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COVER
Lindsay McLaurin Hunt, Jr., D.D.S.
Dean, MCV School of Dentistry

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When Dr. Jim Kennedy accepted the deanship at the University of Connecticut, we lost a very fine dean. Many felt a vacuum would exist until a search committee could choose a new dean. Dr. Jim Revere was appointed acting dean to hold things together until a new dean would arrive. Almost ten years have gone by since his appointment and the students, the faculty, and dentists of Virginia have come to find out that Jim Revere wasn’t just “acting” he was the real thing.

Of course, he looked the role of a young, handsome, and contemporary dean, sitting at the helm of one of the nation’s finest dental schools. But one should have known Jim was more than capable to meet the new demands of the deanship by his past performances within the administration. As Dean of Student Affairs, Dr. Revere worked between students and faculty with skill and diplomacy. He always maintained the respect of both groups because he was, and is, a man of integrity.

Dr. Revere was elevated to Associate Dean for Clinical Affairs, a somewhat thankless job, but no other job in the school was more important or demanding. The very nature of our training requires that the clinical experience be structured so that each and every student can gain enough experience in four years so he/she can go into society and practice dentistry on the public. It is a small task to coordinate seven or eight departments and their needs for clinical time with that of over 350 students and their needs for clinical experience. Dealing with committees, computers, sign-up sheets, failing equipment,
even the custodial staff, Dr. Revere handled the task with the finesse and self-assurance so unique to his personality.

Then it happened. On July 1, 1983, Dr. Jim Revere became “acting dean” but he had no more intention of acting the role than did his predecessor. Jim Revere could stand before a group of deans or a group of students and you knew he was a dean. The dentists of Virginia have learned a new respect for a man whom we already held in high esteem. And now it doesn’t seem quite right that Jim won’t continue to fill the role he has handled so capably. But I expect Jim has yet to see the heights he will achieve. I only hope it will be with us in Virginia.

Michael O. McMunn, D.D.S.

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**CALENDAR OF EVENTS**

(Mark your calendar now for these future meetings)

**VIRGINIA DENTAL ASSOCIATION COMMITTEE MEETINGS**

May 31-June 2, 1985, Cavalier Oceanfront Hotel, Virginia Beach

**VIRGINIA DENTAL ASSOCIATION 116th ANNUAL MEETING**

September 19-22, 1985, Richmond Marriott, Richmond

**VDA LEADERSHIP CONFERENCE**

October 18-20, 1985, Williamsburg Hilton, Williamsburg

**AMERICAN DENTAL ASSOCIATION 126th ANNUAL MEETING**

November 2-7, 1985, San Francisco, California
CAPITATION—THEY FINALLY SPelled IT OUT

They finally did it, the insurance companies have given discount dentists a name we can understand. Now they call it capitation. At first they tried to fool us by disguising it with letters. I guess they never thought we would find out what P.P.O. stood for. The marketing department was slick and they told us we could be “Preferred Providers” if we would sign up for their program. We, among us does not want to be preferred. So we walked around strutting around and feeling great about being “preferred” until someone asked “Who prefers us anyway?” Well it turns out that not just one group prefers us, but the three groups. The insurance companies, the employers, and the employees. Now that doesn’t make a dentist feel special, I don’t know what will. But the disguise fell when someone asked why do so many groups prefer us. It turns out that we helped the insurance companies sell their dental programs for less because we told them we would work for 10-20% less than we normally do when we signed up to be a Preferred Provider. With cheaper labor they could sell more programs. The employers were happy because they bought the same dental insurance packages they bought before but for less money. Why? Because we agreed to work for less so we could be preferred. Remember? And the employees loved us because they were still getting the same kind and conscientious dentist, only now at a 10-20% discount. The insurance companies didn’t offer to take a paycut and the employers didn’t take a paycut to hold down expenses and even the employees didn’t offer to take a paycut. But we did! Just for the opportunity to be preferred. Then when we finally caught on to what was happening they changed the letters to C.D.O. (Contract Dentist Organization.) This name probably stems from the fact that your inside contract into knots when they pay you 20% less on a 3 surface restoration that took you an hour to do because you refuse to compromise quality.

Now they call it capitation and we understand this new form of discount dentistry. In fact it becomes clear in the first three letters, “cap.” The insurance company puts a cap on the amount of money they give for each patient you see. If you do less work than that certain sum of money covers, you make a profit. If you do more work, you lose. How would you like to be on the operating room table of a capitation surgeon? “No nurse, don’t order that it will take us over the capitation limit.” “No x-rays, too expensive.” “No nurse, the less expensive sutures.” Sure, I’m exaggerating, but aren’t the problems the same? The point is that the decisions regarding treatment are no longer based solely on patients needs, but whether we, the provider, can afford to render it. It is one thing when a patient says, “I can’t afford it,” but another when the doctor says, “I can’t afford to do it.” The whole concept of capitation is opposed to the high standards of dental care we have endorsed since our beginning. We have always encouraged everyone to seek dental care. With capitation you will find yourself hoping that the program is underutilized so you can make a profit. Also, the capitation dentist must pay for any referrals to specialists.
of the money allotted him. Could that possibly lead a dentist to perform procedures he is not really qualified to do in order to "save money"?

Whatever they call it, a P.P.O., C.D.O., or Capitation, it is all a form of discount health care with the discount being given by the dentist. I'm not opposed to cost controls even though it is not the dental profession that has been out of control in the cost arena. But the cost control must be shared by all parties, not just the provider. Dentists can't provide the quality of care our patients are accustomed to with the income being discounted and the overhead escalating. We must work through our local, state, and national organization to find a way to care for our patients with a fee structure that is fair to us and to our patients.

Michael O'Neill McMunn, D.D.S.

EDITOR'S NOTE: I wrote this editorial based on what is taking place nationally. The next day I received in my office mail a letter from Blue Cross/Blue Shield. It was announcing a May meeting in which they are presenting their new capitation plan.

Virginia Dental Association
Mrs. Pat K. Watkins
P. O. Box 6906
Richmond, VA 23230

Dear Mrs. Watkins:

I was given your name by the American Dental Association in Washington, D.C. as the person to contact regarding a dentist in Virginia. I'm afraid that many people go through life hearing only negative comments from patients, but I would like to send this letter solely to compliment a dentist in Northern Virginia who has worked on my entire family, and still teaches at Georgetown University. Not only is he a superb dentist, he is gentle, understanding, personable and tries his best to do what's best for his patient, not his pocket. There is a lot to be said for someone who will do that today, and I hope you recognize his abilities as much as we do. Although many "awards" go to people because of the vote of their colleagues, I hope that you will recognize him because of people like us who really need people like him.

Again, please do not let him know that I have written this, as I am going through some dental work now, and I wouldn't want him to think I was asking for any favors—I appreciate his dedication at all times. I hope that you all are proud to have him in your Association.

EDITOR'S NOTE: This letter crossed Mrs. Pat Watkins desk and though it was written about one particular dentist, I feel it typifies an attitude many Virginians hold toward their dentists.
DR. LINDSAY HUNT IS NEW DEAN

Virginia Commonwealth University’s Board of Visitors confirmed the appointment of a new dean of the School of Dentistry at its Jan. 17 meeting. The new dean is Dr. Lindsay M. Hunt Jr., currently with Emory University in Atlanta.

Dr. Hunt’s appointment is effective June 1. He currently serves as associate dean for academic affairs of the School of Dentistry at Emory University, has held the rank of professor of oral biology at Emory since 1975.

He received the doctor of dental surgery degree in 1965 and the doctor of philosophy degree in physiology in 1971 from Baylor University in Waco, Texas. Dr. Hunt is a member of national professional and scientific societies associated with dentistry.

