Journal is publishing the votes of the Virginia Delegation as recorded on their official voting tally sheets. The seven delegates were Doctors Thomas C. Bradshaw, Carlton E. Gregory, Byrnal M. Haley, Myron E. Henderson, Alexander L. Martone, William H. Traynham, Jr. and Thomas T. Upshur. Alternate Delegates were Doctors Jack L. Chevalier, L. O. Clarke, Jr., Henderson P. Graham, T. Roy Jarrett, Jr., Jason R. Lewis and L. Ray Shields. The vote of the delegation is recorded at the end of each resolution. The resolutions are listed in their numerical order, not in the order in which they were taken up for voting. Editor's Note)

50. **Adopted, Resolved, that the** ADA, for the good and welfare of the public, go on record as being opposed to all forms of taxes on Health Care Services. **(Virginia - 4 for adoption, no vote - Haley, Gregory, Traynham)**

51. **Adopted as amended, Whereas,** a severe and distressing calamity has occurred to fellow dentists by Hurricane Camille, and **Whereas,** relief is sorely and direly needed immediately, be it **Resolved,** that

the Council on Relief conduct a special national campaign of solicitation of funds to assist dentists victimized by Hurricane Camille and that financial assistance to such victims be provided in the form of direct grants, no grant to any dentist exceeding $5,000 but the actual amount of any grant being based on individual need as determined by the Council on Relief after due consideration of recommendations from the relief councils of the constituent societies, and be it further **Resolved**, that the balance of the funds raised, if any, be held separately to fund a disaster assistance program. **(Virginia - 5 for adoption, no vote - Gregory, Traynham)**

52. **Adopted, Resolved**, that the officers, trustees and House of Delegates give careful attention to the structure and direction of the Research and Educational Foundation in most directly discharging Foundation's obligations to the American Dental Association and that the ADA Board of Trustees continue to act as the Board of Directors of the Foundation. **(Virginia - 5 for adoption, no vote - Gregory, Traynham)**

54. **Referred to Board of Trustees for study and report at 1970 session: Resolved**, that Chapter I "Membership" Section 30 "Definition of 'In Good Standing'" be amended by the addition of the words "and assessments" between the words "dues" and "for" in the first sentence, so the section will read "A member of this Association whose dues and assessments for the current year have been paid shall be in good standing provided, however, that a member in good standing who is under a disciplinary sentence of suspension shall be designated as a "member in good standing temporarily under suspension' until this disciplinary sentence has terminated and provided further that a member engaged in practice, to remain in good standing, may be required to meet standards of continuing education established within the bylaws of his constituent society", and be it further **Resolved**, that wherever the word "dues" appears n the Constitution and Bylaws in connection with active membership the words, "and assessment" be added. The resolution proposes the granting of authority for making special assessments in order to alleviate critical or emergency financial situations which may arise. **(Virginia - 5 for adoption, no vote - Traynham, Gregory)**

53. **Adopted**, **Resolved**, that the Uniform Code on Dental Procedures and nomenclature as proposed by the Council on Dental Care Programs (Supplement 1, pp. 812) be approved. **(Virginia - 7 for adoption)**

55. **Adopted, Resolved**, that the House of Delegates direct the Council on Relief to explore the feasibility of establishing a retirement and convalescent home for dentists and their dependents. **(Vir-**

ginia - 5 for adoption, no vote - Traynham, abstained - Haley)

55A. **Adopted, Resolved**, that the Council on Relief review the present refund formula for the annual Relief Fund Seals Campaign with a possible view to increasing the refund formula from 75 to 100 per cent. **(Virginia - 4 for adoption, no vote - Traynham, Upshur, opposed - Henderson)**

206. **Adopted, Resolved,** that all states be urged to use the term "work authorization" rather than "prescription" in referring to the written instructions for services to be provided by the dental laboratory technician. **(Virginia: 6 for adoption, Traynham - no vote)**

207. **Adopted, Resolved,** that the ADA through the Council on Federal Dental Services and the Council on Legislation and the Oklahoma State Dental Association and all other constituent societies, seek the statutory rank of Major General for the Chief of the Dental Services of the Department of the Air Force, through legislative amendment of Title 10 U.S. Code, by revitalizing HR-426, introduced by Congressman Ed Edmondson of Oklahoma in the 91st Congress. **(Virginia - 7 for adoption)**

208. **Adopted, Resolved,** that the state "Dental Society Review Committees", **(Trans. 1967:324), be** amended by the deletion of the last sentence in the paragraph entitled "Organization" to remove the restriction against dental society review committees considering matters relating to quality of care. **(Virginia - 6 for adoption, Traynham - no vote)**

209. **Adopted, Resolved,** that the "Statement on Evaluation of Utilization and Quality of Dental Treatment Under Title XIX of the Social Security Act (Medicaid)" be approved. **(Virginia - 5 for adoption, Traynham - no vote, Henderson - abstained)**

210. **Adopted as amended, Resolved,** that the statement "Program for Dental Care in Nursing Homes", as amended, be approved. **(Reports, pp. 47-50)** In the section "Methods of Payment," the first sentence was amended to read as follows: "Advisory dentists will be reimbursed by Medicare for consultant functions. Remuneration for additional services must be made on a fee-for-service or other acceptable basis." **(Virginia - 5 for adoption, Gregory and Traynham - no vote)**

