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COVER

State Capitol Area in Winter
(Photo courtesy of the Virginia Division of Tourism)
EDITORIAL

A Complex Problem Requiring Urgent Attention

Last year, I was having lunch with three other dentists. We are all from different parts of the country, and we found that our regions all suffer from a common problem: a shortage of competent hygienists. Everywhere I go, I hear the same question—from individual dentists, from state dental associations—and from national dental organizations: “What are they doing about getting us some hygienists?” And schools are blamed—and the hygiene associations—and organized dentistry—and state legislatures—and on and on. Maybe it’s time that we realized that “they” is “us.”

Let’s talk a little about hygienist recruitment. It is not a simple issue. The hygienists with whom I have spoken are not at all enthused about their own participation in recruitment. The reasons they cite are fairly obvious: the more hygienists, the less leverage for what they view as “decent” salaries and secondly, if another recession occurs, dentists will begin to lay off hygienists as their practices slow down.

There are additional reasons, I believe. Many hygienists view their jobs as “dead end positions”; in other words, there is no opportunity for advancement or promotion. Hygienists’ activities are fairly repetitious and, candidly, are not terribly stimulating. In many offices, the hygienist is a rather isolated person and may not be made to feel like a part of the office staff. There also may be inappropriate pressure brought to bear, wherein the hygienist is not allocated adequate time to perform. Dental hygiene (along with nursing) may be viewed by bright, career-minded, young women as less desirable than a position in banking, industry or the media. And finally our recruiting target group is diminishing numerically—there are fewer young people in the “pool” than there were one or two decades ago.

Clearly, the problem must be addressed from a number of directions. As a profession, we must think in terms of immediate solutions as well as long-term strategy. How can you and I, as private practitioners, help to alleviate this problem?

First, recruit from within. When young women of high school age are receiving treatment in our offices, discuss the benefits of being a dental hygienist (and there are many) and encourage them to consider it as a career. Sit down and discuss the possibility with our dental assistants. Some of our finest dental hygienists initially were dental assistants.

Secondly, keep our existing hygienists happy. Evaluate their compensation from the perspective of their production and their value to your practice. (Some hygienists are worth more than others.) Allow them adequate time for each patient. Vary their responsibilities to give them some change in routine (e.g. place them in charge of office sterilization, have them structure medical emergency procedures, solicit their input relevant to dealing with geriatric, medically compromised or handicapped patients, etc.). Send them to continu-
ing education courses (preferably with other staff members). Give them a little extra in their paycheck once in a while. Tell them that you appreciate them.

Thirdly, stir up organized dentistry. Does your component go into local high schools to recruit? Is money set aside to take out ads in high school programs, yearbooks, etc.? (or is the problem not that serious that we shouldn’t spend money on it?) Does your local component have a committee established to focus on this issue? Is it active? What has it done? Have you offered to help?

Fourthly, should a Community College Dental Hygienist Program be established in your area? Keep in mind that most Dental Hygiene Education Programs are not full. It would seem most productive to fill the education programs we now have before we set up new ones. Attendant to this is the question: Are four-year dental hygiene programs an impediment to recruitment? Should we emphasize the two-year program? Should we consider emulating other states which are considering a one-year didactic program followed by a one-year preceptorship prior to taking the State Board Examination?

We all have a tendency to compare—what we do, how we’re compensated and what the future holds. Perhaps we should “accentuate the positive” in the recruitment of potential hygienists. Let’s look at some of the good things about being a hygienist:

They control how many days they wish to work  
They maintain the same daily salary whether they work one day or five  
There is no “shift work”  
There are no Sunday hours  
They are not required to travel or to relocate  
Their future is not contingent upon competing  
They have unique job security  
They can easily get employment if their spouse is transferred  
They have career options: hygiene education, institutional care, military, specialist or general dentist employment, employment in a group practice or solo practice, or employment in entrepreneur-type clinics.  
They build long-term personal contacts with patients  
They perform a most valuable and worthwhile health-care service to patients.

No job is perfect (except “the other guy’s”), so I am confident that some will point out the abundant shortcomings of their own employment as dental hygienists. However, we should not let such negative attitudes impair our own recruitment efforts. Let’s sit down together, in our own components, and establish some rational and practical strategy. Supplement the above suggestions with your own ideas. Then, let’s get to work and implement those ideas! And remember—recruit from within!

Richard D. Wilson, D.D.S.
The strength and competence of the dental profession depends on the continuous replenishment of well-educated dentists to replace current practitioner attrition. The recruitment of highly qualified and motivated men and women is crucial to the preservation of a strong profession. Dentists have an inherent responsibility to play an active role in the recruitment of future colleagues.

Since the late 1970's, the number and quality of individuals in the dental school applicant pool in the United States has been steadily declining. During this period, the number of applicants has decreased from greater than 15,000 in 1975 to barely over 5,000 this past year. A number of factors are responsible for this 60% drop in the applicant pool. First is the case of demographics which show a significant reduction in the 21–26 year old age group, a factor which is predicted to continue to at least 1995. Considerable competition exists from other professions for this limited pool of highly qualified students.

A second reason for this diminishing number of applicants is the increasing costs of dental education. Some experts fear a generation of dental students from only high income families. Many students are opting to enter the work force immediately after undergraduate school to seek immediate financial gratification rather than investing four or more years of time and thousands of dollars in graduate education.

Dental schools began to recognize a need to reverse these trends when they realized the size of quality of their application pool was changing. Since 1978, U.S. schools have responded by reducing the entering class size nationally by over 28%. This is equal to having over 15 dental schools close. Based on current demographic projections, it is estimated that enrollment in future years will provide only for an adequate supply of new dentists.

In 1986 the American Dental Association in conjunction with the American Association of Dental Schools announced a jointly sponsored national recruitment program called SELECT. This program is designed to increase the number of high quality applicants to dental schools in the United States. SELECT is coordinated by a National Oversight Committee and Dr. William Harman is the full-time national director. His office and staff are located at the American Dental Association building in Chicago.

The strength of the SELECT program is that it recognizes the practicing dentist as the very best recruiter. The initial pilot program leading to the formation of SELECT indicated that state dental associations and dental schools would be the most effective avenues to the establishment of regional
programs. Virginia was one of the first states to institute a state-wide SELECT recruitment program. The cooperation of the Virginia Dental Association and VCU/MCV School of Dentistry has led to a network of over 200 dentists statewide investing their time as recruiters. Every high school in Virginia has been sent a list of dentists in their locale to notify for career day presentations. Once the dentist is contacted by the high school and negotiates a date for a presentation, the Admissions Office of the Dental School is then contacted for requests for video tapes, slide series, and recruitment brochures.

Even though the SELECT program in Virginia has been successful, additional dentists are needed statewide. Certain locales and specific high schools have very few dentists volunteering, while other areas are overplenished. If you are an individual who enjoys involvement with youths, feels a commitment to your profession and its future and enjoys talking about it, please volunteer by contacting me at my office at (804) 786-9196.

Marshall P. Brownstein, D.D.S.
Assistant Dean, Admissions & Student Affairs
Virginia Commonwealth University/Medical College of Virginia
School of Dentistry
&
SELECT Coordinator for the Virginia Dental Association
LETTER TO THE EDITOR

I read with great interest my good friend Dick Wilson's editorial "A Five-Year Dental School Curriculum: A Controversial Position" in the October-December VDA Journal. As always, Dick is able to provoke thoughtful controversy. Many of the issues he raises have validity within the current educational context; however, I believe that he offers but one solution to a complex problem. Adding a mandatory fifth year to the dental school curriculum might be a quick fix, but it avoids the major problem—the curriculum—and it is this issue which I wish to address.

With few exceptions, the basic dental school curriculum have changed little over the past 50 years. The changes that have occurred have dealt primarily with teaching the same material but in different ways. Curricular experiments have included vertical, horizontal and diagonal curricula and delivery systems have ranged from the traditional to self-paced, self-instructional and media-based to name a few. Still, in my opinion, the major issues of content and process have not been adequately addressed. Much of the material which is taught may be of historical importance but other than that, has little basis in the reality of modern dental practice.

A case in point is the tremendous amount of curricular time devoted to dental laboratory technology—for example, the laboratory fabrication of fixed and removable prostheses. One School is already experimenting with the complete removal of all laboratory technology from the curriculum, focusing instead on the diagnosis, treatment planning, prescription and evaluation of the prosthesis. This has freed up a considerable amount of curricular time and it will be interesting to learn of the experimental outcome, especially in light of state and regional board examination requirements.