Dr. Hunt’s first appointment at Emory in 1971 was an assistant professor of dental research. He was named professor and chairman of the department of oral biology in 1975. In that capacity, and in his role as associate dean for academic affairs of the School of Dentistry at Emory, Dr. Hunt has been concerned with the integration of basic sciences into the dental curriculum and curriculum development.

Dr. Hunt also served Emory through membership on a variety of school and university-wide committees and has participated in continuing education activities in Georgia.

Dr. Hunt has received national recognition for his work in dental education. He has served as a consultant for the Commission on Accreditation of the Council on Dental Education, a member of the Test Construction Committee of the National Board of Examinations, a member of the Editorial Board of "Journal of Dental Education," a consultant to the Southern Association of Colleges and Schools, and a member of the National Committee to Review Requirements and Guidelines for Dental Education Programs.

Dr. Hunt has published papers covering dental research and topics related to dental education. He has served as program director or principal investigator on grant awards from the National Institutes of Health and other agencies, has chaired scientific sessions of the International Association for Dental Research, and has served as a member of a special study section of the National Institutes of Health.

The students, faculty and dentists of Virginia wish Dr. Hunt the greatest success and be assured of our fullest cooperation.
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
1985

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

WHEREAS, total good health -- physical and mental -- can be maintained through good dental health habits learned early; and

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

NOW, THEREFORE, I, Charles S. Robb, Governor, do hereby recognize the month of February 1985 as NATIONAL CHILDREN'S DENTAL HEALTH MONTH in Virginia and I call its significance to the attention of all our citizens.

[Signature]
Governor
A METHOD OF COMPUTER SYSTEM IMPLEMENTATION

by Wm. J. Bennett, D.D.S.*

The use of a computer may be something that you are now considering. The utilization of a computer in your office will result in many changes. If properly implemented and operated, a computer system can result in greater efficiency, improved paper flow, detailed business records, quick filing of insurance forms, organized recalls, aged accounts, billing and many other functions.

However, if not implemented in an orderly manner, you can experience many frustrations and spend numerous sleepless nights. It is the intent of this article to outline a method of computer implementation that has been used effectively and offers a number of advantages.

If your office records are not organized prior to utilizing a computer system, they will be after you are finished. But, All information has to be placed into the computer. This must be done before the system can function properly. If your records are well organized, then you have less to do than an office lacking organization. Regardless, once properly placed in the computer, your records are automatically kept in order. A good phrase to remember though, is "trash in, trash out." The information retrieved from the computer is only as accurate as the information placed into it.

Placing all your patient records and data in the computer is not a simple task and can take a considerable amount of time, particularly if you have a large office. Thus, an implementation system should include some important considerations.

1. Input of data should be an educational exercise for your office staff.
2. Time spent implementing the system should not severely interfere with the normal practice schedule.
3. The computer ideally should be utilized in some manner from the first day of operation. Valuable and costly equipment should not sit idle!
4. Do not attempt to get all the data entered overnight. It is simply a time consuming process. It must be entered accurately or incorrect information will be retrieved. It is better to take more time entering the information than attempting to go back and local entry information errors at a later date. Accept this fact and eliminate a lot of frustrating times.
5. Not all portions of the system should be expected to be operational from the beginning. A lot of information is entered more o

*Dr. Bennett is a private practitioner and a specialist in the subject he discusses in this paper. His address: 146 Penniman Road, Williamsburg, Virginia 23185.
the system becomes functional in a progressive fashion.

6. Stick to a plan and finish it. *DO NOT JUMP AROUND!*

Suggested steps to be taken in the implementation process:

1. Once you get your computer system take the necessary time to become familiar with how it operates before actually entering office and patient data that will be utilized. Enter patients, make charges etc. and experiment with the operational systems. If you feel a little confidence before beginning to use it for the real thing it will be easier going.

2. *Back up information each day!* If an error is made during data entry, the information is only incorrect or lost to the time of the last back up. Since the computer is a new and different type of equipment, errors will occur. Backing up your information is good insurance. Do not overlook this step. You will be sorry if you do!

3. If a word processor is part of the program, this is a valuable item and can be used immediately. Compile a file of form letters to send for various needs and begin using them. Put your computer to work at once. You paid for it. Don’t let it sit idle.

4. Set a future date that you are going to begin utilizing the computer in the daily operation of your office. Allow adequate time to place the patient data in the computer’s files.

5. At first only the active patients should be entered because you want to get the system in operation. No need to put patients that are not active in the computer now. Decide later if you want them entered at all. Your most active patients are the ones appointed on your designated date. Begin with them. Then work from that date to the next day’s appointed patients. This is suggested that a distinguishing mark be placed in an observable location on all the records of the entered patients. This will be of assistance in the future as a mark that this chart has been processed. The only patient records that should be in the system initially are those patients that are going to be treated. Do not get concerned with the rest. Follow an organized system!

6. Soon you will find that there are fewer and fewer patients that will need to be entered each day. You will begin seeing patients that have already been entered. This is the time to begin entering the next important group, patients with accounts receivable. Of course, many of these will have already been entered. It is suggested that you start at the beginning of the alphabet or the lowest numbered account depending on how your records are organized, and work from there. Accounts with a mark have been entered. Remember follow an organized plan to save time and avoid error!
7. At the end of the month you should be able to use the billing portion of your computer system. However, if you do not have all the accounts entered, do not be concerned. What was done before the computer? Your most active accounts will be the patients you have seen in the office and they are in the system. The accounts that are not in the computer can be billed using your existing system. It is a wise procedure to place a notation in your initial computer billings to advise your patients of a new accounting system and to call if they have any questions. In the event of an error it can be corrected initially without complication.

8. Once, all new patients, patients with account balances, and patients seen recently are in the system, it is time to begin with the recall files. Again, select a month in advance for entering these records, then proceed in an orderly fashion. If you get to the selected month and all data has not been entered, just use the computer to process what you have entered and complete the remainder as you have in the past. After you have entered the patients in the recall file, all your active accounts should be in your computer.

9. At this point the accounts that are not entered, are not very active. If you marked all your records as suggested it will be easy to separate these patient records from the ones you have entered. A decision can be made on a chart by chart basis whether to enter the record or not. This is an excellent way to get the dead weight out of your file cabinet and concentrate on the important patients—The ones you see! If your computer has a word processor, though, communicating with your patients is just the thing for which it was intended. Write all these inactive accounts a letter and attempt to get them back into the practice.

If an organized plan is followed a computer system can be implemented into a dental office with minimal hardships. The secret is to do so one step at a time. It is an exciting piece of business equipment that can be of great value to your office and practice, however, suppress the urge to get it into full operation too quickly. A computer is just like a new employee, I named mine Betty to remind me of this concept. Like the addition of any new employee it takes time to get into full production and efficiency. Office procedures and staff need time to adjust and modify to something new, man or machine. Allow the time for a smooth adjustment and I think that you will be more than pleased with the services that your new “computer employee” can provide—not to mention that it does not get sick, is never late to work, will not want a raise, will not move out of town, demands no benefits, will not go on vacation, will not quit, does not argue, does not have an uncle that has died four times.
does not eat lunch, does not need coffee breaks, does not go to the bathroom, does not talk on the telephone, does not forget, is always honest, is trustworthy, has great loyalty and can be depreciated. What more could you ask for? Wishing you an enjoyable future.

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Dr. J. William Goering represented Virginia at the President-Elects Conference held in ADA Headquarters Building, January 28-29, 1985. During the two day Conference the participants addressed recruitment and retention of members, communication and public education, legislative issues and direct reimbursement. One session was devoted to the responsiveness of the American Dental Association.
The use of cheek retractors during impression making


Making an impression is often a trying procedure for both the operator and the patient. Capturing all the necessary details of the prepared teeth, particularly when they are located bilaterally in the arch, may be especially difficult. This procedure frequently requires multiple assistants in addition to the operator. The short working time of the addition silicone and polyether impression materials can further hinder the procedure. One of the key steps in making a good, complete, and accurate impression for a fixed prosthesis is isolation and access of the area to be impressed. The purpose of this article is to present a relatively simple technique which can significantly aid the operator during impression making.