211. **Adopted, Resolved,** that the "Policy Governing Use of American Dental Association Dental Health Education Statement" be approved, and be it further **Resolved,** that the "Policy Governing Use of the Association's Name on Dental Health Education Materials" approved by the House of Delegates in 1955 (Trans. 1955:218) be rescinded. **(Virginia - 5 for adoption, no vote - Gregory, Traynham)**

212. **Referred to Bureau of Dental Health Education for study and report to 1970 session: Resolved,** that the appropriate agency of the ADA set the dates of observance

of National Children's Dental Health Week for the third week in January, or such other week as desired, but not during the month of February. **(Virginia - 5 for referral, no vote - Gregory, Traynham)**

213. **Adopted, Resolved**, that the appropriate agency of the ADA negotiate with the U. S. Veterans Administration to adopt a policy of usual and customary fees for services rendered by participating dentists. **(Virginia - 5 for adoption, no vote - Gregory, Traynham)**

214. **Adopted, Resolved**, that the ADA and its constituent societies call upon and encourage their members to undertake an educational effort to inform their patients of the systemic and oral health hazards of the use of tobacco; placing special emphasis on young people, to warn them against acquiring the dangerous habit of smoking tobacco, and be it further **Resolved**, that the ADA reaffirm its strong support of anti-smoking legislation calling for the banning of cigarette, cigar, and pipe advertising in newspapers and on television and radio and be it further **Resolved,** that the ADA strongly reaffirms this as its official policy on the health hazards of smoking tobacco at its 1969 Annual Session of the House of Delegates, and calls for the implementation of this policy by informing its membership and the general public of this stand. **(Virginia - 5 for adoption, no vote - Gregory, Traynham)**

215. **Referred to Council on Dental Care Programs for study and report to 1970 session, Resolved,** that the President of the American Dental Association assign the appropriate council to investigate the possibility of developing a suitable uniform claim form for transmitting information to insurance carriers for treatment already completed. **(Virginia - 5 for adoption, no vote - Gregory, Traynham)**

217. **Adopted, Resolved,** that the ADA wishes to express its great concern of the health hazards presented by the pollution of our air and water which seems to be on the increase throughout our country, and be it further **Resolved**, that as one of the great health organizations of the world, that we share the responsibility of instituting and supporting effective legislation to control this ravage of mankind, before it is too late, and be it further **Resolved**, that we recommend to our members, as concerned citizens, an educational program both on the national and local level by our participation in civic movements, to curb and control the continued pollution of our air and water so vital to life. **(Virginia - 5 for adoption, no vote - Gregory, Traynham)**

218. **Adopted, Resolved**, that the **Bylaws**, Chapter I, Section 30, Definition of "In Good Standing", be amended by the addition of the phrase "and provided further that a member engaged in practice to remain in good standing may be required to meet standards of continuing education established within the bylaws of his constituent so-

ciety" at the end of the first paragraph, the amended paragraph to read as follows:

Section 30. Definition of "In Good Standing": A member of this Association whose dues for the current year have been paid shall be in good standing; provided, however, that a member in good standing who is under a disciplinary sentence of suspension shall be designated as a "member in good standing temporarily under suspension" until his disciplinary sentence has terminated and provided further that a member engaged in practice, to remain in good standing, may be required to meet standards of continuing education established within the bylaws of his constituent society. **(Virginia - 7 for adoption)**

219. **Adopted, Resolved**, that Section 2, Subsection (2) of the "Requirements for an Accredited Program in Dental Assisting Education" be amended by the addition of the phrase "not less than" between the words "be" and "one" so that it will read as follows: 2. Programs (a) The program must be not less than one academic year in length (2 semesters or 3 quarters) **(Virginia - 7 for adoption)**

220. **Adopted as amended, Resolved**, that the "Requirements for an Accredited Program in Dental Assisting Education" be approved, as amended, and be it further **Resolved**, that the "Requirements for Approval of Educational Programs for Dental Assistants", approved by the House of Delegates in 1960 (**Trans.** 1960:38) be rescinded.

The following amendment to Section 1 of the "Requirements for an Accredited Program in Dental Assisting Education" titled "Dental Assisting Advisory Committee" was approved to make it perfectly clear that dentists engaged in active practice should be represented on the advisory committee: 1. **Dental Assisting Advisory Committee** - Each dental assisting program shall have an advisory committee including practicing dentists, dental assistants, faculty and school administrators. In dental assisting programs sponsored by dental schools, the advisory committee may be made up of faculty members provided that some members of the committee shall be engaged in private practice. **(Virginia - 7 for adoption)**

221. **Adopted, Resolved**, that the **Bylaws**, Chapter IX, Councils, Section 110, Duties, I. Council on Hospital Dental Service, be amended by the addition of subsection c, as follows:

c. To study and make recommendations on the effective involvement of hospital dental services in community, state, regional and federal health care programs. **(Virginia - 7 for adoption)**

222. **Adopted, Resolved**, that the responsibility of the dentist for the supervision of dental auxiliaries should be determined by state den-

tal practice acts or regulations. **(Virginia - 7 for adoption)**

223. **Adopted, Resolved, that the** Council on Dental Education be directed to study the feasibility of instituting, or sponsoring, a nation-wide Intern Matching Program. **(Virginia - 6 for adoption, Gregory - opposed)**