Apart from curricular reform in the preclinical technique courses, a careful reevaluation of didactic content and the process of transmitting that information should be addressed. For example, as a result of the knowledge explosion, new information is discovered and disseminated at an ever increasing rate. To expect all students to understand and apply all of this new information, as well as the basics, is to avoid reality. To expect students to regurgitate this material on an objective examination as an indication of true learning is likewise folly. Would not it be better to provide students with the basic information, access to an ever expanding data base, and provide them with the critical thinking tools necessary to evaluate and apply the new information.

I, for one, believe this to be true. Therefore, I would propose that the content be revised and the process of education should involve a closer interaction between faculty and students in order to guide them through the critical thinking process. Whether or not this would increase or decrease curricular time remains to be seen, but, in the least, I believe it would provide students with the tools necessary to handle increasing complexity.

While I have theorized a bit as to the philosophy of education, there is
another area in which I believe dental schools can do a better job and that is in clinical education, especially in the sense of providing more clinical experience without necessarily increasing the length of the curriculum. For example, at MCV as at many dental schools, students traditionally treat one patient in the morning and one in the afternoon. This is due primarily to the limitations of the student owned instrument kit and the long turn-around time for sterilization. Very shortly, MCV will be implementing a tray distribution system by which instruments for any procedure will be instantly available thereby allowing students to see more patients and gain more experience in a given amount of time.

In summary, I do not believe that the “quick fix” five-year curriculum is the solution to the problem. The problem is the educational system. If done properly, it might just be possible to provide the appropriate education in the current time frame. As a closing thought, the five-year curriculum plus advanced education (for which 48% of graduates currently enroll) could mean up to nine years of education beyond college. This could potentially lead to a decrease in the applicant pool which is already perilously low.

Lindsay M. Hunt, Jr., D.D.S.
Dean
MCV School of Dentistry
LETTER TO THE EDITOR

This is a response to your editorial on Dental School Curricula. The idea of a fifth year in dental school does not seem to be a solution to the problems.

It could be taken as self-serving by those outside the profession because it keeps students in “the pipeline” a bit longer thus reducing competition. It also raises costs of dental care by making the cost of education higher and the cost to the taxpayer greater.

The argument about a knowledge explosion is also disturbing. A few years ago, schools went from four to three years when they received federal funds. Did the “knowledge explosion” reverse during these years? After federal funds stopped, the schools went back to four years. Did “the explosion” start again? With all federal funds, it would seem like knowledge would have exploded, but it seemed to do just the opposite.

Even in San Francisco, the “knowledge explosion” is irregular. U.O.P. Dental School has a three year curriculum and a few blocks away, UCSF Dental School has a four year curriculum. Maybe the knowledge explosion has fallen into a “fault”.

The most nebulous matter of all is what would schools do with an extra year? Presently, dental educators don’t even agree on what makes a dentist. To substantiate this one only need to look at the national curriculum survey and see the huge hourly differences in various subjects between schools. Do patients’ dental problems vary that widely from one state to another? (I have practiced in five states and a foreign country, and was amazed how consistent their problems were.)

Next to consider is who in the school would decide what is done with the extra year. In some schools a non-dentist may have greater influence on the curriculum than the dentists. Are those who will be making the decision any more perceptive than the rest?

What seems to have been lost in the whole affair is the patient. What are their problems? If we can focus our efforts on this matter, everyone can win, and dentistry and dental education can be more responsive and accountable.

John W. Wittrock, D.D.S., M.A.
Associate Professor of Restorative Dentistry
IMPORTANT
Membership Directory Information

The Virginia Dental Association Membership Directory will be published June, 1989. If you have a change of address or expect to change your address as of June 1, 1989, or if you have qualified with the American Dental Association as a Specialist since our last Directory (1987), please send these changes to the VDA Central Office, P. O. Box 6906, Richmond, VA 23230. Deadline is April 15, 1989.

A REMINDER

ALL VIRGINIA DENTAL LICENSE RENEWAL FEES ($65.00 FOR DENTISTS, $25.00 FOR HYGIENISTS) MUST BE PAID BY MARCH 31, 1989

SEND YOUR CHECK TO
VIRGINIA BOARD OF DENTISTRY
1601 ROLLING HILLS DRIVE
RICHMOND, VA. 23229
(this is now an annual renewal fee)

CALENDAR OF EVENTS
(Mark your calendar now for these future meetings)

VIRGINIA DENTAL ASSOCIATION COMMITTEE MEETINGS
June 9–11, 1989, Resort & Conference Center, Virginia Beach

VIRGINIA DENTAL ASSOCIATION 120th ANNUAL MEETING
September 21–24, 1989, Richmond Marriott Hotel

VIRGINIA DENTAL ASSOCIATION LEADERSHIP CONFERENCE
October 6–8, 1989, Roanoke Airport Marriott Hotel

AMERICAN DENTAL ASSOCIATION 130th ANNUAL MEETING
November 4–9, 1989, Honolulu, Hawaii
CERTIFICATE of RECOGNITION

By virtue of the authority vested by the Constitution in the Governor of the Commonwealth of Virginia, there is hereby officially recognized:

NATIONAL CHILDREN'S DENTAL HEALTH MONTH

WHEREAS, the continued progress of the Commonwealth of Virginia is to a large extent dependent on the good health of its children and youth, the citizens of tomorrow; and

WHEREAS, total good health -- physical and mental -- is enhanced through good dental health habits learned early; and

WHEREAS, the Virginia Dental Association and the Virginia Department of Health promote programs in support of good dental health habits for young people and the fluoridation of public water supplies to prevent dental disease;

NOW, THEREFORE, I, Gerald L. Baliles, Governor, do hereby recognize the month of February, 1989, as NATIONAL CHILDREN'S DENTAL HEALTH MONTH in Virginia and call its significance to the attention of all our citizens.

[Signature]
Governor
National Children's Dental Health Month
JUSTICE DEPARTMENT INVESTIGATION INVOLVING DENTISTS

The ADA Council on Dental Care Programs has received several inquiries about the implications of the present Justice Department investigation involving dentists. Recently newspapers have reported that a federal grand jury in Tucson, Arizona has been hearing testimony from dentists in that area. In addition, grand juries have also been investigating allergists in Boston, Massachusetts and obstetricians in Savannah, Georgia. Newspapers have reported that these investigations involve allegations of price-fixing by doctors.

In a recent speech to the AMA, Mr. Charles Rule, head of the Justice Department's antitrust division, sternly warned doctors that they are not exempt from the antitrust laws and that they would be fully prosecuted for violations of those laws. The type of illegal conduct warned against by Mr. Rule is conduct that has always been illegal under the antitrust laws. Mr. Rule specifically warned against:

- Agreements by independent competing doctors on any term of price, quantity or quality;
- Agreements by independent competing doctors on minimum price or other terms they will insist upon when negotiating contracts with health care delivery systems (such as capitation plans, PPOs and independent practice associations);
- Agreements by independent competing doctors that they will not participate in a particular health care delivery system;
- Agreements by independent competing doctors on the patients they are willing to serve, the locations from which they are permitted to draw patients, or the location of their offices.

All of the agreements described above are illegal.

It is important to understand that an "agreement" does not have to be written on paper or stated verbally in order to exist. Agreements can be implied from many different facts. If the circumstances show there was a mutual commitment or understanding between two or more independent doctors that illegal conduct would take place, a violation of the law can be found.

For example, assume that a local dental society held a meeting where it was suggested and discussed that everyone present agree not to participate in a capitation plan, or that everyone refuse to contract with the plan unless the rates were raised. Also assume that, although members of the group did not
expressly state their agreement to act in this manner, each individually carried out the prohibited conduct. In this example, the existence of an agreement could be implied from the fact that a meeting took place where the illegal activity was discussed.

This example is not meant to imply that dental society members do not have a right to meet. Dental societies have every right to meet with their members in order to share information. The obligation on the societies is to make sure that the information being shared is accurate and unbiased. While this may seem like a fine line when the issue being discussed is an alternative benefit plan, it is incumbent upon the leadership of the dental society to facilitate an unemotional discussion based on fact. It should always be stressed that the decision whether to participate in an alternative benefit plan, and on what terms to participate in the plan, must be made individually. If help is needed to distinguish between proper and improper activities, contact your society attorney or call the VDA or ADA.

Although the antitrust laws prohibit agreements to boycott alternative benefit plans and agreements about the terms under which doctors will become participating providers in those plans, the antitrust laws do not prohibit doctors from participating in those plans. It also is not illegal for doctors to participate in Delta plans or similar programs which require doctors to submit their confidential fee schedules for reimbursement purposes. In effect, the law treats a capitation plan or a Delta plan as a purchaser of dental services. It is therefore not illegal for those plans to insist on minimum fee schedules or other terms in exchange for purchasing the doctor's services.

We hope this information will clear up any confusion that may have been caused by the recent newspaper reports.

**MCV LUNCHEON AT D.C. SPRING MEETING**

During its 57th Annual Spring Meeting, the District of Columbia Dental Society will be hosting a luncheon for the Medical College of Virginia School of Dentistry.