Cheek retractors are routinely used for intraoral photography; and we have found that the use of photographic cheek retractors during impression making can significantly reduce the difficulty of the procedure. One of the key steps in making a good, complete, and accurate impression for a fixed prosthesis is isolation and access of the area to be impressed. The purpose of this article is to present a relatively simple technique which can significantly aid the operator during impression making.

Cheek retractors are routinely used for intraoral photography; and we have found that the use of photographic cheek retractors during impression making can significantly reduce the difficulty of the procedure. The retractors may be placed during any procedure which requires additional access. However, once the essential steps of the procedure are completed, the retractor should be removed to allow the patient to reposition his lips and cheeks on both sides simultaneously (Figure 2 and 3). While the bowed design may seem to place a significant amount of pressure on the lips and cheeks, few patients complain of discomfort. The retractor may be placed during any procedure which requires additional access. However, once the essential steps of the procedure are completed, the retractor should be removed to allow the patient to reposition his lips and cheeks on both sides simultaneously (Figure 2 and 3). While the bowed design may seem to place a significant amount of pressure on the lips and cheeks, few patients complain of discomfort. The retractor may be placed during any procedure which requires additional access. However, once the essential steps of the procedure are completed, the retractor should be removed to allow the patient to reposition his lips and cheeks on both sides simultaneously (Figure 2 and 3).

Prior to actually making the impression, the operator should practice inserting the tray through the opening produced by the retractor (Figure 5).

This type of retractor is provided in several sizes, and it is advisable to have a selection of sizes available since the best way to choose the appropriate size is by trial.
Figure 1. Bow type cheek retractors are available in two sizes.

Figure 2. Retraction of cheeks and tongue by assistant using mouth mirrors.

Figure 3. Large cheek retractor in place during preparation of tooth #18 for impression. Note good access and visibility without assistant being committed to retracting.
Figure 4. Larger size retractor in place illustrating ample retraction of cheeks and the patient is unable to occlude her teeth without displacing retractor.

Figure 5. Smaller retractor in place in same patient as Figure 2. This patient is able to occlude her teeth but the opening produced is too small to accommodate an impression tray.
INTRODUCTION

Many people regard a visit to the dental office as an unpleasant experience, for they have expectations of a painful ordeal. Apprehension is not only a problem for the patient, but for the dentist as well. Because music touches the daily lives of a great percentage of the population, the serious usage of music as a therapeutic agent in dentistry deserves renewed consideration.

The acknowledgement of music's potential to affect human behavior is hardly a new phenomenon, in fact, today's music therapy (as a relatively new discipline) may be viewed as having its genesis in ancient Greece. In 20th century dentistry, the desire to keep disturbing noises from reaching the patient's ears led to the initial research concerned with incorporating sound therapeutically into dental practice.¹

Some sound qualities may affect patients more adversely than others. Undoubtedly, the unpleasant noise created by the dental drill contacting a tooth provokes anxiety in most individuals. This sound alone usually elicits a conditioned response (fear of pain) which leads to greater tension through-out the body. At this point, any sensation the patient experiences as pain will be intensified. Indeed, if music is used to supersede agitating noises, and furthermore, if a specific piece of music may be identified and classified according to its value as a therapeutic agent, then the chance of a successful incorporation of music into dental practice becomes greater.² A selective, critical review of previous research in this area will be undertaken. This process aims to stimulate further research in this largely neglected area of dentistry.

SELECTED LITERATURE REVIEW

In 1948, Cherry and Pallin reported on the use of music as a premedication. During the period of their research, the drugs typically used in conjunction with nitrous oxide-oxygen general anesthesia were considered less than satisfactory. For example, some of these premedications caused inconveniences for the dentist and the patient because of the inordinant amount of preparation time required. An equally cumbersome postoperative recovery period which demanded the assistance of an additional trained individual posed further problems. Moreover, the possibility that a patient could become addicted to a drug could not be dismissed, especially considering the fact that many dental procedures required repeated visits. Other general anesthetic agents could not be used to avoid the problems inherent
with nitrous oxide-oxygen anesthesia, for they were regarded as unsuitable for use in the dental office because of other problems, including the undesirable amount of postanesthetic pain. All of the above difficulties compelled Cherry and Pallin to try music as an alternative premedication.

For their procedure, they brought a record player equipped with earphones into the operating room. Not only did this arrangement allow the patient to hear music, but the earphones eliminated the routine sounds of the operating environment. The patient was free to adjust the volume of the music, thus giving him a sense of control over his surroundings. Lines of communication were kept open, however, because the dentist could speak through the sound system directly to the patient. The gentle manner of the doctor’s and assistant’s speaking tone was considered to be of the utmost importance. Assuring words were spoken to the patient, and caution was taken to avoid negative remarks. When music was introduced into the procedure, the words of the dentist were chosen carefully to help the patient become more involved with the music.

Out of 10,000 cases studied, particular recordings were found to be the most effective:

- Beethoven *Moonlight Sonata*
- Debussy *Claire de Lune*
- Fibich *Poeme*
- Humperdinck *Dream Pantomine*
- Wagner *Evening Star*
- Wagner *Forest Murmurs*

The researchers described the above pieces as having “a smooth even tone and contain[ing] no conflicting, harsh or startling instrumentation.”

Musical works with rapid tempi (rate of speed) were found to be ineffective. However, only very general statements were made regarding the musical compositions that were deemed as most successful.

In another study, Gardener and Licklinder sought to eliminate the noise generated by the dental equipment. They believed these unpleasant sounds were a major source of anxiety, and initially attempted to replace them with so-called “white sound” (a mixture of all audible frequencies). The quality of sound it produces may be described as like that of rushing water. It effectively masked the sound of the dental drill, but could not be tolerated by the patient for any sustained period of time. Music was later added into the sound system in such a manner that the patient could choose to listen to it or “white sound”. The patient was given control of the volume, and was allowed to select the music he wished to hear. This latter technique was found to be clinically effective. The successful reduction of pain was attributed to the elimination of conditioned anxiety, because the sound of dental equipment was masked either “white sound” or music. This technique helped to stimulate the patient to focus his attention away from the dental procedure, thus creating...
beneficial distraction. The patient also felt a sense of control over the situation by being able to adjust the music to his desire. 8

Today authorities generally agree that for "white sound" to be of any clinical value the decibel must be so high that the patient experiences the sound as pain and, the possibility of hearing impairment is far too great a risk for any therapeutic benefit to be worthwhile. Therefore, music presents the most promise as an aural aid in dentistry.

CONCLUSIONS

Music is often employed in dental practice today; however, it is recommended that any capricious selection of it should cease. The possibility that the patient may associate so-called canned music with anxiety-provoking situations must not be dismissed. Indeed, a more thoughtful approach towards music in the dental office might well be fruitful. Certainly then, classical music presents promise as a meaningful aid in modern dentistry. Past research suggests that musical works with slow tempi, and pieces with no sudden changes in dynamic levels, may be incorporated effectively into the patients' surroundings.

The dentist has a great spectrum to explore, and may wish to seek the advice of a learned musician who has a firm understanding of the psychology of music. It is recommended that the musician present the dentist with a variety of musical recordings. By giving the doctor several works to choose from, he will be more able to meet the needs of each individual patient. Then, the dentist must observe his patients' reactions to the given musical works, and discuss these responses with the musician. The goal of this course of action is to stimulate the formation of further hypotheses, creating impetus for more specialized study.