224. **Postponed Indefinitely, Resolved,** that the House of Delegates of the Pennsylvania Dental Association requests the House of Delegates of the ADA to direct the Council on Dental Education to insert in and attach to the "Essentials of an Advanced Educational Program in Oral Surgery" on pages 2 and 3, under the heading of "General Requirements" before making any further distribution of these booklets, the following statements: "Before private or other patients are 'utilized' for teaching purposes, they must be fully informed that their operation may be performed in whole or in part by the dental resident or intern under the direct supervision of the dentist on whose service the patient is admitted and who will be fully responsible. The patient who agrees to this procedure will sign a statement indicating that he has been fully informed as to the operation and as to the role the dental trainee, resident, or intern will play in his operation and agrees thereto." **(Virginia - 7 to postpone indefinitely)**

225. **Postponed indefinitely, Resolved,** that the ADA House of Delegates directs the Council on Dental Education to include the following statement in the "Requirements for National Certifying Boards for Special Areas of Dental Practice" (approved by the House of Delegates of the ADA in September, 1959 with subsequent amendments) under the heading, Organization of Boards, at the end of paragraph I: "Each Board shall have a constitution and bylaws which provides for the diplomates of that Board to have full voting rights so that they may participate in establishing policies, and the requirements of that specialty board". **(Virginia - 7 to postpone indefinitely)**

226. **Adopted as amended, Resolved,** that the revised "Standards for Dental Publications", as amended, be approved, and be it further **Resolved**, that the "Standards for Constituent Dental Society Publications" approved by the House of Delegates in 1952 (**Trans.** 1952: 181), with subsequent amendments (**Trans.** 1960:225), be rescinded.

(Copy available from C. Office.)

The following amendments to the revised "Standards for Dental Publications were approved: The paragraph entitled "Objectives", last sentence, (**Reports:** 110) was amended to read: "To accomplish these objectives, an association's publications should:". The paragraph entitled "Contest", first sentence, was amended to read: "Each dental society must first determine the types or types of publications that will best serve the need of its

members—newsletter, tabloid, bulletin or journal." The first full paragraph, first sentence (**Reports:** 111) was amended to read: "The type or types of publications selected by the dental society will depend on the purpose it is to serve, but whatever type or types are selected they should be well designed, attractive and readable—the best the society can afford." The second paragraph (**Reports:** 111) was amended to read: "To communicate adequately with its members, the dental society should issue some form of publication no less than four times a year." (**Virginia - 7 for adoption**)

227. **Adopted**, **Resolved**, that the Council on Insurance of the ADA in cooperation with the councils on insurance of the constituent societies extend their efforts to seek out malpractice insurance procedures to correct this serious matter. (**Virginia - 7 for adoption**)

228. **Adopted**, **Resolved**, that the ADA join the Mississippi Dental Association and the Fifth Trustee District in expressing its heartfelt appreciation for these available health-saving services performed for the victims of "Hurricane Camille" and the dentists in the area of devastation to the associations and business firms mentioned above, and be it further **Resolved,** that copies of this resolution be sent to each of these associations or companies as a commendation of and tribute to them for demonstrating the highest traditions of public service to which the dentists of the United States are dedicated. (**Virginia - 7 for adoption**)

229. **Adopted**, **Resolved**, that the Board of Trustees instruct the appropriate Association agencies to explore the feasibility of establishing an Association mechanism to supply financial assistance to members who are victims of natural disasters, and to report their findings to the 1970 session of the House of Delegates. (**Virginia - 7 for adoption**)

230. **Adopted as amended**, **Resolved**, that the "Principles of Ethics" be amended by the addition of a new Section 20, Professional Corporations, to read as follows: **Professional Corporations.** A dentist or group of dentists may practice as a professional corporation or professional association if permitted by state law. The use of corporate names other than the names of participating dentists is unethical unless such other corporate names are required by state law. A dentist may not use "Professional Corporation", "Professional Association", "P.C.", "P.A.", "Inc.", or similar corporate designations, as a part of the name of a practice on cards, letterheads, office door signs, directories and announcements, unless required by state law, and be it further **Resolved,** that existing Section 20 of the "Principles of Ethics" be renumbered as Section 21 and existing Section 21 be renumbered as Section 22. (**Virginia - 7 for adoption**)

231. **Adopted**, **Resolved**, that the "Principles of Ethics" be amended

by the deletion of the definition of "group practice" as it appears in Section 16 and the substitution of the following: "Group practice is that type of dental practice in which dentists, sometimes in association with members of other health professions, agree formally between themselves on certain central arrangements designed to provide efficient dental health service." **(Virginia - 6 for adoption, opposed - Upshur)**

232. **Adopted, Resolved**, that Resolutions 44 and 47 and the requests from the 13th Trustee District be postponed indefinitely. The resolutions and request related to the definition of group practice. **(Virginia - 6 for adoption, opposed - Upshur)**

233. **Postponed indefinitely, Resolved**, that the "Principles of Ethics" be amended by the addition of the following sentence to Section 17: "A dentist who increases his fees because it is known that there is a third party reimbursing agent is unethical." **(Virginia - 7 to postpone indefinitely)**