Come and join us on Sunday, April the 9th at the Washington Hilton Hotel in Washington, D.C.

Our speaker will be the Dean of MCV School of Dentistry, Dr. Lindsay M. Hunt, Jr. We are planning an excellent turnout!
Dental care for children and the specialty of Pediatric Dentistry has come a long way from the days of “general dentistry for little mouths”. Each of the other clinical areas and specialties is defined by specific treatment modalities on all patients. Pediatric Dentistry is the only area which deals with all aspects of dental care defined by the age of the patient. The specialist not only deals with the general dental care of children but also with a number of problems specific to children that are beyond the scope of the generalist.

Many recent advances in materials and treatment techniques commonly used in the treatment of adults apply to the treatment of children, often with very little alteration. There are several areas of care that are more specific to the pediatric dental patient. Some that are of interest include the management of oral problems in infants and children, especially those with craniofacial birth defects, preventive therapy such as fluorides, sealants, preventive restorations, and behavior management.

**PREVENTION**

Fluoride has exerted the single most significant effect on the practice of dentistry for children. The fluoridation of municipal water supplies has become common with approximately 69% of the country’s population living in areas of fluoridated water. If the patient’s home water supply is deficient in fluoride it is recommended that children, from shortly after birth through 16 years of age, be placed on a supplement (figure 1).

Over the past decade the combination of fluorides, sealants and composite materials has brought us closer to the elimination of caries than ever before. Although there have been no major changes in the recommended protocols for the use of both professionally applied and home applied fluorides, the introduction of over-the-counter fluoride mouthrinses for daily use has greatly increased the availability of a very effective caries preventive measure to many children. The use of a 0.05% Sodium Fluoride mouth rinse has been shown to be effective in children and adolescents beginning as soon as the child is able to reliably swish and spit, typically around the age of 6 years. These rinses are used in the same way as conventional mouthwashes. To judge a child’s readiness for the use of a fluoride mouthrinse and to orient him to it, plain water and then diluted conventional mouthwash can be used.
Controlled-release fluoride devices (CRFD) provide a new approach to systemic fluoride therapy. The principle is simple: a fluoride containing copolymer matrix is encapsulated by a copolymer membrane allowing the controlled release of fluoride ions (1 mg/day) into the oral cavity. Research conducted at the National Institute for Dental Research has shown an elevation of salivary fluoride concentration from 0.02 ppm to 0.20–0.30 ppm for up to 100 days. Various intraoral appliances have been used to place the encapsulated fluoride in the oral cavity including the bonding of fluoride capsules to the buccal surfaces of molars. These studies indicate that this approach is effective and it can be anticipated that a practical method for including this in practice will evolve from this research.

For over fifty years various techniques have been employed to reduce the incidence of pit and fissure caries. As early as 1923, Hyatt introduced the prophylactic odontotomy technique with this goal in mind. Today the use of sealants and posterior composite resins provide the latest methods for eradication of this type of decay. The most recent national caries studies show that, in children between 6 and 13, occlusal lesions account for over 50% of the caries in both fluoridated and nonfluoridated groups. A 53% decrease in proximal caries over the past decade has been shown in this same age group yet decline in buccal-lingual and occlusal caries has been only 26%. Similar studies in Virginia show the same pattern. Pit and fissure sealants currently provide the best preventive procedure to address this problem.

The term “pit and fissure sealant” describes the placement of a resin material into the pits and fissures of a tooth surface to form a protective layer that acts to prevent demineralization of the enamel surface. The effectiveness of sealants is due to their ability to block the interaction between cariogenic bacteria and their nutrient substrate, thus preventing the initiation of the caries process. Introduction of the acid etch technique in 1955 by Buonocore, followed by technique refinement during the 1960’s and 70’s, led the way for the development of present day pit and fissure sealants. Studies over the past 30 years, including the National Institute of Health Consensus Development Conference in 1983, have clearly established the effectiveness of sealants. Despite these studies there still exists a reluctance on the part of some practitioners to include this technique in their practices. A recent study
done in Virginia showed that only 72.5% of general practitioners and 97.1% of pediatric dentists used sealants routinely. While this does represent an increase over usage reported in previous studies, it also shows room for improvement in this area.

The selection of specific teeth to be sealed has been and continues to be controversial, especially with the evidence that properly placed sealants will arrest incipient carious lesions. Children who are potential candidates for pit and fissure sealants can be placed into three general groups:

1. Patients whose teeth are not carious and probably will not become carious. Occlusal surfaces that have shallow, rounded, coalesced grooves and have remained caries free for at least four years fall into this category.

2. Patients whose teeth are currently caries free but can be expected to become carious if left unsealed. Newly erupted teeth with clearly defined deep pits and fissures and those with potentially incipient lesions fall into this category.

3. Patients with rampant caries who will, in all likelihood, become involved with interproximal caries as rapidly as pit and fissure caries.

The second group presents with the greatest indication for the use of sealants. However, the division between groups is not clear cut and the most realistic approach to case selection is the use of clinical judgment to select the teeth that are most likely to become carious, based on age, oral hygiene, past caries experience and fluoride history.

The sealant technique has several critical steps that must be completed correctly if sealants are to be successful. Isolation is crucial, and whether accomplished with a rubber dam, cotton rolls or other commercial products available for this purpose (figure 2A & B), it must be established and scrupulously maintained. Inadequate isolation may in fact be the single most common reason for sealant failure.

Proper etching of enamel prior to the application of sealant material is also essential for success. In this case, if some is good, more is not necessarily better! Etching for 60 seconds with a 30% to 40% phosphoric acid solution or gel produces a rather uniform pattern throughout the etched enamel. Longer etching times or greater concentrations of solution actually decrease the uniformity and quality of the etched enamel, rendering a less retentive surface for the sealant.

The selection of a sealant material is very much a matter of individual choice. If ADA approved materials are used as directed, satisfactory results can be expected. Autopolymerized materials are faster to use if multiple teeth are being sealed at one time. Light cured materials can be faster and offer more control when sealing single teeth. Colored materials are easier to see clinically, but both tinted and clear materials are easily detected with an explorer. Regardless of the material chosen, familiarity with the appropriate application of that material and careful technique are essential.

Through the expanded use of pit and fissure sealants, combined with appropriate fluoride therapy, we now
have the means to predictably prevent common types of decay in our young patients.

An interesting extension of the acid etch technique is seen with the preventive resin restoration (figure 3A & B). The use of alloy requires extension of the preparation through all the potentially carious grooves and fissures in the occlusal surface. The use of sealants and posterior composite resin materials conserves tooth structure while still properly protecting the remaining unaffected tooth surface. Many practitioners feel a reluctance to seal occlusal surfaces that have deep and/or heavily stained grooves because there is no totally objective method of determining when the incipient lesion becomes classified as active. The preventive resin restoration technique allows the removal of only obviously stained, carious material without extension through the remaining developmental pits or grooves. The excavated carious areas are restored with a filled resin material and then the entire surface is covered with sealant.

The preventive resin restoration provides an alternative to the conventional amalgam restoration. The combined use of composite resin material and sealant allows the conservation of tooth structure without sacrificing caries control. Because of the compatibility of the two materials, longevity of this type of restoration appears to be excellent.

BEHAVIOR MANAGEMENT

Behavior management is an essential yet controversial part of dental care for children. It may pose the greatest reason for the reluctance of many practitioners to treat the pediatric patient. Successful management of a child’s behavior enables efficient, quality dental care, while mismanagement can adversely affect both the quality of care and the child’s attitude toward later dental care.

Modern dental practice requires that we be acutely aware of the importance of patient management. The manner in which dental care is provided and the child’s acceptance of this care is as important, possibly more important, than the technical aspects of repairing teeth. The concept of treating the entire patient, not just the tooth, should apply to all patients, but is essential with children. Failure to recognize the psychological needs of the child will quickly lead to dealing with the uncooperative patient. Mistakes made in managing the psychological needs of the adult patient are often masked by the stoic nature of the adult or by the failure of the patient to return for treatment. The child has not learned to mask feelings, thus errors made in managing the child have to be dealt with immediately, but may also have to be addressed when the child is unwilling to return for treatment.

An additional aspect of providing care for children is the relationship that must be developed with the parent. Many of the child’s attitudes toward dentistry are learned from the parent, thus education of the parent and communication concerning treatment is of prime importance if the dental experience is to be a positive one. The most common parental complaint is a lack of communication.
The child is often separated from the parent, treated and returned to the parent without adequate communication regarding treatment or the child’s acceptance of that treatment.