1. The term sound is used here in reference to music and so-called "white sound".
2. This more thoughtful incorporation of music in the dental office is a far cry from the manner in which so-called "canned music" is often employed into the dental environment. The latter type of music may possibly provoke anxiety, for it is often associated with dental procedures. A wide variety of classical music presents the most hope to modern dentistry.
4. Certainly, if more information on the elements of music (rhythm, melody, harmony, instrumentation, etc.) had been given, perhaps it would have aided later research.
5. Unfortunately, no specific information on the music is given, not even that of the most general nature.
6. Yet precisely the choices of music genres (classical, jazz, etc.) available to the patient is not made clear in Gardner's and Licklider's study. Also, was the music very rhythmically active, slow, or what?

Bibliography


TO DICKENS WITH GREAT EXPECTATIONS?

by Richard P. Elzay, D.D.S., M.S.D.*

Note: Given as the keynote address to the Annual initiation program for the Virginia Commonwealth University Chapter of PHI KAPPA PHI Honor Society on 24 April 1984 at the Richmond Academy of Medicine.

Members of Phi Kappa Phi, initiates, honored guests and friends. I consider it a distinct honor to address such a distinguished ensemble of eclectic “bright stuff”. Before I heighten your expectation index unreasonably, I must patently confess that I do not consider myself composed of “bright stuff.” It would be ludicrous for me to feign expertise in the humanities, sciences or the field of business. As a matter of fact, I find the task of imparting any morsel of wisdom and/or sagacity awesomely frightening. Since I lack the genetic endowments to meet that challenge, perhaps I can titillate your cerebellums by raising some questions.

I’m confident that most of you, prior to assembling here this evening, anticipated the outcome of certain possible events. For instance, you may have considered what you expected in the nature of fellowship with your esteemed colleagues; conjured up an impression of the interior of the Richmond Academy of Medicine; anticipated how you would relate to the person who accompanied you this evening or theorized on the content, delivery or length of my address. How much thought have you given to the concept of anticipation and/or expectation in your life? Can you honestly say you do not have expectations? Do you feel your life burdened by excessive expectations, either self inflicted or imposed by others? As a caveat, remember Benjamin Disareli’s statement—“What anticipate seldom occurs; what least expected generally happens.” I think that the terms wish, desire, anticipate, probability, expect and expectation are closely related. For the sake of this discussion, I hope you will tacitly accept this premise.

To illustrate the fickleness of expectation I would like to relate the following scenario as given by Walt Mulé. “On November 30th, 1979 Fred Kritzler invited his girlfriend over for an evening in front of a campfire. He used two boxes of matches, one pint of starter fluid, the Sunday edition of the New York Times and failed completely to get the fire started. Determined to enjoy romantic flickering flames, he drove with his girlfriend to the Vista Inn, a fireplace equipped lodge in the nearby mountains. On the way, he lit a cigarette, threw the match out of the car window and started a forest fire that devastated...”

*Professor and Chairman, Department of Oral Pathology, Medical College of Virginia Commonwealth University, Richmond, Virginia 23298.
acres of timber and burned the Vista Inn to the ground.”

This episode is both sad and amusing, but demonstrates that not infrequently our expectations and the outcomes we experience lack congruity. In fact, eventualities can sometimes be characterized as abysmal failures.

An aircraft engineer by the name of Captain E. Murphy, in 1949, referring to a technician said “If there is any way to do it wrong, he will.” The project manager, George E. Nichols, assigned the name “Murphy’s Law” to this and similar statements. As the story goes it has commonly and mistakenly been supposed that Murphy’s first initial—E. stood for Edsel; however, the initial E. stands for the prophetic unlikely name of “Error”. It seems that Murphy’s given name was Errol, but his Japanese mother, still confusing L’s and R’s erroneously entered “Error” on his birth certificate. Thus, Murphy was, in fact, a victim of the very law he discovered. Murphy’s Law is frequently quoted as “If anything can go wrong, it will”.

Most of us quote this law in jest; but upon closer examination doesn’t it connote a negative attitude or expectation? Nevertheless, this law has been a guiding concept for engineers to explain why wires cut to the exact length will always be short and why an expensive color television tube protects a ten cent fuse by blowing first. A shortcoming of Murphy’s Law is the fact that it cannot be expressed in mathematical form. It was Samuel F. Dude who investigated how Murphy’s Law operated on dual systems (where there are two possible results, for example, heads or tails, up or down, etc.). Dude expressed his findings in Boolean algebra equations and these equations formed the basis of Dude’s Law of Duality. This law simply stated is—“Of two possible events, only the undesired one will occur.” Admittedly, when I first read this law it evoked a smile. Do we smile because we recognize a modicum of truth expressed in this law as we retrospectively examine past events in our lives and/or the lives of others? Illustratively, Dude’s Law of Duality was the only contribution made by Samuel Dude inasmuch as his genius was cut short by a skydiving accident where Dude had to choose between a backpack and a seatpack parachute. Que sera sera? Was Dude’s disaster a fulfillment of his law, a fortuitous accident or ominous fate? In this regard Shakespeare shared some keen insight when he said “Oft expectation fails, and most oft there where it promises, and oft it hits where hope is coldest and despair most fits”.

As humans are we in error to expect eventuation of our desires? Are our expectations benevolent or malevolent? Further, where is hope without expectation and more importantly would you like to live a life without hope? Note that Dude’s Law of Duality mentions the concept of desirability and hope can be defined as—to cherish a desire with expectation.

To leaven the lump of expectation a tad more, we must include the work of Dr. Gumperson who incorporated the concept of desirability into a gen-
eral law. Gumperson's Law states that—"The probability of a given event occurring is inversely proportional to it's desirability." Yet, Gumperson's Law could not explain why the person with the most raffle tickets has the least chance of winning inasmuch as the law does not incorporate the concept of effort. The probability of an event occurring varies inversely not only with this desirability but also with the effort expended in order to make it occur. Can you think of situations in your life where this has been so? Thus, Gumperson's Law has been improved by restating it mathematically as—"The probability of an event occurring is inversely proportional to the effort expended times the desirability". Therefore, the greater the effort, the less likely the desired event will occur and vice versa.

These aforementioned laws are indeed interestingly humorous. But I wonder if, in some cases, we don't unwittingly accept them as infallible truths and resultantly develop possibilities for self-fulfilling prophesies. Of course, these prophesies may be benevolent or malevolent depending upon our attitudes or mind set. As a matter of fact, could intermittent attitudes of pessimism, skepticism, optimism or cynicism be related to our expectation level? Should we take the advice of Alexander Pope who stated—"Blessed is he who expects nothing for he shall never be disappointed"? Is it reasonable to assume that we can obviate expectation from our lives as it relates to friends, mate, finances, career, stockmarket, grades, jobs, slot machines or the level of performance of our students? Personally, I feel that life without some degree of positive expectation would be depressing. Depression not, in part, a lack of hope. The words hope and depression remind me of the gentleman who suffered from excruciating headaches. Two physicians advised him that the only cure which would relieve his headaches was to be castrated. Relinquishing the last vestige of hope he finally conceded to have the operation. After the surgery he felt quite depressed. Attempting to lift his spirits, he decided to purchase some new clothes inasmuch as he had noted that when a lady was depressed she often felt better after having purchased a new hat. He went to the haberdashery.

"Good morning sir!" greeted the salesman. "You look depressed. I'll lift you up with a new outfit and make you feel like a new man. Let's see—you wear a size 38 regular jacket."

"You're right! How did you know that?" the gentleman remarked.

"It's my business and I would see—you wear a size regular jacket," said the salesman.

"You're right again," said the gentleman surprisingly.

"Now you also need some under wear," pursued the salesman. "Let's see—you wear a size medium shirt."