234. **Adopted as amended, Resolved,** that the "Principles of Ethics" be amended by deletion of the last sentence of the first paragraph of Section 15 and the substitution of the following: "A dentist has the obligation of not using his professional identification in connection with any commercial activity which renders a disservice to the profession, the patient or the public." **(Virginia - For adoption - Gregory, Haley, Martone, opposed - Henderson, no vote - Bradshaw, Upshur, Traynham)**

235. **Adopted, Resolved,** that the House of Delegates of the ADA direct the Judicial Council to study the matter of general practitioners in offices of specialists and report to the 1970 House of Delegates along with recommendations for possible amendments to the "Principles of Ethics". **(Virginia - 6 for adoption, no vote - Traynham)**

236. **Referred to Council on Legislation for study and report to 1970 House of Delegates, Resolved,** that the House of Delegates of the ADA hereby goes on record in favor of H.R. 7723, and be it further **Resolved,** that a copy of this resolution be forwarded to the Honorable Frank Horton, House Office Building, Washington, D.C. 20515. Representative Horton introduced H.R. 7723 which would lower the social security rates for the self-employed. **(Virginia - 6 for referral, no vote - Traynham)**

237. **Postponed indefinitely, Resolved,** that the Judicial Council of the ADA be asked to study the problem of patient discrimination solely on the basis of race, creed, color or national origin, and be it further **Resolved**, that the Judicial Council present an advisory opinion on this matter to the 1970 House session of the House of Delegates. **(Virginia 6 for postponing indefinitely, no vote - Traynham)**

238. **Postponed indefinitely, Resolved,** that the Judicial Council be re-

quested to submit an amendment to the ADA "Principles of Ethics" specifying that discrimination in the selection of patients solely on the basis of race, creed, color or national origin is unethical, and be it further **Resolved,** that the amendment be presented to the 1970 House of Delegates. **(Virginia - 6 for postponing indefinitely, no vote - Traynham)**

239. **Adopted**, **Resolved**, that Section 8 of the American Dental Association "Principles of Ethics" be amended by the substitution of the word "public's" for the word "patient's" in the second sentence, the amended section to read: **Section 8. Unjust Criticism and Expert Testimony.** The dentist has the obligation of not referring disparagingly, orally or in writing, to the services of another dentist to a member of the public. A lack of knowledge of conditions under which the services were afforded may lead to unjust criticism and to a lessening of the public's confidence in the dental profession. If there is indisputable evidence of faulty treatment, the welfare of the patient demands that corrective treatment be instituted at once and in such a way as to avoid reflection on the previous dentist or on the dental profession. The dentist also has the obligation of cooperating with appropriate public officials on request by providing expert testimony. **(Virginia - 6 for adoption, no vote - Traynham)**

240. **Adopted as amended**, **Resolved**, that Section 2 of the "Principles of Ethics" be amended by adding the following as the second paragraph of Section 2: In serving the public, a dentist may exercise reasonable discretion in selecting patients for his practice. However, a dentist may not refuse to accept a patient into his practice or deny dental service to a patient solely because of the patient's race, creed, color or national origin and by deleting the following as the first paragraph of Section 2: The dentist has a right to win for himself those things which give him and his family the ability to take their proper place in the community which he serves, but there is no alternative for the professional man in that he must place first his service to the public, to make the amended Section read as follows: **Section 2. Service to the Public.** The dentist's primary duty of serving the public is discharged by giving the highest type of service of which he is capable and by avoiding any conduct which leads to a lowering of esteem of the profession of which he is a member. In serving the public, a dentist may exercise reasonable discretion in selecting patients for his practice. However, a dentist may not refuse to accept a patient into his practice or deny dental service to a patient solely because of the patient's race, creed, color or national origin. **(Virginia - 6 for adoption, opposed - Upshur)**

241. **Adopted, Resolved,** that the Board of Trustees designate the Council on Dental Health and the Council on Dental Care Programs, in consultation with other agencies of the Association, to review as a matter of high priority all existing Association policies relating to national health programs and, upon completion of such review by these agencies, appoint a broadly based dental health task force to design the American Dental Association's position with respect to the participation of the dental profession in national programs concerned in the delivery of health care to the public when and if such programs ever become necessary and to submit a progress report at the 1970 annual session. **(Virginia - 7 for adoption)**

242. **Adopted, Resolved,** that the ADA honor Dr. Horace H. Hayden on the 200th anniversary of his birth for his many contributions to the dental profession, particularly his participation in the founding of the first dental school in the world, the first American dental society and the first American dental periodical. **(Virginia - 7 for adoption)**

243. Referred to Board of Trustees for study and report at 1970 session, **Resolved**, that Chapter V, House of Delegates, Section 120, Rules of Order, Subsection C, Approval of Annual Budget, be amended by deleting the first sentence in the subsection and the substituting therefor of the following sentence: "The proposed annual budget shall be submitted by the Board of Trustees to the members of the House of Delegates at least fourteen (14) days prior to the opening meeting of the annual session, shall be referred by the Board of Trustees to a special information committee on budget for hearings at the annual session and then shall be considered for approval as a special order of business at the second meeting of the House of Delegates," to make the amended Subsection C read as follows: "The proposed annual budget shall be submitted by the Board of Trustees to the members of the House of Delegates at least fourteen (14) days prior to the opening meeting of the annual session, shall be referred by the Board of Trustees to a special information committee on budget for hearings at the annual session and then shall be considered for approval as a special order of business at the second meeting of the House of Delegates. In the event the budget as submitted is not approved, all recommendations for changes shall be referred to the Board of Trustees to prepare and present a revised budget. This procedure shall be repeated until a budget for the ensuing fiscal year shall be adopted. **(Virginia - 7 for referral)**