Inseparable from the issue of communication with parents is that of informed consent. Unlike adult patients, children often have no desire to be in the office or to be treated, and are not legally able to consent to treatment. It is incumbent upon the dentist to inform the parent or guardian of the child’s oral problems, the recommended treatment needs, how treatment is to be carried out and consequences if treatment is not rendered. It is also imperative that this be done in terms that the parent can understand, and that all questions are answered in this same manner.

Opinions vary regarding the presence of the parent in the operatory. Generally the younger the child, the more positive the parent’s presence can be. Studies indicate that children under three years of age generally behave better with the parent present, at least for initial appointments. The parent’s presence has some advantages in that the rapport between the dentist and parent is enhanced and the parent can see first hand what is happening during treatment. This can also decrease the time necessary for the dentist to explain to the parent what has been accomplished during treatment. The parent’s presence can, however, be detrimental to the child’s behavior if the parent is extremely fearful of the dental experience and transmits this discomfort to the child by reacting to the treatment or the child’s response. It should be carefully explained to parents that the child can only effectively listen to one person at a time and that his or her attention is easily distracted from the dentist by parental reactions. Thus, the request is made not to interject commands or repeat directions that the dentist might make or to otherwise distract the child.

Appropriate communication with patients is also of utmost importance. The dentist and staff must be able to communicate in a manner which the child can understand, but which does not insult the child’s intelligence. A working knowledge of children’s cognitive and expressive abilities at various ages is essential. The pediatric dental specialist has a distinct advantage over the general practitioner in being able to develop a vocabulary and office protocol that is specific to the child and adolescent and does not have to repeatedly make the transition from adult to pediatric patients and back.

In our present litigious society, with increased media attention to children’s health issues, traditional behavior management techniques are being closely scrutinized. The behavior management methods used in the dental environment have previously been considered dental procedures and a routine part of dental practice. Present concern centers around the immediate and long term effects that some forms of management may have on children. At the present time there is little in the professional literature on this subject. Regardless of individual opinions concerning this issue, it is prudent that dental practitioners reassess the behavior techniques used
in treating their pediatric patients as to effectiveness, safety and long term effect.

NEONATAL CARE

A child’s need for dental care can arise at birth, long before the eruption of any teeth. Airway and feeding problems have recently come into the realm of the Pediatric Dentist. This often involves the fabrication, placement and monitoring of a variety of intraoral appliances (figure 4A & B).

Newborns with cleft lip and palate anomalies are the most obvious beneficiaries of such treatment. Primary objectives usually center around establishing a normal feeding pattern and assisting in airway management and respiration. Similar appliance therapy is continued as the child grows, to aid in speech and alignment of the bony structures of the oral cavity to optimize the final surgical repair. Other medically compromised infants also become pediatric dental patients at an early age. Infants requiring orogastric feeding tubes, oral airways, sump tubes or other intraoral management often benefit from the placement of appliances to shield the palate or hold various airways and tubes.

The fabrication of these appliances in newborns involves impressions of the maxillary arch with enough accuracy to allow construction of a precisely fitting appliance (figure 5). At this age, the patient’s arch is often the size of the dentist’s thumb print, making it a true challenge to obtain an accurate, complete impression. Management of the infant during these procedures requires a knowledge of infant respiratory physiology and airway maintenance. The appliances are usually a combination of acrylic, wire and the necessary tubes to fill the design requirements and must be carefully adjusted and monitored during use. As the infant grows, these appliances must often be remade with similar or different designs to maintain their effectiveness. Follow up continues long after the infant is sent home, and often involves specific instruction for parents in how to manage their child's oral condition on a continuing basis.

CONCLUSION

The treatment of children is an exciting and dynamic facet of contemporary dentistry. It has progressed far beyond the simple repair of teeth in little mouths. Like our profession, the pediatric patient population is diverse and rapidly changing. As has been said, children are our glimpse of the future; this is certainly no truer than in the practice of dentistry.

References

SEALANT ISOLATION TECHNIQUES
Rubber dam isolation (A) cotton roll isolation (B), if carefully monitored, are ideal for sealant placement.

PREVENTIVE RESIN RESTORATION
Note that the small, distinct carious area has been restored with a composite resin and then a traditional sealant has been placed to cover this restoration as well as other caries susceptible areas of the tooth.
NEONATAL APPLIANCES

(top to bottom) Palatal obturator for feeding, appliance with wire tongue positioner, appliance with oral airway tube.

NEONATAL MAXILLARY IMPRESSION

This moderate size maxillary impression is of a one week old infant with a cleft of the hard palate.
In an earlier article, the authors reported a change in employment plans for graduating dental students noting that students entering "private practice employed by other" has become the "dominant immediate career plan." It is our belief that employment of the junior dentist by the senior dentist is the first phase of a complete transition in a dental practice. Following employment, the junior dentist begins to buy into the practice, usually becoming an equal owner for a period of time and eventually purchasing the entire practice. At this final juncture, it is not uncommon for the senior dentist to become the employee. If this concept of "Role-Reversal" is recognized when the original employment agreement is negotiated and a similar contract is agreed upon for the final phase, the negotiations tend to be much easier.

The reasons why a younger dentist would buy or buy into an existing practice are similar to those used in deciding to associate. However, after a period of time the need to share in managerial decisions, to share in the practice profits (or losses) and, most importantly to share in the increased value of the practice itself more than likely will convince the employee that he should consider becoming an owner. The senior dentist at some point probably will concur with this decision so that he will have someone to share managerial decisions, to share profits or losses, and most importantly have someone to purchase what is probably his most valuable asset.

We are often surprised but pleased to see that a predominant motive for a buyer's decision to purchase a specific practice is based on respect and admiration for its most valuable asset, the senior dentist. On the other hand, the owner's decision to sell most often reflects his belief that his patients will receive the best possible care from this new associate. We, therefore, highly recommended whenever possible to have a period of working together before the decision is made to sell the practice.

The paper approaches the practice valuation and sale process from two views: First, is an outline of those assets that must be evaluated to arrive at a fair price for the practice; second, are the major considerations which must be agreed upon to complete the sale. But first a comment on timing. The purchase of a dental practice is a time-consuming and often frustrating process. We have seen instances where it takes more than a year for either party to raise the issue after both had initially expressed an interest in negotiating a sale. It is amazing how long two people, who work together on a daily basis, can postpone discussions on such a matter. After discussions of mutual interest, several
months may be spent collecting and interpreting data. This may be followed by protracted periods of intermittent negotiations. Before the parties realize it, several years have passed and their needs and goals may be different from what they were when the process began.

For the senior dentist, it is important to begin early when the practice is at or approaching its peak value. In this manner he can obtain the highest return on his investment and still have time to find another buyer if negotiations prove unsuccessful. Beginning early is also important for the junior associate so that the goodwill he purchases is only that of the current owner and so that he can start a search for another opportunity if negotiations prove unsuccessful. For these reasons, we recommend that the initial agreement stipulate a mutually convenient time for the parties to begin the valuation and sale process.

To determine a sales price, responses for the following questions must be obtained:

- When was the practice started?
- How long has the seller owned the practice?
- Why does the owner wish to sell?
- When does the owner wish to sell?
- What are the owner's plans after the sale?
- What has been the trend of profits?

This is evaluated by using tax returns from the last three to five years and if they exist, annual income statements which are extremely helpful in the valuation process. A practice which has been incorporated should supply Form 1120 and explanatory documents. The proprietorship should supply Schedule C and its working papers. It is not necessary to see the entire tax return.

- Does the practice have an annually prepared Balance Sheet or Statement of New Worth? If so, is the current financial position sound?

**Is the net profit consistent with:**

- The number of patient visits? If not, the fee schedule may be low or collections may be poor.
- The Gross Income? If not, it may be necessary to determine which overhead items are excessive.
- Are the fixed assets properly valued?
- Are they modern?
- Are they in good working condition?

It is very helpful if the accountant for the practice can provide a list of all depreciable assets. The list should describe the asset, give its location, date of purchase, and original acquisition price.

- In terms of both patient visits and new patient visits, is the practice growing, declining, stable?
- What are current normal days and hours of operation?
- If the building is or will be rented, what is the nature of the lease?

The major considerations are rental cost per square foot; term of the lease; renewability; method for increasing rent; current value of leaseholds; need for improvement in leaseholds.

- Is it a general or specialties practice?

If general what services generate most of the income? Also, what is the mix of procedures currently performed. If specialty, what is the refer-
ral pattern? What is the assessment of continuation? —Ask!

What is the overall reputation of the practice?
Check with patients, other area dentists, suppliers.

• What is the condition of the recall system?
While an effective and efficient recall system is an obvious asset that increases the value of the practice, an inefficient system coupled with an increasing income from the practice may provide an excellent opportunity for a new associate. Efficiency should be measured by the proportion of patients who receive a recall notice; effectiveness is measured by the number who return.