"You're right again. How do you do it?" replied the gentleman.

"I told you it's my business," replied the salesman. "And you wear a size 34 short", he added.

"That is the first mistake you have made. It's not the shirt size that is wrong, it's the shorts size. You wear a size 31 short," replied the salesman.

"But you said..."

"It is my business and I am going to tell you the truth," said the salesman. "Let's see—you wear a size 34 short," he added.
made. In fact, I wear a size 32 short,” said the gentleman.

“Oh no you don’t!” assured the salesman. “If you were to wear a size 32 short it would give you a headache every time!”

And so the gentleman, having lost the last morsel of expectation and hope slipped morosely back into his depression.

Now I ask you, should we say “To Dickens with Great Expectations”? I believe the answer, as with many other facets of our life, lies in maintaining a quality of balance somewhere between unrealistic hope (expectation) and total acceptance (fatalism). Obviously, to tenaciously adhere to either extreme in a monomaniacal fashion is to practice fanaticism and in that circumstance we close our minds to the process of questioning. I’m confident that this group, above all others, appreciates the importance of asking the right question. Moreover, I’m cognizant that this group recognizes that definitive answers to our questions are infrequent and more often than not we’re left with proverbial “shades of gray” rather than “black or white.” I, like you, would like to know with certitude the outcome of an event. In some cases we can appreciate, to some degree, what the eventuality of an event will be based on our previous experiences and garnered objective data. Excluding our occasional penchant for reading tea leaves, having our palms read, checking the bumps on our heads, playing with the tarot cards or having faith in our stockbroker, can we be certain of the eventuality of an event or the answer to questions we raise? So often I’ve been frustrated by the fact that, through introspection, I am confident that I have the right question—but there is no answer. At times like this, within recent years, I have gained great solace from the advice given by Rilke to a young poet. Rilke wrote “You are so young, so before all beginning, and I want to beg you, as much as I can, dear sir, to be patient toward all that is unsolved in your heart and try to love the questions themselves like locked rooms and like books that are written in a very foreign tongue. Do not seek the answers, which cannot be given you because you would not be able to live them. And the point is, to live everything. Live the questions now. Perhaps you will then gradually, without noticing it, live a long some distant day into the answer.”

If I have caused you to question the veracity of Murphy’s Law, how do you explain the fact that a person who failed the first grade, was passed up through the 7th grade as the village idiot and dismissed from High School, was asked to address a group of people who have demonstrated superior intellect and achievement?

In summation, I recommend that you dream beneficial dreams; ask the right questions, not fear to live the questions remembering that—“Success is getting what you want and happiness is wanting what you get” (Gerald Heard). Thank you. Pleasant dreams!

Bibliography Available From Editor
Impact of Nutrition on Dental Health in a Changing Environment

Jorge A. Contreras, DDS and Osie A. May, Jr., DDS MPH*

ABSTRACT

"Impact of Nutrition on Dental Health in a Changing Environment"

In the modern practice of preventive dentistry it has become increasingly evident that nutrition plays a significant role. Both the hard and soft tissues by virtue of their physical location and function in the oral cavity are prime targets for a wide variety of temperature changes, physical and chemical stimuli and a broad spectrum of microorganisms. Therefore it is the intent of this article to review the relationship of nutrition to dental caries and periodontal disease and thereby discuss the results and conclusions of germane scientific research data obtained in both human and animal studies.

INTRODUCTION

In the past twenty years the science of nutrition has made a major contribution in the development and maintenance of the oral tissues as in the development and maintenance of tissues in other parts of the body. Also, the tissue components of the mouth are nearly comparable to tissues found in other regions of the body with regard to their metabolic processes during development, growth and maintenance.

By virtue of the location and function of the oral cavity its tissues are subjected to a wider variety and probably a more stringent series of stresses than are tissues in other moist intercavities of the body. When you consider the large variety of foods consumed, which must be masticated into a form suitable for swallowing, along with a wide range of chemical stimuli at varying temperatures, the oral cavity becomes an ideal environment for the growth and multiplication of large spectrum of microorganisms. The mastication of food by the teeth and the buffering and diluting capacity of the saliva greatly reduce the intensity of some of these stresses before the food is passed along to other areas of the gastrointestinal tract.

NUTRITION AND DENTAL CARIES

The hard tissues found in the oral cavity which are the components of tooth structure are enamel, dentin and cementum. Enclosed within these calcified tissues is a highly vascularized connective tissue known as the dentin pulp.

During recent years a number of facts have been clearly established about dental caries, the disease...
affects these hard tissues. Some of these facts pertain to the etiology of the disease, with concepts which were previously postulated for generations, but which have now been definitively demonstrated in experimental trials using laboratory animals.

Microorganisms are required to cause the destruction of susceptible tooth structure along with a suitable substrate i.e. (carbohydrate). This point was established in studies with caries-susceptible rats that were maintained throughout life under germ-free environment. In this experimental situation, the laboratory animals did not develop tooth decay when fed a caries-producing ration. Consequently by using the germ-free technique, researchers were able to evaluate the microorganisms suspected of causing dental caries.

In one study scientist inoculated germ-free caries susceptible rats with a mixed culture of enterococci and found that characteristic carious lesions developed in the sulci of the molars. Carious lesions have also been produced in rats that were maintained under germ-free condition except for inoculation with a single strain of an oral streptococcus isolated from a rat or with each of two strains of streptococci isolated from human carious lesions.

Streptococcus mutans has received special attention in recent years, first by reason of the recognition that this microorganism was important in the causation of dental caries in hamsters. Later it was found to colonize tooth surfaces in infants soon after the tooth erupted and to be present in many carious lesions in children. Streptococcus mutans has the interesting ability to synthesize from dietary sucrose a polyglucose (dextran) which enable this organism to colonize surfaces of the teeth and form plaque there. Under this conglomerate the interaction between the metabolites of the microorganisms and tooth structure can occur to cause dental caries.

It has been indicated via clinical observation that the salivary glands are of considerable importance in the maintenance of teeth. Where salivary glands are congenitally missing or are destroyed by disease or radiation of the head and neck region, there is invariably an increased susceptibility to dental caries. Similarly, in experimental animals, the surgical removal of the major salivary glands results in spectacular increases in tooth decay. Of the several salivary glands, the parotid and submaxillary glands have been shown to be most important in the rat, with the sublingual gland contributing relatively little to the maintenance of the teeth. In human studies the quantity or consistency of the saliva has not yet been shown conclusively to have a definite relation to caries incidence except where xerostomia has been induced by surgical removal or radiologic destruction. Therefore the total amounts of certain salivary constituents secreted may be more important than the total volume in which they are secreted.

The truism that "A clean tooth never decays," and the difficulty in obtaining such a condition have been demonstrated by experiments in rats where the diet was introduced directly
into the stomach by feeding tube.\textsuperscript{11} The normal oral microbial flora were observed in those animals but no carious lesions developed. When the same caries-producing diet was eaten in the usual fashion by littermates, a high incidence of tooth decay was observed. It is apparent that the presence of carbohydrate in the oral cavity is essential for the production of dental caries. When a carbohydrate-free diet is fed for prolonged periods either to intact rats or to ones from which the principal salivary glands have been removed, no carious lesions developed.\textsuperscript{12} If all the diet except the carbohydrate is introduced into the stomach by tube and only the carbohydrate ingested orally, carious lesions developed at approximately the expected rate for rats that consume the entire diet by normal route.\textsuperscript{13} Likewise, when caries-susceptible rats consume a liquid diet, they have appreciably less tooth decay than when their littermates (control rats) consume the same ration in solid form.\textsuperscript{14}

In humans, streptococci comprise the highest number of bacteria in the dental plaque (the gelatinous coating of the teeth). They seem to have a particular affinity for carbohydrates and act upon them rapidly. It has been shown in controlled tests that only thirteen minutes after carbohydrate was present as a substrate, streptococci alone lowered the pH of the dental plaque from 6.0 to 5.0.\textsuperscript{15} However the oral flora is complex and bacterial effects can vary because of symbiosis between two or more microorganisms.