244. **To be submitted to 1970 House of Delegates for action, Resolved,** that Chapter I, Section 50A of the **Bylaws**, be amended by the dele-

tion of the words "fifty-five dollars ($55)" and insertion in lieu therefor the words "sixty dollars ($60)" to make the amended section read as follows: **Active members.** The dues of active members shall be sixty dollars ($60) due January 1 of each year. **(Virginia - 6 for submitting, opposed - Upshur)**

246. **Adopted, Resolved**, that whenever and wherever feasible and possible, the Association and its officials be urged to check with the appropriate component or constituent society officers on any Association news release which might adversely affect that society before such release is disseminated to the news media. **(Virginia - 7 for adoption)**

247. **Adopted, Resolved**, that Chapter II, Section 110, line 423, of the **Bylaws** be amended by substituting "North Dakota Dental Association" for "North Dakota State Dental Association". **(Virginia - 7 for adoption)**

Fifth District ADA Caucus Breakfast. The Fifth District includes Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina and Virginia.

248. **Referred to Board of Trustees for study and report to 1970 House of Delegates, Resolved**, that, upon retirement from a position entitling one to direct membership in the American Dental Association, con-

tinued membership be through a component society. **(Virginia - 7 for referral)**

249. **Referred to Board of Trustees for study and report to 1970 House of Delegates, Resolved,** that the **Bylaws,** Chapter I, "Membership", Section 20 "Qualifications", Paragraph A, be amended by the addition of the words "on active duty" after the word "service" on line 89. It will then read: **A. Active Member.** A dentist shall be classified as an active member of this Association who is licensed to practice in a state, the District of Columbia, the Commonwealth of Puerto Rico or a dependency of the United States, providing he is a member in good standing of this Association, its constituent and component societies, if such exist, or is a member in good standing and licensed to practice in a dependency of the United States wherein a constituent society does not exist, or is a member of a federal dental service on active duty. **(Virginia - 7 for referral)**

250. **Adopted, Resolved,** that Chapter II, Section 110, line 440, of the **Bylaws** be amended by substituting "West Virginia Dental Association" for "West Virginia State Dental Society". **(Virginia - 7 for adoption)**

251. **Adopted, Resolved,** that the **Bylaws,** Chapter XV, Finances, be amended by the deletion of Section 40, Research Fund (lines 1671-1679). **(Virginia - 6 for adoption, no vote - Upshur)**

252. **Adopted, Resolved,** that Chapter I, Section 50F of the **Bylaws** be amended by deletion of the words "forty dollars ($40.00)" and the substitution of the words "twenty dollars ($20.00) in lieu thereof. The resolution reduced the dues for associate membership in order to encourage maintenance of this membership classification. **(Virginia - 6 for adoption, no vote - Traynham)**

253. **Adopted as amended, Resolved,** that the House of Delegates recommends that the Board of Trustees rescind its allocation of an estimated $248,000 from the 1969 surplus of the Group Life Insurance Program to the American Dental Association Research and Educational Foundation, and be it further **Resolved,** that the House of Delegates requests that the Board of Trustees shall allocate any future surplus from the Group Life Insurance Program to either improvements of the program, reduction of premium or refund to the certificate holders, and be it further **Resolved,** that the Board of Trustees consider rescinding the amendment of the Rules of the Board of Trustees concerning surplus from the Group Life Insurance Program adopted at its October, 1969 meeting. **(Virginia - 7 for adoption)**

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The *Department of Stomatology, University Hospital, Boston, Massachusetts,* in conjunction with *Boston University School of Graduate Dentistry,* announces an approved internship in the general practice of dentistry commencing July 1, 1970. Applications will be considered from graduates of approved American dental schools and their foreign equivalents. The program stresses diversified training in anesthesiology, oral surgery, oral medicine and diagnosis, periodontology, endodontics, prosthetic dentistry and pedodontics. The intern engages in the clinical conferences in medicine and surgery at University Hospital and is afforded the unusual opportunity to attend classes and seminars within the postdoctoral courses of the School of Graduate Dentistry. The intern is supervised by members of the hospital and school staffs who are qualified by training, experience and board certification in the various specialties of medicine and dentistry. The stipend is $7,000 per annum. Uniforms are supplied. Library and research facilities are located close by within the Medical Center. Research preceptorship is afforded to those interested in investigative endeavors. Inquiries and requests for applications should be directed to *Dr. Henry M. Goldman, Head of the Department of Stomatology, University Hospital, Boston, Massachusetts 02118.*

Applications are now being accepted for the following house staff positions in the Department of Dentistry at the Kingsbrook Jewish Medical Center:

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The annual course in "ORAL DIAGNOSIS AND THERAPEUTICS" will be given at the *United States Army Institute of Dental Research* April 13-17, 1970. The course will be directed by Col. S. N. Bhaskar and will include discussions on various aspects of clinical oral diagnosis, surgery, endodontics, periodontics, pulp therapy, x-ray interpretation, prosthodontics and operative dentistry. The five-day program is specially designed for the clinical dentist. The course is open to civilian members of the dental profession and is without fee. Due to heavy enrollment, early application to the *Director, United States Army Institute of Dental Research, Walter Reed Army Medical Center, Washington, D. C. 20012,* is recommended.