• Are the current employees of value to you?
Are they willing to remain? What is the current salaries and benefit costs? Is there an existing retirement plan for staff that can (or must) be taken over? Are employees willing to adapt to your style?

• What is the nature of the “community”?
Is it growing? Are there prospects for new businesses or residential establishments? What is the prevalence of dental insurance? What is the competition? What is the socioeconomic mix of the area and its probable patients?

• What is the type of building?
Is it accessible and does it have convenient parking? Are there other tenants who may provide referrals or services (e.g. accounting or legal)? Is the size of the office adequate? If not, is there room for expansion?

What is the quality of:
Patient records?
Financial records?
Asset ownership records?

• Will the investment in this particular dental practice earn as high a return as could be made by starting a new practice in a similar location?

The typical dental practice sale includes both tangible and intangible assets. The tangible assets are those that are usually included in the net worth statement as long-term assets. Short-term assets such as cash and liabilities are seldom included in the purchase. The assumption is that the seller can give clear title to all assets being purchased and that all practice liabilities will have been remitted before the sale is completed. It is also reasonable for the buyer to assume that all the tangible assets of the practice (with the exception of corporate-owned automobiles) are part of the sale. We recommend that the seller prepare a list of all property that is not to be included with the sale. An antique instrument cabinet, a refrigerator in the lounge, and a photocopier are examples of items we have seen cause hard feelings in a potential sale because their disposition was not made clear at the beginning. The actual purchase price will be apportioned to the following assets:

TANGIBLE ASSETS

Real Estate
If the selling dentist owns his building it may constitute a larger share of the total purchase price than all other assets. Because it is such a large expense it is frequently not included in
the sales agreement. If the building is to be sold, the typical method for determining the price is for each party to select a competent commercial real estate appraiser who will provide an assessment of its value. If the assessments are within 10 percent of each other, the average of the two is selected. If the difference is larger and the two parties do not agree on using the average as the price, then both appraisers should select a third individual whose appraisal would establish the price.

The location of the property is a major element among the many factors that must be considered in determining the value of a practice. Therefore, if the building is not included in the sale, the buyer must have some assurances that he will be able to purchase it and maintain the same location in the future. This requires that the buyer either be given an option which is a commitment that the buyer can and will buy the property at some determinable future period (e.g., in no less than five years, nor greater than ten years) for a price usually arrived at by the previously mentioned appraisal process or a right-of-first refusal which simply affords the buyer the right to match any offer to purchase the practice but does not convey a guarantee that he may purchase.

**Equipment**

Equipment includes dental operatory equipment, laboratory equipment, business office equipment and furniture, furniture in the reception area, the private office, the staff lounge and any other appropriate location. It should also include those instruments which are relatively long-lived and expensive (e.g. surgical instruments used in a general practice). Several methods are available for determining the value of such equipment. First, is to have an appraisal made by someone who is knowledgeable about dental equipment, usually a dental supplier. While we believe that this is the best method, we have recently seen an appraisal of the identical list of equipment where the estimate made by the buyer’s appraiser was 83 percent higher than that made for the seller. Just the estimate of the value of miscellaneous instruments alone was three times higher for the buyer than for the seller, yet both estimates attempted to arrive at the “fair market value”. While this may be an extreme case, it points out the need for careful analysis of the appraisal figures and may indicate a need not only for two appraisals but also for a method for resolving major discrepancies. This method could be similar to the “arbitration” appraisal for the real estate. Both parties should expect to pay for these appraisals.

The second method for determining the value of equipment requires a complete and accurate list of all equipment which has a useful life of more than one year. If your accountant can provide the list of assets in the format given earlier, a value can be arrived at by stipulating salvage or residual value (usually about 20 percent) and then “depreciating” the equipment over a period from eight to twelve years. The average of ten years is used unless there is evidence of either extraordinary care or abuse. A
final method, which we do not favor, involves the capitalization of income where the entire value of the practice is some multiple of earnings. This will be discussed further under goodwill.

**Supplies and Miscellaneous Instruments**

These should not be inventoried because of the time involved and because by the time the sale is completed the inventory probably will be consumed and replenished to some degree. The typical dental office maintains about a three month inventory of consumables. This means that about 25 percent of the average annual amount of dental and office supplies and materials would be included in the inventory and would represent a fair price.

**Accounts Receivable**

This should be the easiest asset to evaluate because a specific value is assigned to each account. However, what is actually collected on each account may be quite different. To avoid unnecessary disputes, we recommend that the seller retain ownership of all receivables. This eliminates many questions concerning payment plans, slow payments, insurance balances, etc. If the seller is leaving the practice, the buyer can continue to collect accounts applying payments to existing balances and remitting on a monthly basis to the seller less a collection activity fee of 8 percent (small number of accounts with large balances) to 10 percent (large number of accounts with small balances or slow payors). If the seller must be paid for receivables, the generally suggested approach is to pay 70 percent to 80 percent of all accounts on which payments have been made within the last 90 to 120 days. We favor the higher percent and the shorter period.

**Intangible Assets**

The Small Business Administration in its publication “Buying and Selling Small Business” states that goodwill “arises from all the special advantages connected with a going concern . . .” and represents, “ . . . the ability of a business to earn above-normal profits as a result . . .”. In an unpublished monograph on Dental Practice Appraisal, Jack Trask defines “goodwill” as the “physical possession, of control of and access to patient records”. James Jackson and Roger Hill, in an excellent book on the subject of valuation divide the entire set of intangibles into “Going-concern Value”, which includes items such as staff, records, and location, and “Goodwill” as “the expectation of future profits under the ownership of someone other than the present owner”. This definition is taken from Revenue Ruling 59-60. Carl Caplan defines goodwill as “the inherent value brought to the practice by the owner-doctor” and suggests that practice activity be used as a benchmark for goodwill. Our classroom working definition of goodwill is “the potential patient flow available to the new dentist which would not otherwise be available if he started a new practice and the associated efforts on the part of the seller to ‘persuade’ patients to remain with the practice”.

In terms of valuation, intangible as-
sets include some combination of: Patients Records, Covenant Not to Compete, Consulting Agreement, and Goodwill. The total price for intangibles is allocated over these areas as may be appropriate and as taxes may dictate. The following table adapted from the American Dental Association shows the tax consequences of amounts apportioned to each item. One beneficial result of the recent tax changes is that the parties are no longer in an adversarial position on the allocation of total price to different intangible assets now that the real tax consequences of capital gains and ordinary income has been eliminated.

"Tax Treatment for Practice Assets"

<table>
<thead>
<tr>
<th>Assets</th>
<th>Seller</th>
<th>Buyer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buildings</td>
<td>Gain over basis (May be partly ordinary income)</td>
<td>Depreciable over 3½ years</td>
</tr>
<tr>
<td>Equipment and Furnishings</td>
<td>Gain over basis (Part ordinary, part capital gain)</td>
<td>Depreciable over 7 years</td>
</tr>
<tr>
<td>Supplies</td>
<td>Ordinary income if previously deducted</td>
<td>Deductible</td>
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<tr>
<td>Accounts Receivable</td>
<td>Ordinary income</td>
<td>If purchased, deduction against actual collections</td>
</tr>
<tr>
<td>Leasehold Improvements</td>
<td>Gain over basis (May be partly ordinary income)</td>
<td>Depreciable over the life of the lease.</td>
</tr>
<tr>
<td>Restrictive Covenant</td>
<td>Ordinary income</td>
<td>Depreciable over covenant period.</td>
</tr>
<tr>
<td>Consulting Agreement</td>
<td>Ordinary income as services are performed</td>
<td>Deductible as services are paid for.</td>
</tr>
<tr>
<td>Goodwill</td>
<td>Capital gain</td>
<td>Not deductible</td>
</tr>
<tr>
<td>Other Intangible Assets: e.g. Patient Records</td>
<td>Capital gain</td>
<td>Amortizable or depreciable over useful life</td>
</tr>
</tbody>
</table>

From: ADA Valuation of a Dental Practice. Chicago: American Dental Association, 1984 (Adapted and Updated for recent tax law changes. It should be noted that currently there is no tax rate differentiation between capital gains and ordinary income.)
Intangible Valuation Methods

In all the literature on determining the value of dental practice, there is one (and probably only one) firm and consistent point of agreement: There is no single formula, number, method, or approach that can be used in placing a value on all dental practices for the purpose of a sale. A common claim is that the selling price of a dental practice should be based on the previous year's gross income. Some say that this includes tangible assets while others claim this is in addition to physical assets. Other suggestions are that the selling price should be based on some portion of gross income, the average of several year's gross, or a fixed percent of last year's gross plus a variable percent of last year's gross depending upon the overall efficiency (however that might be measured) of the practice.