As carbohydrate food accumulates in the mouth, it provides the necessary media for the normal growth of acidogenic microorganisms that cause tooth decay. Also, bacterial activity is increased in sites of greatest food particle retention and with food texture that readily adhere to the teeth. Persistent and continuous eating of adhesive carbohydrates, therefore, is prime factor in tooth decay. The most convincing proof of this fact comes from a five year study in Sweden in which a steady controlled diet situation at a constant caloric level was maintained with a group of institutionalized patients.\textsuperscript{16} Over the years, different variables were added at different times. Supplementation of vitamins and minerals produced no difference but the addition of carbohydrates brought about increases in the incidences of dental caries.

Other nutritional or dietary components that affect the teeth are for example strong acid drinks. Taken frequently, they can gradually dissolve and wear down the enamel. Fibrous foods like apples and carrots have a scouring or detersive action which reduces plaque formation when they are eaten after a meal, but they protect the biting surfaces, not the sides of the teeth or fissures. Several other foods are reported to be protective, including cheese and peanuts which increase the flow of saliva and also have an inhibiting effect on dental plaque by raising the pH and increasing its calcium content.\textsuperscript{17}

Another dietary element that has a large influence on dental caries is fluoride. Repeated studies consistently confirm about 60\% reduction in the incidences of dental caries in children
both in pre- and post-natal exposure to fluoridated water. A significant extensive project on the dental caries activity in children from eleven areas in five Western states (Oregon, Idaho, Montana, Utah and Washington) found the one most significant factor was the fluorides in the water supply. Dental caries rates in children consuming the fluoridated water were less than half in the children whose water was fluoride-free.\textsuperscript{15,19}

While the problem of dental caries is by no means solved, recent advances in the knowledge of nutrition and its relationship to caries provide useful information to that end. Therefore, based on the previously discussed findings, two nutritional factors seem apparent. First, adhesive carbohydrates consumed at frequent intervals increase dental caries to a much greater extent than in liquid form. Secondly, fluoridated public water supplies do decrease caries rates, although this practice still remains a source of controversy in many communities.

**NUTRITION AND PERIODONTAL DISEASE**

The diagnosis and treatment of diseases of the human periodontium is also essential in maintaining good dental health. The clinician must thoroughly evaluate all local factors which might subject the oral tissues to excessive physical or chemical trauma. In addition, systemic abnormalities such as infections, endocrine imbalances or poor nutrition may also affect the resistance of the oral tissues. Certainly a thorough visual examination of the oral tissues, as well as of the eyes, hair and skin should be made to ascertain if any classical signs of nutritional deficiency are present. When none of these signs is found to exist as an indication of frank deficiency, evidence of subclinical dietary deficiency should be sought through discussions with the patient about his diet and also by laboratory tests and whatever clinical methods of evaluation are applicable in each individual case. Frequently such subclinical deficiencies may predispose to a sufficiently low tissue tone and resistance.

Numerous studies in animals as well as in humans have suggested the importance of physical consistency of the diet in the maintenance of optimal periodontal health.\textsuperscript{20,21,22}

Although nutritional imbalance does affect the severity, duration and extent of periodontal disease by alteration in the tissue’s defense and repair capabilities, no clearcut evidence is available in man to support the aforementioned statement, which is more a clinical impression than a specific documentation.

There is an increasing concern among oral clinicians that many low-grade abnormalities of the oral tissues, such as mild gingivitis are being dismissed as “normal” because of the frequency of their occurrence. The optimal goal to strive for is healthy tissue rather than any less satisfactory condition even though the latter is much more commonly observed in the population seen by an oral clinician.
SUMMARY

The impact of nutrition on dental health is quite a very important one. It plays a key role in the development and maintenance of the tissues of the oral cavity.

The hard tissues of the oral cavity are influenced to a large extent by the local environment which surrounds their external surfaces. In the case of dental caries, it has been shown in numerous studies, both animal and human, that carbohydrates form the necessary media for the normal growth of acidogenic microorganisms to cause tooth decay. It has been reported that some foods such as cheese, peanuts, as well as fluorides, provide a protective or inhibitory effect against dental caries.

Periodontal and other diseases of the soft tissues are mostly caused by local factors which are modified by other systemic factors. Therefore, in any successful periodontal therapy, the first step should be to eliminate all local factors, then any known systemic factors. Nutritional guidance is always desirable as a part of the overall local and systemic therapy of periodontal disease.

References


FIRST INTERNATIONAL BEIJING (PEKING) SYMPOSIUM IN DENTISTRY AND THE FIRST INTERNATIONAL DENTAL TRADE SHOW

Co-sponsored by the Institute of Stomatolgy, Peking Medical College and the International Quintessence Publishing Group, this dual show will make dental history when it commences on November 7 and continues through November 9 in Beijing, China. The inaugural symposium theme will be dental materials and their clinical use. This event has been viewed as a breakthrough in the international dental community. Strong early response has been demonstrated.

Twelve leading Chinese researchers will join numerous world-renowned clinicians to offer a truly global perspective on dental material application and innovation. Speakers from the U.S.A. will include Drs. Jack Preston, Herbert Shillingburg, and Richard Simonsen, who is co-chairman of the Scientific Program with Dr. Xu Heng-Chang. Also participating will be Professors Takao Fusayama, Sumiya Hobo, Eiichi Masuhara, John McLean, and Heiner Weber. Several additional experts will be added to the program in the weeks ahead. Simultaneous translation of all presentations will be provided.

In addition many prominent international dental manufacturers have already expressed a desire to exhibit and establish business contacts at the First International Dental Trade Show.

Also planned is a post-congress tour to explore the mysteries of Mainland China including such cities as Beijing (Peking), Hangchow, and Shanghai. This tour includes sightseeing and visits to select medical facilities.

Individual registration fees are $250 and $50 for each accompanying registrant. More than 1,000 Chinese dental professionals are expected to participate. Due to brisk interest already shown and Chinese governmental limitation on the number of foreign participants, the sponsor urges that requests for detailed symposium/tour information be made promptly.

Contact: Quintessence Publishing Co., Inc.
8 S. Michigan Ave., Suite 2301
Chicago, IL 60603
(800) 621-0387
A REPORT ON THE SCHOOL OF DENTISTRY

On July 1, 1983, Dr. James Kennedy assumed the deanship at the University of Connecticut, and an interim administration was appointed and has been functioning for the last two years. The administration, while limited in its ability to make significant changes, has attempted to address issues and make changes both necessary and beneficial for the educational program. In January 1985, the Board of Visitors appointed Dr. Lindsay Hunt (Associate Dean for Academic Affairs, Emory University School of Dentistry) as Dean, effective July 1, 1985.

All dental schools are evaluated and accredited by the ADA Commission on Accreditation. The School's last site visit occurred in 1979 and all programs were fully accredited. As with any evaluation process, a number of recommendations for change and improvements came from the school's self-study and the commission site visit. The timetable called for an interim five-year paper review reporting on these changes, with the next regular site visit to occur in 1988. I am pleased to report that the five-year review was evaluated and accepted by the Commission in December 1984 and all of the programs (dental, advanced education, dental hygiene) again received full accreditation.