UNIVERSITY OF KENTUCKY

"THE FORWARD LOOK IN DENTISTRY FOR CHILDREN" — Dr. Norman H. Olsen, Northwestern Univ., Evanston, Illinois; Two days, March 23-24, 1970; FEE: $100.

"ENDODONTICS FOR THE GENERAL PRACTITIONER" — Dr. Andrew E. Michanowicz, Univ. of Pittsburgh; Two days, April 15-16, 1970; FEE: $100.

"ADVANCED PEDODONTIC SEMINAR" — Dr. Charles Waldron, Emory University, Atlanta, Georgia and Dr. Richard E. Stallard, Eastman Dental Clinic, Rochester, New York; Two days, April 23-24, 1970; FEE: $125.

"PHARMACOLOGY AND THERAPEUTICS IN GENERAL PRACTICE" — Dr. Donald Knapp, U. of Ky. College of Dentistry; Two days, April 27-28, 1970; FEE: $60.

"ORTHODONTICS IN GENERAL PRACTICE" — Dr. William T. Parker, Dr. Jerry Harrison, Dr. Charles Pritchett and Dr. David L. May, U. of Ky. College of Dentistry; Two days, April 30 and May 1, 1970; FEE: $60.

"ADVANCED PERIODONTICS FOR THE GENERAL PRACTITIONER"—Dr. Walter Cohen, Univ. of Penn. School of Dental Medicine and Dr. Stanley E. Ross, Boston U. Grad. Schl. of Dent.; Two days, May 3-4, 1970: FEE: $100.

"NEW CONCEPTS IN EDGEWISE ORTHODONTICS" — Dr. James L. Ackerman, Univ. of Penn. School of Dental Medicine; Two days, May 18-19, 1970; FEE: $125.

"CLINICAL APPLICATIONS OF RECENT RESEARCH IN RESTORATIVE DENTISTRY MATERIALS" — Dr. Donald A. Welk, U. of Ky. College of Dentistry; One day, May 20, 1970; FEE: $25.

"BASIC PERIODONTICS FOR THE GENERAL PRACTITIONER" (to be held at KENTUCKY DAM VILLAGE STATE PARK, Gilbertsville, Ky.) — Dr. Donald Carman, and Dr. Raymond Kopczyk and the Department of Periodontics, U. of Ky. College of Dentistry; Three days, May 21-23, 1970; FEE: $75.

"REMOVABLE PARTIAL DENTURES" — Dr. Davis Henderson, U. of Ky. College of Dentistry; Three days, May 25-27, 1970; FEE: $75.

"PORCELAIN FUSED TO METAL" — Dr. George Mumford, Tufts

Univ. School of Dental Medicine, Boston, Mass.; Three days, June 8-10, 1970; FEE: $250.
Write to: *University of Kentucky College of Dentistry, Dept. of Continuing Education, Lexington, Kentucky 40506*

POSTGRADUATE DENTAL PROGRAM ALBERT EINSTEIN COLLEGE OF MEDICINE

"COMMUNITY DENTISTRY AND THE PRIVATE PRACTITIONER," DPD 78, Herbert J. Levin, D.D.S., Ernest Leatherwood, D.D.S., Professor Harry Becker, and others; Friday, March 6, 1970; $50.

"GETTING STARTED IN WORK SIMPLIFICATION," DPD 74, Milton Macon, D.D.S., and Joseph Fisch, D.D.S., Friday, March 20, 1970; $50.

"FINANCES AND THE DENTIST," DPD 76, Leon Brown, Friday, April 3, 1970; $50.

ANESTHESIOLOGY DPD 15, (Practical Physical Evaluation of the Dental Patient; Why One Should "Never Treat A Stranger" — a participation course), Stanley R. Spiro, D.D.S., and Others, Thursday and Friday, April 9 and 10, 1970; $100.

PERIODONTICS DPD 64, (Tenth Anniversary Alumni Lecture - "Rationale of the Full Range of Periodontal Treatment"), Gerald Kramer, D.M.D., Wednesday, April 15, 1970; $50.

PROSTHETICS DPD 87, (Implants and Transplants), Isaih Lew, D.D.S., Friday, April 17, 1970; $50.

"PREVENTIVE ORTHODONTICS AND MINOR TOOTH MOVEMENT", DPD 51, Frank Kanter, D.D.S., Walter Bogad, D.D.S., and Joseph Lidestri, D.D.S., Thursday and Friday, April 23 and 24, 1970; $100.

PROSTHETICS DPD 82, ("Fixed Partial Prosthesis"), Lester E. Rosenthal. D.D.S., and Harold Schwartz, D.D.S., Friday, April 24, 1970; $50.

PROSTHETICS DPD 89, ("Comprehensive Oral Treatment"), Gerald S. Wank, D.D.S., Fridays, May 1 and 8, 1970; $100.

