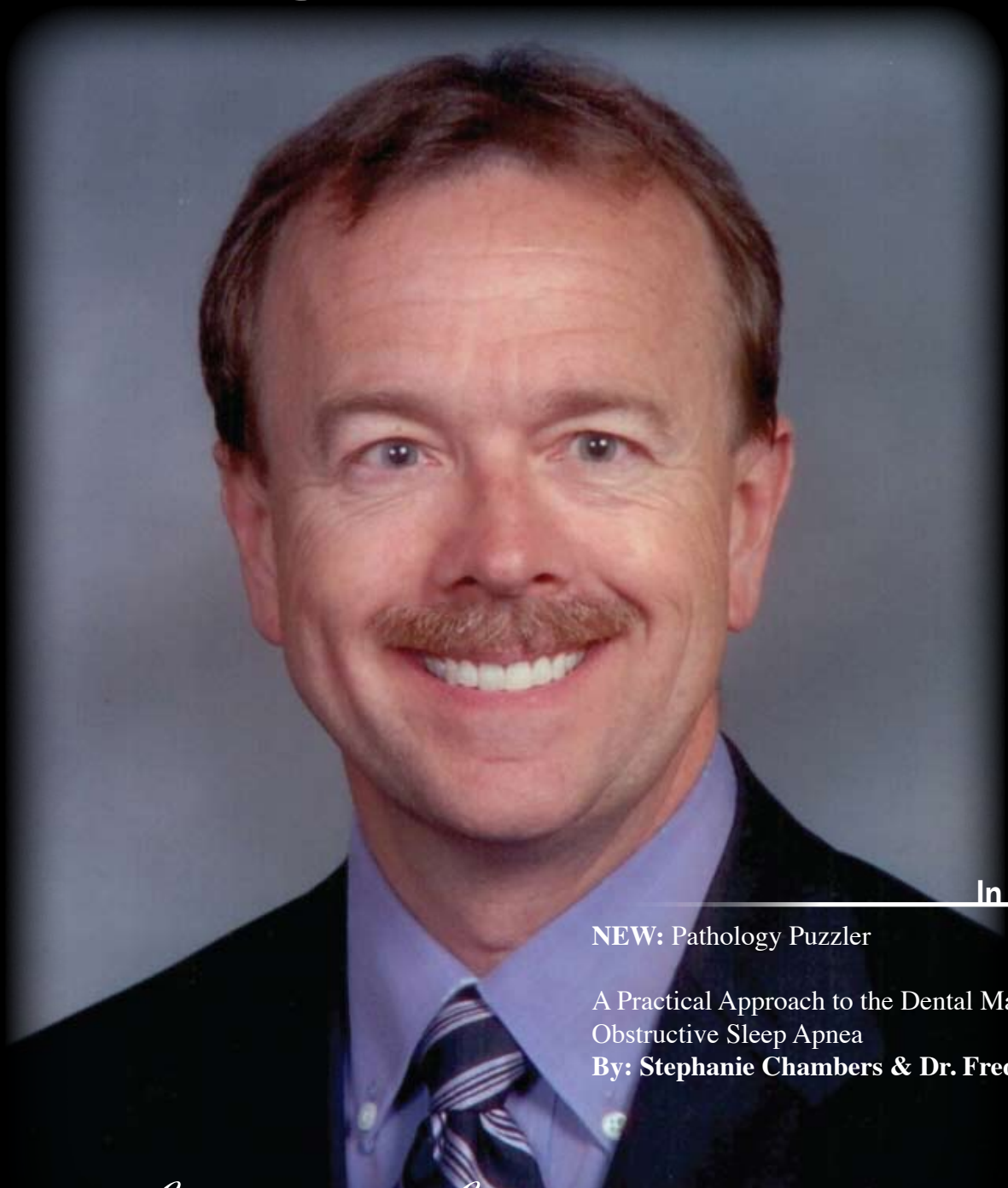
Volume 85, Number 4 • October, November & December 2008

VDA Virginia Dental Association Journal



In This Issue:

NEW: Pathology Puzzler

A Practical Approach to the Dental Management of Obstructive Sleep Apnea
By: Stephanie Chambers & Dr. Fred Certosimo

Dr. Ralph Howell • 2008-2009 VDA President

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Virginia Dental Journal

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Volume 85, Number 4
October, November & December 2008

Headlines & Articles

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REPRESENTING AND SERVING MEMBER DENTISTS BY FOSTERING QUALITY ORAL HEALTH CARE AND EDUCATION.