Some progress has been made in the areas of physical facilities. Four years ago, the Pediatric Dental Clinic was completely renovated, and last summer, a central evacuation system was added in the main clinic of Lyons Dental Building. Funds have been identified to begin replacement of the older dental units in Lyons Clinic. Ten of sixty units will be replaced this spring and a central evacuation system will be added in the graduate clinic. Through the efforts of the school, university, and VDA, the funds necessary to renovate the preclinical laboratory area (called "the pits") located in the basement of the Wood Memorial Building were approved by the 1985 General Assembly. In addition, the university will send forward a capital outlay request to the 1986 General Assembly, which will include funds for modernizing the emergency clinic and general replacement of older equipment in the Lyons Building.

The class size has been reduced from 110 to 90 students per class with the first reduction occurring in the 1983-84 academic year. In the fall of 1983, ninety-three students were enrolled (selected from an applicant pool of 580) comprised of sixty-five percent Virginians. Thirty percent of these students are female and ten percent are from various minority groups. This minority group, two percent black. The overall undergraduate grade point average for this class is 3.09, compared to 3.08 in 1983, 3.06 in 1982, and 3.12 in 1981. On a national level, there has been a significant reduction in the number of dental students applying to dental schools, and Virginia reflects this trend. We have continued to experience a decline in the resident component of our dental students.
nt pool and have taken steps to offset this trend. The school initiated an active recruitment program, which includes activities such as college campus visitations, a college health advisor program, and the raising of university funds for scholarships for incoming students. Efforts will be made to develop a relationship with the practicing community and the admissions office so that together we can recruit the qualified applicants to the school. The baccalaureate program in dental hygiene continues to be viable and is currently accepting applicants for enrollment in August 1985. The number of applications for dental hygiene has also decreased significantly probably due to a lack of recent efforts and competition from other hygiene programs in the

As a result of the self-study and accreditation report, the curriculum has changed over the last three to four years and the academic calendar has moved to a full ten-month program. The didactic component permitted second-year students more access to patient care opportunities and increased the amount of time available to third-year students. The didactic component of the year, once all elective, has been required to include required lecture courses, as well as electives. The program has been reduced from four to two weeks and emphasis has been placed on providing students opportunities to deliver dental care to diverse patient populations, special needs. Extramural rotations include hospitals, public health clinics, migrant worker sites, and many students complete these rotations during the summer between their junior and senior years.

In general, students continue to perform above average on National Board Examinations but fall short of the desired expectations for clinical licensure exams. Virginia participates in the Southern Regional Testing Agency which includes the states of Virginia, Kentucky, Tennessee, and Arkansas, and it is now a regionalized test, given three times a year in Virginia. On the first attempt (usually in June), approximately 80-88 percent of the MCV graduates pass all portions of the four-part exam. Any applicant failing a portion usually retakes that section failed in July and the success rate is 99.9 percent. There are many factors influencing success rate, and while this success/fail rate is not unlike, or perhaps better than other areas of the country, it is still undesirable, and efforts are under way to strengthen certain aspects of the program in order to improve overall performance.

The school is fortunate to have an excellent faculty dedicated to providing a quality education. For the current academic year, there are 75 full-time positions distributed among the programs in dentistry, dental hygiene, continuing education, and administration. Approximately 75 percent of the faculty have completed advanced education programs in one or more of the specialties and 33 percent hold graduate degrees (MS or PhD) in the
basic sciences or education. Of the 143 institutions which receive support from the National Institute of Dental Research (NIDR), we rank ninth (9) in total dollars. The School also has one of three Centers for Clinical Research in Periodontal Disease. The research activities within the School of Dentistry are enhanced by a spirit of cooperation and collaboration with the faculty and administration of the School of Basic Sciences.

In summary, the overall state of the school is healthy. Certainly, there are areas and programs requiring change. Greater emphasis must be placed on developing the students' ability to solve problems and exercise judgment.

We must examine and change the current clinical format for delivery of care, so that students spend less time in juggling patient appointments and more time in effective patient care. And finally, the curriculum must be continually evaluated and updated to meet the needs of the future.

ANOTHER A.D.A. MEMBERSHIP SERVICE—THE PACKAGE LIBRARY

A reference service which is provided by the American Dental Association is the package library service. This is a special service which is unique to the Bureau. A package library consists of about 25 articles which are selected specifically to answer the question at hand. The package library is lent for a period of 4 weeks for a $10.00 service charge to members or $15.00 to nonmembers. The borrower may make one copy of any article in the package for his own file so long as he stays within the limits of the U.S. Copyright Law of 1976.

Articles in the package library collection are clipped from about 250 dental and medical publications. No articles are included from publications which are designed for the lay public.

Package libraries are sent by United Parcel Service within the continental U.S., and by Air Parcel Post elsewhere around the world. Borrowers are asked to return the material at their expense, and to reimburse the Bureau for air shipping when it is necessary to use it for shipping to them.

Please note that the A.D.A. Bureau of Library Services will answer routine questions by phone if an immediate response is necessary.
Our faculty members of the Dental School continue to be recognized at the National level for their individual achievements in dentistry.

Dr. Dewey H. Bell, Jr., Professor and chairman of the Department of Removable Prosthodontics, was one of three prosthodontists who presented papers before the Clinical Congress on the Management of the Geriatric Patient. Dr. Bell’s papers were entitled: (1) Prosthodontic Considerations in Alveolar Ridge Preservation for the Geriatric Patient and Prosthodontic Considerations in the Management (2) Rehabilitation of the Soft Tissues for Geriatric Patients.

The other dentists presenting prosthodontic papers were Dr. Ronald Desjardins of Rochester, Minnesota and Dr. George Zarb of Toronto, Canada. The two-day Clinical Congress was sponsored by the American Association of Oral and Maxillofacial Surgeons and was held in Hollywood, Florida, with over 500 dentists attending.

Dr. Richard Ranney, Professor of Periodontics, was named the recipient of the 1985 “Research in Periodontal Disease Award” by the International Association of Dental Research. The award was established to recognize, encourage and stimulate outstanding research achievements in periodontal disease and was presented to Dr. Ranney at this year’s IADR Meeting in Las Vegas, Nevada. As many of you know, Dr. Ranney was one of the first researchers to provide direct evidence for the role of immunity in the development of periodontal disease; he is also Director for the Clinical Research Center for Periodontal Disease at MCV—one of only three such centers in the United States.

CONFERENCE AMERICAN ACADEMY OF PERIODONTOLOGY

The American Academy of Periodontology has announced plans to sponsor a national Conference on Issues Related to the Delivery of Periodontal Health Care on July 8 & 9, 1985 in Chicago. The Conference, which will be co-sponsored by Procter and Gamble, will be held in Hillenbrand Auditorium at the American Dental Association building. Details of the Conference and registration forms are available from the American Academy of Periodontology, 211 E. Chicago Avenue, Room 924, Chicago, IL 60611.
REPORT OF EXECUTIVE COUNCIL MEETING
January 27, 1985
Hyatt House, Richmond, Virginia

ACTIONS IN BRIEF...

1. *Approved* that the Virginia Dental Association oppose a change in statute that would permit the practice of dentistry under a firm or assumed name, Article 4, Section 54-184 of the dental laws.

2. *Approved* a moratorium on dental hygiene scholarships while the Loan and Scholarship Committee conducts a study of scholarship needs of dental students and all dental auxiliaries (dental hygienists, assistants, and dental laboratory technicians).

3. *Encouraged* Executive Council members to attend the February Board of Dentistry meeting.

4. *Approved* recommendation of the Advisory Committee that the VDA give a lapel pin to Past Presidents rather than a key.

5. *Approved* that the $100,000 Certificate of Deposit invested for six months, and the $50,000 Certificate of Deposit invested for six months, be relied upon maturity at the best interest rate available.

6. *Approved* that the current assets checking account be converted to an interest bearing account.

7. *Received as information* report of the Dental Care Programs Committee.