PERIODONTICS DPD 65, ("Occlusal Adjustment" - a participation course), Marvin N. Okun, D.D.S., and Irving Yudkoff, D.D.S., assisted by Joseph Puccio, D.D.S., and Zachary Dembo, D.D.S., Wednesdays, May 6, 13, and 20, 1970; $150.

ORAL SURGERY DPD 33, ("Exodontia and Minor Oral Surgery"), William Rakower, D.D.S., Herbert I. Calman, D.D.S., and Associates, Thursday and Friday, May 7 and 8, 1970; $100.

ORAL SURGERY DPD 36, ("Bone Healing and Bone Grafting in Oral Surgical Procedures"), Philip J. Boyne, D.M.D., Wednesday, May 13, 1970: $50.

"HOW TO TEST, HIRE AND MOTIVATE PERSONNEL," DPD 73, Miriam Felder Shore, Friday, May 15, 1970; $50.

PROSTHETICS DPD 85, ("The Role of Restorative Dentistry in the Etiology and Treatment of Periodontal Disease"), Herbert J. Bartelstone, D.D.S., Friday, May 22, 1970; $50.

"CEPHALOMETRIC APPLICATION TO DIAGNOSIS", DPD 53,

Abraham I. Fingeroth, D.D.S., Murray M. Fingeroth, D.D.S., and Irvin Forest, D.D.S., Friday, May 22, 1970; $50.

PROSTHETICS DPD 90, ("Basic Prosthetics for the General Practitioner"), Louis I. Rubins, D.D.S., Wednesday, June 3, 1970; $50.

PERIODONTICS DPD 68, ("Periodontia & Restorative Dentistry - Diagnosis and Treatment Planning"), Marvin N. Okun, D.D.S., and Irving Yudkoff, D.D.S., Wednesday, June 10. 1970; $50.

"PHYSICAL FITNESS FOR THE PROFESSIONAL MAN", DPD 75, Thomas Kirk Cureton, Jr., Ph. D., Friday, June 12, 1970; $50.

POSTGRADUATE EXTENSION PROGRAM (Off Campus Courses): Faculty members of the Postgraduate Dental Program, who are specialists in their fields, are available for short, intensive courses that can be given in various cities, if a sufficient number of practitioners evince interest. If clinical facilities are available these courses can be a combination of lectures and demonstrations.

For further information and application, write to: *Dr. Irving Yudkoff, Director, Postgraduate Dental Program, Albert Einstein College of Medicine, 1165 Morris Park Avenue, Bronx, New York 10461.*

UNIVERSITY OF PENNSYLVANIA

DR. GEORGE W. FERGUSON will present a one day course on *MODERN OPERATIVE DENTISTRY WITH AMALGAM* on Friday, April 17, 1970. This course will be an intensive one day review of amalgam as a restorative material in which the basic principles will be reviewed and important facts concerning the new materials and new techniques taught.

DRS. IRVING L. YALISOVE and JOSEPH B. DIETZ, JR. will present a two day course on *THE CROWN AND SLEEVE COPING RETAINER: ITS USE IN FIXED AND REMOVABLE PROSTHESIS* April 23, and 24, 1970. The crown and sleeve-coping (telescopic crown) prosthesis makes use of as few as two remaining teeth in an arch to insure that the appliance has less horizontal and vertical movement than a complete denture, that the alveolar ridge is better preserved and that the patient maintains some proprioceptive capacity. In addition to step-by-step documentation with color transparencies, a video-type demonstration of the construction of an actual case will be shown.

DRS. D. WALTER COHEN and MORTON AMSTERDAM will present a one day course - *REFRESHER COURSE IN PERIODONTAL THERAPY* on Saturday, April 25, 1970. This seminar will review current advancements in periodontal therapy for those who have had basic postgraduate instruction in periodontics.

DR. D. WALTER COHEN and ASSOCIATES will present a five day *BASIC COURSE IN PERIODONTAL THERAPY* April 27th through May 1, 1970. The objective of this course is to acquaint the practitioner with the importance of periodon-

tics in the general practice of dentistry. The etiology and diagnosis of periodontal diseases will be stressed. Case planning will be emphasized. For further information please write — Continuation Courses, University of Pennsylvania, School of Dental Medicine, 4001 Spruce Street, Philadelphia, Pa. 19104.

"A Century of Progress" is the theme for the 1970 Thomas P. Hinman Dental Meeting, March 22-25 at the Atlanta Marriott Motor Hotel. This 58th annual post-graduate clinic for dentists will commemorate the 100th anniversary of the birth of Dr. Hinman, a pioneer in dentistry and founder of the meeting. More than 8,000 dentists and auxiliary personnel from throughout the Southeast are expected to attend, according to Dr. C. Levitas, general chairman.