We are convinced, as are most others, that gross income is not the right place to start in placing a value on a dental practice valuation. For example, if two practices had a gross income of $200,000 per year, but one had a net income of $90,000 while the other had a net of $120,000, they would be treated equally in an approach based on gross revenue. If we accept the fact that goodwill represents a potential patient flow not available to a new practice, then it seems logical that a buyer should be willing to pay for the income stream that this potential patient flow represents. However, that income stream would be based on the profit or earnings realized by the buyer, not the production necessary to generate the profit.

Profit or earnings when used to determine the value of a dental practice are different from those determined for income tax purposes. In our determination of earnings, we include actual profit or loss, officers' salaries if incorporated, spouse's salary if only working sufficient time to generate salary for a retirement contribution, depreciation (as a non-cash expense) investment income, retirement plan contributions, and 50 percent of the cost of what we term "beneficial requirements", which include items such as travel, meals, entertainment, lodging, registration fees, reimbursed disability insurance, etc. Each practice has its own unique collection of these "profit" items and each must be evaluated individually. The listing of profit items should reinforce the idea that the seller should consider selling the practice when it is at its peak earnings level rather than during the slow-down phase prior to the owner's retirement.

After the profit or earnings are determined, a variety of techniques are still available to compute goodwill. The Small Business Administration recommends the "capitalization of average net earnings", or the "capitalization of average excess earnings", including asset values and earnings as methods for deriving the entire value. Jackson and Hill discuss both of these methods in addition to their preferred Discounted Cash Flow Method which projects earnings into the future and then discounts them back to current value. All these approaches start with a strong empirical base, the recorded earnings, but then base the entire valuation on the selection of a capitalization rate or discount rate. Unless
some standard for determining these rates can be developed their selection remains in the realm of wizardry and places excessive reliance on a single unverifiable figure, minor modifications of which can result in huge changes in the final value. We prefer to use the appraisals if they are fair and a weighted average of adjusted earnings to arrive at a figure on which both parties can begin to negotiate. Earnings are adjusted in a range of 90 percent to 150 percent, depending upon the perceived and assessed value of the intangible assets previously described. This simply reflects the realization that the true worth of the practice is the price that both buyer and seller can agree upon.

OTHER CONSIDERATIONS

Financing

While a great deal of time and effort are usually devoted to determining and negotiating the selling price of the practice, the discussion on the terms for financing the sale are even more crucial. When sold the typical dental practice has twenty to forty percent of the total price represented by tangible assets. This means that the prudent banker will be willing to lend the buyer 10 to 20 percent of the total cost of the practice. We have met very few buyers who can raise sufficient funds to finance the balance. The terms for financing the sale should be the major area where both buyer and seller can have mutually beneficial terms. We recommend that the buyer make a 10 percent down payment on the purchase, with the balance financed by the seller at the current prime lending rate. This rate is often two to three points lower than the buyer could secure commercially, and is probably one to two points above the fixed rate of return the seller could receive for an investment involving the same risk. The rate can be either fixed or variable, depending upon the wishes of the parties to adjust payment schedules. The period ranges from five to ten years; an eight year repayment schedule is most common. As a word of caution, the parties should check with the IRS or their own accountant for the IRS required rate to avoid a portion of the sale being considered “imputed interest”.

At the time of sale, the buyer makes the downpayment and signs a promissory note for the balance. The note should be the same as in any other lending situation and is secured by the practice and any personal assets that the seller may wished pledged. At this point, the buyer owns that proportion of the practice represented by the note.

Compensation Agreement

An agreement stating in detail how each party will be compensated is needed in all instances except where a complete buyout has taken place and the seller is not remaining with the practice. This is especially important with phased buy-in situations where the seller's and the buyer's production and equity are unequal. The best format for this agreement is the one that was originally negotiated when the buyer was the employee. However, we are seeing an increasing number of situations where the parties no longer divide patients and revenues but share
the total income on a predetermined basis, such as time worked. This not only simplifies the bookkeeping but also provides a greater opportunity for the buyer to see and treat the seller’s patients and thereby facilitate the transition process. Whatever the basis for sharing income, there should be a written agreement which both parties understand and to which they agree.

Restrictive Covenant

The restrictive covenant or covenant-not-to-compete is becoming commonplace and acceptable in the employment agreement. It is far more crucial in the purchase agreement. The employee who leaves a well-developed and well-managed practice after a year will probably not severely damage that practice. On the other hand, should the seller of a practice (usually the senior dentist) decide to return to the practice of dentistry in close proximity to the prior location, the effect can be devastating to the buyer or junior dentist. However, in most states, including Virginia, the same test for reasonableness could be applied. Our article on “Associate-ships in Dental Practice” described the details of these tests which require that the restriction be: “(1) not greater than necessary to protect . . . the legitimate business interest; (2) not unduly harsh . . . in curtailing efforts . . . to earn a livelihood, (3) reasonable from the standpoint of public policy”.

In all cases the restrictive covenant must be reasonable in terms of the period of time involved and geographical area which is restricted. Liquidated damages should also be specified. It is our opinion that the time may be somewhat longer and the restricted area somewhat greater in the sales agreement than in the employment agreement. It is also possible to stipulate that the value of the intangible assets represents the appropriate amount for liquidated damages and that one-half to one-third of this value be repaid for each year of violation. The advice and assistance of a qualified attorney is essential in this area.

Maintenance of Records

The buyer must be required to maintain appropriate charts, records, radiographs, casts, and models. These should be kept in a manner and for the length of time as recommended by the appropriate body (e.g. American Dental Association, American Academy of Pediatric Dentistry, American Association of Orthodontics, etc). The seller should be guaranteed access to these records during normal working hours with some mutually agreed upon (e.g. one day) notice.

Insurance

Quite possibly the most complicated section of the buy-sell agreement is that dealing with insurance. The parties should purchase insurance for the sale, using the same guidelines as any other insurance purchase: “purchase insurance for those perils which you cannot insure yourself”. The following insurance products can be considered:

Life Insurance

Term life should be carried by the buyer so that his estate can complete the obligation to the seller. When both parties are owners each should carry sufficient term coverage on the
other to effect the buy-out in case of death.

**Keyman Disability/Business Interruption**

This can be purchased by the buyer so that, if he is disabled, a substitute can be hired (the seller, if possible), the practice can continue to operate, and the purchase payment can still be made.

**Disability “Buy-Out”**

This is coverage which the owners can purchase on each other so that the buy-out can be continued (or be reversed if the parties choose) if either is disabled. The minimum waiting period is twelve (12) months.

**Personal Disability**

While this has nothing to do with the sale, it may provide coverage to the disabled’s family which other policies do not provide. If sufficient, it may eliminate the need for some other coverage.

Needless to say, the cost of this insurance is expensive. Both parties must carefully review their own and each other’s needs and purchase that combination of coverages which are considered essential.

**Conclusion**

We are convinced that each dental practice is unique and that the sale and purchase of the practice must reflect this quality as well as the special needs each buyer and seller brings to the transaction. Before considering a sale or purchase both buyer and seller should be properly represented. Your current attorney, accountant or financial or management consultant is the appropriate person to consider for such representation. If they cannot properly represent you, ask them for references. We feel such representatives should know dentistry, be able to help both parties reach agreement and should be someone who has been recommended by your colleagues. Be sure to determine what is being provided: an appraisal, a total evaluation, an agreement, all legal contracts. Also, find out the costs of whatever services are provided. We have seen such transactions range from a free appraisal of equipment to a completed contract (excluding direct party negotiations) which cost more than 10 percent of the value of the practice.

The ADA’s publication on Valuation of a Dental Practice includes the statement that the buying and selling of a dental practice causes more confusion, uncertainty, and anguish than any other business transaction encountered by dentists. While some problems may be inevitable, a well-developed agreement especially one starting with the buyer as employee and ending with the seller in that position can minimize the anguish in this crucial phase of a transition in a dental practice.

**Bibliography**


Doctor Arthur A. Dugoni, a San Francisco orthodontist and dean of the University of the Pacific dental school since 1978, was installed as President; and Doctor R. Malcolm (Mike) Overbey, a general dentist from Memphis, was elected President-Elect. Installed for a one-year term as First Vice-President was Doctor Charles H. Smith from Atlanta; and Doctor Charles E. Wilson of Fairfield, California, was installed as Second Vice-President. Doctor Gary Rainwater, a general dentist from Dallas, was elected Speaker of the ADA House of Delegates.

Doctor Bennett A. Malbon, Chairman, presided over the Sixteenth District Caucus Meetings. Doctor James H. Gaines from Greenville, South Carolina was re-elected Trustee of the new District and Doctor French H. Moore, Jr. was re-elected Secretary-Treasurer.

The following action was taken by the 1988 ADA House:

**Budget and Administrative Matters:**

The proposed 1989 budget of more than $42 million was approved. The budget was trimmed by more than $500,000 from 1988 expenditures with no dues increase.