8. *Received as information* report of the Dental Health and Public Information Committee.

9. *Approved* recommendation of the Insurance Committee that the $1 deductible option for Washington National Major Medical Insurance be continued for new applicants and that a new $2,500 deductible be available.

10. *Approved* recommendation of the Journal Staff Committee that due to increasing cost of publishing the Journal, that the publishing schedule be changed to provide quarterly issues of the Journal each year, and other year have a fifth issue or separate issue which will be the Member Directory.

11. *Approved* that the Executive Council encourage members of the Virginia Dental Association to run for public elective office.
12. *Approved* recommendation of the State Institutions Committee that the VDA correspond with the appropriate official to have a dental representative on the Health Interdisciplinary Team with the Department of Mental Hygiene and Health.

13. *Approved* that the VDA Student Loan Fund at MCV Financial Aid Office be limited to Virginia residents—without limiting the dollar amount per student.

14. *Referred* to the House of Delegates with recommendation to adopt, Bylaws amendment and addition to Article III, House of Delegates, Section 5., Reference Committees.


16. *Received as information* report of the Dental Environmental Health and Safety Committee.

17. *Received as information* report of the Dentist’s Health and Effectiveness Committee.

18. *Received as information* report of actions of the 1984 ADA House of Delegates.

19. *Received as information* report of the Division of Dental Health, State Health Department, by Dr. Joseph M. Doherty, Director.

20. *Received as information* report of the MCV School of Dentistry by Dr. James H. Revere, Jr., Acting Dean.

21. *Approved* list of dental students as student members of the Virginia Dental Association.

22. *Received as information* Preliminary Program for the 1985 VDA Annual Meeting.

23. *Received as information* the 1984 financial statement.

24. *Approved* that a letter be written to Dr. Ackell commending Dr. James H. Revere, Jr. for his outstanding service as Acting Dean of the Dental School.

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**UPPERAIRWAY COMPROMISE/DENTOFACIAL DEVELOPMENT SYMPOSIUM:**

Donald Timms, DDS, Donald Warren, DDS, and Robert Rubin, DMD. Holiday Inn on the Ocean Front, Virginia Beach, Va. Friday, June 28 and Saturday, June 29. $175 early / $250 late registration. Respond to: George Meredith, MD, Suite 206, 844 Kempsville Road, Norfolk, Virginia 23502. (Phone 804/461-5051).
A beautiful early spring has all but erased memories of all time record cold weather this past winter. Early buds have helped us forget those burst water pipes and downed power lines. How quickly we forget.

But T.D.A.'s activities continue strong. We had good turnouts at the Leadership Training Program in Williamsburg, the State Committee Meetings in Richmond, and the Southeastern Virginia Dental Symposium in Williamsburg. Our Spring Meeting in Virginia Beach with Dr. Joe Camp on Treatment of Traumatic Injuries to the Pulp will also draw a good crowd.

Dr. Allan Sundin presented to our Executive Committee an identification project wherein a micro disc is bonded to molar teeth. A new program to help identify lost children or strayed senior citizens. We will begin this program shortly.

The First Annual Lewis Zeno Memorial Award of $300 will be presented by the T.D.A. Foundation this spring at M.C.V. to the rising senior who shows the most promise in laboratory prosthetics.

Thanks again to Doctors Chris Hammerlin and Bud Zimmer, our Dental Health Month program was a huge success.

Component I continues to grow—We've taken in 20 new members this past year.
Dr. Harry D. Simpson, Jr. is a board member of the Newport News Boys Club. He is helping raise $900 to build a new Boys Club in Denbigh (Upper Newport News). Harry says he is paying the club back for making it possible to receive a college education and complete dental school at M.C.V. Congratulations Harry!

We have selected our slate of officers for next year:
- President ........................................ Richard D. Barnes
- President-Elect ................................. William J. Bennett
- Secretary ....................................... McKinley L. Price
- Treasurer ...................................... G. Curtis Dailey
- Executive Councilor ........................... Ronald L. Tankersley

I look forward to a good year and working with the members of the Peninsula Dental Society.
We hope there have been no serious injuries on the golf course this spring. It's a welcome problem after the joys of winter frostbite.

Component III held its February meeting at Holiday Inn South at Petersburg. Dr. John Svirsky, an oral pathologist at MCV Dental School presented a program on oral ulcers, herpetic lesions and other “things that go bump in the night”. We all thoroughly enjoyed his presentation and insight into new treatment of old problems.

All members are encouraged to take an active role in your component. This includes attending your annual meeting which will be held at the Richmond Marriott during September.

Ranks of dentists were not out in force at last year’s meeting in Roanoke.

The Component is indebted to the Dental Auxiliary for helping during Dental Health Month. Several members went to local schools presenting a puppet show on proper dental care. It was received well by all audiences.

Have a safe and relaxing summer!
Dr. Harry Hodges is never content to just do one or two big jobs at any one time. Now he has been appointed to the A.D.A. Search Committee for a new executive director. He better be careful or they just might ask him to fill the job. No doubt he could do it.

The National Foundation for Ectodermal Dysplasias has formed a special committee on dentistry to address the problems experienced by ectodermal dysplasia patients. Appointed to that committee is Dr. Frank Farrington, chairman of Pediatric Dentistry at VCU/MCV.

The Richmond Dental Society wants to congratulate the Dental Class of 1985. Welcome to a fantastic profession and be sure to get involved in organized dentistry. You are our future!
In the absence of any meetings or activities to report, let us discuss Keogh retirement which may well be your most important financial decision.

Starting your plan early enough, you will have a substantial tax deferred sum to be taken in installments according to your life expectancy with the money (principal and interest) being depleted at the supposedly date of your demise. These installments must be adequate to pay taxes and living expenses. Here is the "catch"—should you survive your life expectancy, these funds terminate therefore, if you have not saved for this optimistic gamble, you will not only be old but also poor. That's pretty bad. It is a sad situation when a retired person has to save for his old age.

There are also other gambits to consider such as income averaging, lump sum payment, insurance annuity, etc. However, any plan dealing with tax deferred money has drawbacks.
The spring meeting of our component is scheduled for April 26, 1985 at the Sheraton Inn in Harrisonburg. Dr. Gary Maynard and Dr. Richard Wilson of Richmond will be speaking on periodontal-restorative considerations in dentistry. These speakers will be returning to our component having lectured to us ten years ago.

Registration for this meeting begins at 8:30 A.M. with the presentation from 9:00-4:00. A fee of $40.00 for doctors and $10.00 for auxiliaries is necessary for this course due to a reduction in state sponsored programs from 16 to 8 per year. This fee includes lunch and a coffee break.

Registration for this meeting should be sent to:

Dr. J. Darwin King
1220 N. Augusta Street
Staunton, Va. 24401
Times are changing for the Northern sister of the State—we not only have all day, dinner, and lunch meetings; but we now have breakfast meetings! Our first breakfast meeting “starred” Margaret R. Abernathy, M.D., the Director of the Headache Center at Georgetown University Hospital. Both the new early morning format and speaker were well received. No head or stomach problems were reported.

Northern Virginia is looking towards further continuing education courses dealing with such subjects as “Malpractice Susceptibility—Its Effects On Your Practice and You” in April and “Newer Concepts In the Management of Temporomandibular Joint Disorders” in May. Finally in early June we have our “Annual Field Day” which includes various competitive sporting events ending with an evening dinner trophy presentation. Perhaps if each component would have a similar type event, then the best from each component could meet in an olympic-like event at our annual state meeting. This would help give some solidarity to the growing diverse cross-section of Virginia dentists.

As you can see from these courses (and previous programs this year) the Northern Virginia has had an excellent and varied set of continuing education programs. A big thank you goes to our program Chairperson for this year.

—Dr. H. J. Barrett!
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