Featured clinicians include: Dr. Manuel Album, Jenkintown, Pa., "Hospital Dentistry" and "Drugs in the Dental Office"; Col. Surindar Bhaskar, Walter Reed Army Institute of Research, "Oral Pathology"; Dr. Walter Doyle, Lexington, Ky., "Pedodontics"; Mr. Robert P. Levoy, New York, N. Y., "Dental Practice Administration"; Dr. Isaih Lew, New York, N. Y., "Dental Implants"; Dr. Claude Nabors, San Antonio, Tex., "Periodontics"; Dr. Ralph Phillips, University of Indiana, "Dental Materials"; Dr. Herbert Schilder, Boston, Mass., "Endodontics"; Dr. David Shelby, New York, N. Y., "Crown and Bridge"; Dr. Sidney Silverman, New York, N. Y. "Prosthetics"; Dr. Charles E. Stuart, Ventura, Calif., and Dr. Peter K. Thomas, Beverly Hills, Calif., "Restorative Dentistry — A Gnatological Concept", and, Dr. Robert Walker, Dallas, Texas, "Oral Surgery".

The meeting will feature the largest display of technical and scientific dental exhibits in the South. The Thomas P. Hinman Dental Meeting is presented each year by the Fifth District Dental Society, Dr. J. Wendell Glass, President.

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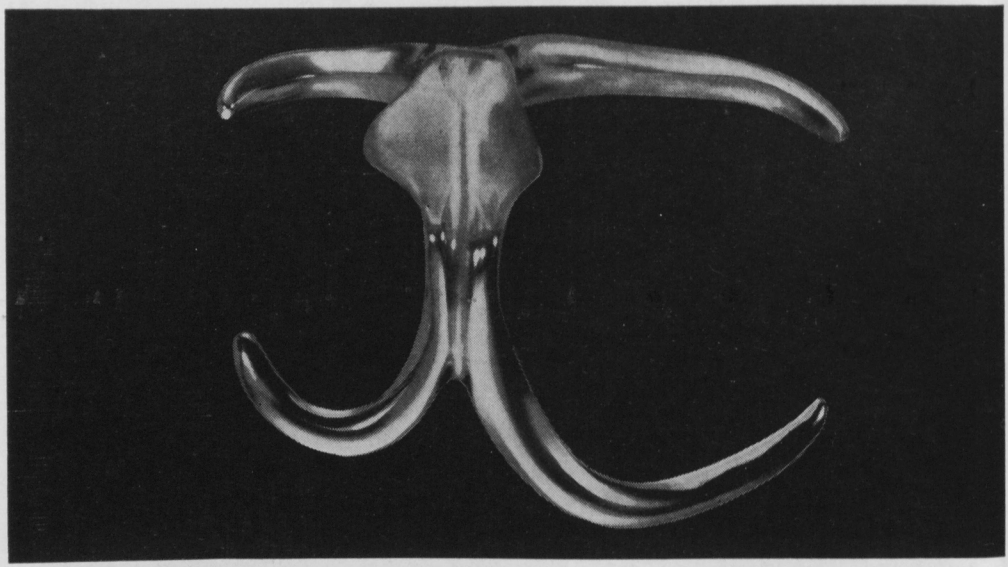

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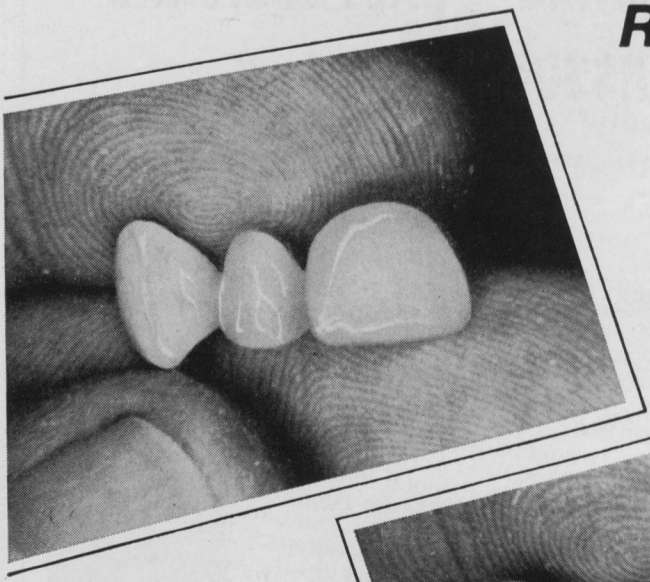

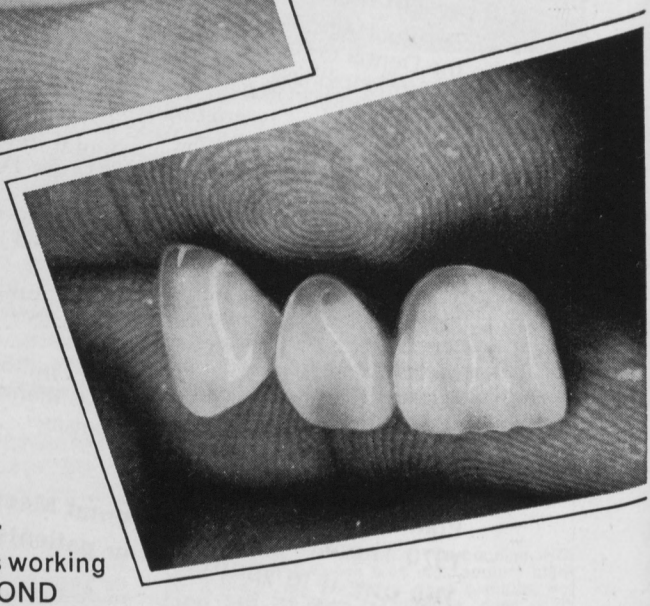

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