In approving the $42 million budget, the House also approved a controversial $35 registration fee for the 1989 ADA Scientific Sessions in Hawaii. The registration fee was introduced to offset loss of exhibit income.

**Scientific Matters:**

A revised policy statement on AIDS and HIV infection was adopted. The statement includes several revisions clarifying the issue of appropriateness of referrals of HIV infected patients and by incorporating the advisory opinion adopted by the Council on Ethics, Bylaws and Judicial Affairs that a practitioner should not refuse to treat a patient solely because the patient is HIV infected.

The House revised a resolution adopted last year stating the Association’s opposition to classifying AIDS as a “handicap” rather than as a “communicable, infectious disease.” In the revision, a new resolving clause was added making it clear that the Association opposes discrimination on any basis, including discrimination against infectious patients. This statement was added to counter some legislators and the news media who have suggested the 1987 ADA policy condoned discrimination against infectious patients.
LEGAL AND LEGISLATIVE MATTERS:
Relative to infection control, the House adopted a resolution recognizing that the individual dentist should have both the authority and responsibility to determine whether a procedure poses risk of infection, and determine the proper measures to take in order to minimize risks. Further directed that the principles involved in infection control be reviewed recognizing the dentist's professional judgment and such principles be forcefully advocated to OSHA and other appropriate agencies.

DENTAL EDUCATION AND HEALTH:
The House adopted a detailed policy statement defining the Association's position on dental auxiliary education, credentialing and utilization. The statement replaces interim policy adopted last year. The statement serves as a basic reference on auxiliary issues (i.e., delegation of auxiliary functions, supervision, employment settings, education and licensure). The statement clearly focuses on the dentist's ultimate responsibility for patient care.

I would like to commend the Virginia Delegation for their hard work and dedication in representing Virginia well at the 129th ADA House of Delegates. We were in full attendance at all Caucuses, Reference Committee Hearings, and House of Delegates Sessions. It is a personal privilege to serve as Chairman of the Virginia Delegation to the ADA.
The T.D.A. is starting a program of communal service by providing free dental treatment to deserving people recommended by the social service departments. Fifty members have volunteered to treat five patients a year for basic dental care. We hope to bring more dentists into the program as time goes by.

Four T.D.A. members were honored at the A.D.A. Annual Meeting in Washington D.C. this past October. Inducted as fellows of the American College of Dentists were Herb Bonnie, Bill Dodson and Bob Rubin. Larry Cash was inducted in another ceremony as Fellow of the International College of Dentists. Congratulations.

Component One is starting a series of mini-scientific meetings with a two hour program on Thursday, January 19, 1989 at 7:30 in Hofheimer Hall of E.V.M.S. The speakers from the M.C.V. School of Dentistry are Dr. John Svirsky on “Oral Pathology Lesions” and Dr. Tom Koertge on “Status of Oral Antimicrobials”. All dentists and auxiliaries are invited. There is no fee.

The Annual Southeastern Virginia Dental Symposium sponsored by T.D.A. will be held at the Hilton Convention Center at Kings Mill in Williamsburg on March 9, 10 and 11, 1989. The speaker on Thursday, March 9 will be Dr. Charles Ben Bissell on “Managing Change and Transition for the Dental Practitioner” and on Friday, March 10 and Saturday morning, March 11 Dr. Clifford W. Fox, Jr. on “Restorative Dental Procedures.” Dr. Fox is Section Editor of Restorative Dentistry of the Journal of Craniomandibular Practice. Plan to attend this excellent program.

HAPPY NEW YEAR!
COMPONENT IV

RICHMOND DENTAL SOCIETY

Carl O. Atkins, Jr.
Associate Editor

The holiday season is over, winter is leaving us and spring is knocking at the door. With all these changes the Richmond Dental Society moves steadily on towards the end of our year.

Our fall schedule was full and varied. In October Dr. Robert Steadman spoke on "Splint Therapy". In November Dr. Joe Niamtu presented an "Oral and Maxillofacial Surgery Update", Dr. Reuben R. Roach presented "Rx for Excellence in Restorative Dentistry" and we staffed a health fair associated with the Tuckahoe Y.M.C.A.'s annual Ribbit Run. Our annual Christmas program featuring Madri-jazz from Lee Davis High School was enjoyed by members and their spouses in December.

The New Year brings many interesting programs. Dr. Steve Saroff will speak on "Periodontics of Tomorrow... Today—Laser Surgery and Implants" in January. Dr. Norman J. Marks will speak on "Posterior Composites" in February. Laboratory Night will be held starring local labs in March. Dr. Benita A. Miller will speak on "Periodontal Disease Activity—Some New Approaches to an Old Problem" in April. Coach Dick Tarrant will speak on "College Basketball" in May.

All-day programs for the coming year include an A.D.A. program on the "Do's and Don'ts of Associate-ships and Practice Valuation" by Larry Domer, D.B.A. and Randall K. Berning, J.D. on January 20, 1989, "Dynamic Practice Management—Course III" on March 10, 1989 by Linda Miles and "Winning Financial Management Strategy for Dentists" and "Planning Today for Tomorrow's Retirement" in a two day program on May 12–13, 1989 by Dr. James Jackson.

I would like to take this opportunity to welcome the new members to the Richmond Dental Society Dr. Scott A. Allegretti, Dr. Hood E. Biggers, Dr. Kathryn Finley-Parker, Dr. B. Jackson Friend, II, Dr. Ralph M. Hoffmann, Dr. Connie S. Kitts, Dr. Gregory K. Kontopanos, Dr. Thomas G. Schleicher and Dr. Vera Tarasidis. I hope you find your association with the Richmond Dental Society rewarding.

Here's looking for spring!
The Fall Meeting of the PDS was held Friday, 28 October 1988 at the Lynchburg Holiday Inn. The meeting was called to order by the President, Duane Burnett. Bernard F. Smith is the President-Elect and W. H. Frazer, III is the Secretary-Treasurer. The members of the Executive Committee are James Muehleck, Martinsville, Nathan Stephens and Fred Alouf, Jr., Salem and Albert Payne, Danville. The following new members were announced: Drs. Robert Kinney, James Reynolds and Douglas Ross from Roanoke and Bruce Bently and Donald Wallace from Lynchburg.

Dr. Walter Dickey from Roanoke reported on activities of the Virginia Board of Dentistry. Dr. Jim Johnson was recognized as the new President-Elect of the VDA. Dr. Johnson discussed the importance of contributions to ADPAC and VADPAC. Your PAC contributions help make our legislators more responsive to our profession. The more we dentists become involved, the better off the citizens of our state, and likewise our profession, will be.

Revisions to the PDS By-Laws were approved and a copy of the new By-Laws will be published for distribution to members.

The continuing education course “Osseointegrated in Clinical Dentistry—Restorative Aspect” was presented in two parts. Dr. William C. Bigelow discussed surgical techniques and considerations and Dr. E. Wayne Davis discussed the restorative aspects of implants.

Since the meeting Marvin Thews reported that Dr. Lewis E. Witherow passed away in Roanoke at the age of 80.

For your information, the following is a listing of the officers for the local dental societies in the PDS. Danville-Pittsylvania Dental Society: President—Albert Payne, Vice-President—Jim Evans, Secretary-Treasurer—Jessie Wade. Patrick Henry Dental Society: President—Kenneth Midkiff, Secretary-Treasurer—Mark Crabtree. Roanoke Valley Dental Society: President—Marvin Thews, President-Elect—Scott Anderson, Secretary—Norman Peets, Treasurer—John Harris. Lynchburg Dental Society: President—Dave Kiger, President-Elect—Richard Zechini, Secretary-Treasurer—Dan Grabeel, Officer-at-Large—Wayne Coleman.

The Spring Meeting of the PDS will be given with the Roanoke Valley Dental Society on Friday, 12 May 1989 at the Roanoke Airport Marriott Hotel. Dr. Harold Meador, a periodontist from San Antonio, Texas, will speak on “Expanding Periodontal Services to Increase Production and Reduce Liability”.

COMPONENT V

PIEDMONT DENTAL SOCIETY

Cleve H. Porter, Jr.
Associate Editor
The Southwest Virginia Dental Society was very fortunate to have the Empire chapter of the American Red Cross conduct a full day CPR course for its December meeting. The meeting was held at the Virginia Highlands Community College and was well attended by dentists and staff. Certification cards were given upon completion of the eight hours of intense practice, practical test, and written test. We are very grateful to the Red Cross for their great effort.

Our next meeting will be March 7, 1989, again at the Virginia Highlands Community College in Abingdon. Dr. Richard E. Wilson will be speaking on "Porcelain Laminates and Resin Inlays". We look forward to this interesting subject by a very gifted speaker.