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VIRGINIA DENTAL ASSOCIATION

Constituent of the American Dental Association

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July 21, 2008

Governor Timothy M. Kaine

Dear Governor Kaine,

I wish to inform you of the illegal practice of dentistry occurring in many areas of Virginia. Various companies are setting up kiosks at shopping malls, Wal-Marts, Sam's Clubs and Costcos and performing the dental procedure of teeth whitening. As President of the Virginia Dental Association, I informed the Board of Dentistry of this situation at their June 6, 2008, board meeting. I know the Board of Dentistry has also received complaints from other licensed dentists in the state of Virginia. The primary purpose of the Virginia Board of Dentistry is to protect the citizens of Virginia from receiving harm from licensed dentists. I also believe they should protect these same citizens from non-dentists performing dental procedures.

The persons providing these services have had no formal training in dentistry and have no knowledge of the whitening solution that is being used in these procedures. The public needs to be protected - the solution used may not be FDA approved and the individuals providing the service don't seem to know the concentrations. A strong concentration of peroxide solution used to whiten teeth can damage the teeth and the surrounding soft tissue of the mouth if proper precautions are not observed. Also, these operations may not have instructed the individuals in OSHA compliance and training in universal precautions to prevent the spread of infection and disease.

At the June 6, 2008 Board of Dentistry meeting I presented the board with a newsletter from the Commonwealth of Kentucky Board of Dentistry. It stated Kentucky considers these operations to be practicing dentistry illegally and the Board of Dentistry has taken actions against them. Numerous other states are taking the same actions and the Board of Dentistry of Virginia needs to do likewise to protect the citizens of the Commonwealth.

If you have any questions, please feel free to contact me or contact Dr. Terry Dickinson, Executive Director of the Virginia Dental Association.

Sincerely your,

Gus C Vlahos DDS

Gus C. Vlahos, DDS
President, Virginia Dental Association

Message from the Editor

Dr. Richard F. Roadcap

Not long ago a new patient checked into the office. In the course of conversation he disclosed he had been a newspaper reporter, but recently started his own company. Times are tough in the newspaper business, he told me. He went on to say, in his opinion, television destroyed the evening papers, and the Internet is doing the same to morning editions. His comments reinforced the widely held belief print media are destined for the dustbin of history. Close to home, Media General's flagship publication, the Richmond *Times-Dispatch*, has lost over 22,000 paid subscribers in six years.[1] Nationwide, dailies are shedding staff and trimming pages as they cope with the flight of readers to online publications. According to a recent Zogby poll, senior news executives say the greatest threat to their industry is the declining number of young people who read newspapers.[2]

All of these events leads one to wonder – is there a future for the printed dental journal?
Many dentists, and not just members of Generation "X", depend on the Web for all information and news. Print is passé. Printing and mailing costs are escalating, perhaps faster than the robust inflation plaguing the economy. In a recession businesses view advertising as discretionary and ads underwrite each issue. The question we must answer – what's the best way to communicate with members – confronts us. Many publications are trying the ever-so-expensive "hybrid" approach, with print and online versions operating concomitantly. (In case you missed it, this publication has been posted on the VDA website since the first of the year. Pay us a visit.) I don't know of any state association to do so, but it's not hard to imagine dental journals being available only in an online format to be downloaded and opened later or, unfortunately, never.

Someone once said every college needs a football team – for alumni, it's their only connection to the school. Journals also are a connection, or tangible member benefit. But just as alums can now root for their alma mater online via streaming video, VDA members may not have to hold each issue in their hands to be informed. A month ago, Dr. Alonzo Bell was chosen President-Elect of the VDA in the first online election in the association's history. No longer do members have to appear in person to participate in the election of officers. Will printed journals suffer the same fate as film cameras, gold foil restorations, and copper band impressions? The future will decide the best format – print, online, or a combination of both. Maybe an upcoming issue will carry a blue postcard for members to cast their ballot for one of these choices.