Our May meeting will be May 12, 1989, at the Radford Best Western Inn. Dr. Phillip A. Cook will be our guest speaker. Dr. Cook is the director of the Prosthodontic Residency Program at William Beaumont Army Medical Center, El Paso, Texas. Dr. Cook will be speaking on dental implants from the general dentist viewpoint.

Our officers were very enlightened by attending the VDA's Leadership Conference in Charlottesville in October. The conference emphasis of professionalism with its distinguished speakers was very uplifting. We now look forward to the committee meetings in Richmond on January 28 and 29.
The Northern Virginia Dental Society finished 1988 in grand fashion, offering seminars entitled “Orthodontic-Periodontic Interrelationships” with Dr. Slick Vanarsdale and “Taking an Associate” with Dr. Bernard Fink, the first Component VIII member to address our group. Both were comprehensive in content and well-received by the membership. The holiday season was highlighted by a Legislative Brunch hosted by our Component and held at the boyhood home of Robert E. Lee in Old Town Alexandria. Dr. Al Griffin, Sr., organized a very pleasant and successful gathering with the able assistance of staff members Sue Hamilton and Ellen Flanagan. Attendance consisted of two State Senators, eight State Delegates, Dr. and Mrs. Steve Bissell, Dr. and Mrs. Richard Wilson, Mrs. Pat Watkins, component officers, and members of the Executive Committee.

We welcomed 31 new members into our group recently.


In closing, our component was proud to announce that Drs. David C. Anderson and Rodney J. Klima were the recipients of the International College of Dentists’ 1988 Gold Scroll Honorable Mention in Division II of the Section’s Journalism Competition for their work as Editors of the NOVA NEWS. The award was presented at the recent ADA/FDI 1988 World Dental Congress in Washington, D.C.
Enjoy sun, sand, surf and science in Honolulu at the 130th Annual Session of the American Dental Association, November 4-9, 1989. “Challenge, Change and Commitment” is the theme of the meeting, which will be held in the beautiful capital city of Hawaii, Honolulu. With its ideal climate, magnificent sights and lively nightlife, Hawaii offers glimpses of a unique culture in a resort setting.

The Scientific Session, November 4-7, will feature technical exhibits, lectures, registered clinics, limited clinics, workshops and table clinics.

The Business Session, including the House of Delegates meeting, will be held November 5-9 at the Hilton Hawaiian Village. Special events include the President’s Dinner Dance, a fashion show luncheon and a traditional Hawaiian luau.

Three different 2-day post-convention seminars will be held on the neighboring islands of Maui, Kauai and Hawaii, and escorted sightseeing excursions to the outer islands are also available.

Tours have been arranged following annual session to various Pacific Basin destinations, including Australia; Australia and New Zealand; China and Hong Kong; and Bangkok and Singapore.

Advance registration, ticket sales and reservations for housing and tours are being processed in the order received, so make your plans early!

The Preview of the meeting, including registration and reservation forms, is included with the January issue of the Journal of the American Dental Association (JADA).

For further information, contact the Council on ADA Sessions and International Relations, Suite 1616, 211 E. Chicago Ave., Chicago, IL 60611, or call WATS extension 2658.
In addition to the teaching efforts of the MCV School of Dentistry, the faculty are involved in many other endeavors. To recognize some of the outstanding work done by the faculty, the editor plans to feature one or two departments in upcoming issues of the Journal.

RESTORATIVE DEPARTMENT HIGHLIGHTS

The Restorative Department consists of 17 full-time faculty, all with diverse areas of interests. Between March and November 1988 faculty efforts resulted in 10 publications, 7 grants/fellowships, and 14 presentations at the national and state levels. Although it is not possible to list all the research projects, publications, and presentations, some of the works in the department have included (1) G. Button, P. Moon, et al., effect of preparation pretreatment on crown retention (International Association Dental Research); (2) D. Covey, punch-shear test on light/heat cured posterior composites (A. D. Williams Summer Student Research Fellowship); (3) R. Barnes, comparison of marginal fit of castings fabricated from impressions using Kerr's Reflect and Caulk's Hydrosil (L. B. Caulk); (4) P. Moon, R. Barnes, retention of an improved resin for resin-bonded retainers (IADR); (5) R. Eshleman, C. Janus, R. Jones, “Tooth preparation designs for resin-bonded fixed partial dentures related to enamel thickness” (J. Prosthetic Dent); 6) D. Pratten, “An evaluation of finishing instruments for an anterior and a posterior composite” (J. Prosthet Dent); (7) H. Douglas, “Making Perfect Impressions and the Restoration of Endodontically Treated Teeth” (C. E. Course); (8) D. Beck, C. Janus, “A study of shear bond strength of composition resin porcelain repair materials bonded to porcelain and metal” (J. Prosthet Dent); (9) F. Bush, et al., temporomandibular joint syndrome vs myofascial pain dysfunction: one and the same? (IADR); (10) R. Sheats, L. Rubenstein, bone grafting to permit tooth movement at a later date (NIH Grant); and (11) B. Hagan, financial impact of employer-employees relationships in dental practice (A. D. Williams Grant).

Also, the department established two awards that will be presented annually in recognition of teaching excellence. The FitzHugh Adjunct Faculty Award was given to Dr. William D. Covington, and Dr. Gilbert Button was recognized as the Restorative Dentistry Teacher of the Year for 1987–88.
The Dial-A-Doc telephone program, offered by the School of Dentistry, began its second year this fall. This service, which is a free consult and referral service for dentists, is available to all dental practitioners in the Commonwealth of Virginia, as well as all alumni of MCV/VCU whose practices are located anywhere in the United States.

During the first year of implementation of this endeavour, over 100 calls were received and processed. "We are trying to enhance both the usage and availability of this program this year," said Tom Burke, Director of External Affairs. "We are mailing pressure-sensitive telephone stickers with the Dial-A-Doc number in our annual campaign giving letter. Additionally, we are installing an answering machine for individuals who may find it more convenient to call the service in the evening. All calls will be promptly returned the next work day."

At the present time, calls are taken between 8 a.m. and 4 p.m., Monday through Friday. In most instances, the calls pertain to requests for information relative to new dental techniques, dental materials, drug allergies, reconstructive surgery, etc. Our Dial-A-Doc operator immediately refers all incoming questions and/or requests to the proper department for the appropriate action. A faculty member from the designated department returns the call within 24 hours. Emergency calls are handled immediately, or as soon as the on-call faculty member is located (which is usually within 15 minutes).

"I have been pleased with the initial usage," said Dr. Lindsay M. Hunt, Dean. "During our second year, and with the improvements mentioned, I sincerely hope many more of our colleagues will utilize the "Dial-A-Doc" service."
FUTURE PROGRAMS PLANNED FOR THE VIRGINIA DENTAL ASSOCIATION’S STATEWIDE PROGRAM OF CONTINUING EDUCATION IN 1989

A brochure describing future continuing education courses in 1989, sponsored by the Virginia Dental Association, will be sent to members in the next several months. The list includes:

COMPONENT 1
May 5, 1989
Norfolk, VA
Financial Planning for the Dental Professionals
W. Charles Blair, D.D.S., Ph.D.

COMPONENT 2
November 17, 1989
Hampton, VA
Restoration of the Mouth With Dental Implants
Wayne V. Campagni, D.D.S.

COMPONENT 3
August 25, 1989
Franklin, VA
Problem Solving in the Restorative Practice
Richard Daniel K. Wilson, D.D.S.

COMPONENT 5
October 13, 1989
Lynchburg, VA
Straight Talk: Communications Skills
C. Ben Bissell, B.S., D.Min.

COMPONENT 6
August 11, 1989
Abingdon, VA
New Advances in Periodontics—The Role of the Generalist
Roland M. Meffert, D.D.S.

COMPONENT 7
August 18, 1989
Charlottesville, VA
Dental Insurance
Tom Limoli, D.D.S.
EDITOR'S NOTE:

With gratifying fidelity and admirable scholarship, faculty members of the School of Dentistry, Medical College of Virginia—Virginia Commonwealth University, have contributed excellent articles to this Journal. The sustained high quality of these articles is a reflection of state of the art education and ideally represents awareness of faculty responsibility to share knowledge. We appreciate it.

RDW

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Lifelike vitality of the Micro-Bond Ceramic restoration is achieved in any light environment, including ultra violet. This is the direct result of a three layer (opaque, body, incisal) depth of fluorescence, a form of luminescence obtained through proper absorption of energy and a significant emission of light plus the exacting influence of translucency.

A unique rare earth fluorescing agent is the contributing factor to its natural fluorescence under UV light, when compared to conventional porcelains that do not fluoresce at the same level as vital dentition.

UTILIZE THE MICRO-BOND NATURAL CERAMIC RESTORATION THAT ASSURES PROFESSIONAL AND PATIENT SATISFACTION.