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1 Farrar, Bill, "Rewiring the Times-Dispatch", *Richmond* Magazine, August 2008
2 *Your Dental Advocate*, "Newspapers in the Future", May 19, 2008

Message from the President

Dr. Ralph Howell

Mr. Speaker, Delegates, and Officers of the Virginia Dental Association it is my honor to speak to you as your President –Elect. As we all clean up from Tropical Storm Hanna, I am reminded of another storm that rolled through New Mexico in March of 2000. As lightening lit up the sky, one bolt managed to hit an industrial building owned by Philips NM, and caused a small fire in the furnace of Fabricator #22. The alarm sounded and automatic fire control systems were set in action. By the time the local fire department arrived, which was just a few minutes later, the plants' employees had the fire under control and completely extinguished. The incident was so small that the fire department did not even get out of the truck or fill out a service report. What was a problem; however, was the series of events that ensued. The plant manager notified the home office of the fire and the company notified its customers that there would be a slight delay in production.

The company had two major customers and each reacted in different ways. One customer took the manufacturer at its word and decided to wait for the slight delay. The other customer, saw this as a major delay in production and began to secure other manufacturers just in case Philips did not come back as quick as projected. Well the small fire turned out to major problem. The fire had occurred in a clean room of a silicone chip plant and the dust, smoke, water from the small incident stopped production for over six months on that particular line. Even though the loss amounted to less that .6% of Philips production, it had a major impact on the plants' two major customers. When all the clients were made aware of the significance of the damage, only one had made earlier enough plans to compensate for the change in supply. The two major customers were the cell phone divisions of Ericsson and Nokia. Because of Nokia's philosophy of treating any small problem as a potential large problem, they had already secured other chip suppliers so when Ericsson began to look, there were no other manufacturers available. Thus Nokia was able to corner the cell phone market completely shut its competition out.

As I stand before you today, I am telling you that the fire is still burning in the Commonwealth and if we are to survive we must take actions otherwise we will be ones left out. It is not just one fire, it is many fires and each one has the potential to completely change dentistry for the worse. Some of the fires are related access to care, some are related to infringement on our ability to practice, some are related to our strength as an organization, and some are related to other organizations attempting to speak on our behalf. Just as a small fire can cause global problems for the cell phone industry; we too, must be prepared to extinguish these fires and to strategically plan our own future.

First, we must have a strong organization in order to survive. We have made great progress over the last decade, we have a more streamlined form of governance, we have an excellent Association Staff, and we have the best Executive Director in the Nation. Financially, we are in the best shape that we have ever been and now is the time to build upon that. I urge the VDA to change its policy and seek to have a minimum of 50% in liquid cash reserves of its annual operating budget.

With online voting, we have seen more members vote for officers than has ever voted in a VDA election. The members of the Association have become more interested in what is best for the VDA than what will help regional politics. With these changes and the need for the Association to be more efficient, I am asking the House to direct the Board of Directors to change the Constitution and By Laws to allow for the House of Delegates to meet in one location beginning in 2011. The efficiency given to the Association to make a series of hotel reservations and the need not to move staff makes Richmond the ideal location for the Annual Business Meeting to occur. Furthermore, online voting takes the regional advantages out of moving the meeting around the state. If approved, the House will vote on these changes at the 2009 House of Delegates.

To continue to strengthen the organization, it is paramount to improve communication and committee operation. I am requesting that the House approve the annual budget to allow for a Fall Leadership Conference and a set location for Spring Committee Meetings. The Fall Leadership Conference will offer leadership training to Officers, Committee Chairman, Board members, and new members desiring to improve the Association. The conference will also allow all attendees to plan for a productive year. Spring Committee meetings held together will allow for greater communication among committees and interaction among members to help solve the complex problems that we face as an Association.

We are a membership organization, and as such we have been losing market share over the past several years and this year we have seen a decline in membership numbers as well. Membership is not just a committee responsibility it is a membership responsibility. Years ago, organized dentistry meant membership in the ADA. Today, there are many other dental organizations trying to gain your membership. There is the Academy of Cosmetic Dentistry, the Academy of Computerized Dentistry, Academy of Sleep Dentistry, just to name a few as well as local and internet based study clubs. These virtual associations offer some of the things that have previously only been seen in the ADA. We need to recharge our membership committee so that each person who does not renew membership is given a personal visit from a member and is encouraged to rejoin. Membership retention is a problem with local solutions. Members remain because they see a value in membership and it is up to each one of us to value colleagues as members and to take the responsibility of educating them about the value and importance of membership. As a dentist, you can help change the lives of a few thousand patients; but as a member of the Virginia Dental Association, you can change the face of Oral Health in the Commonwealth.

Membership diversity is one area that we need to build upon if we are to thrive in the future. If you look out among the members of the House and you look at the students in the dental school; you will see that we are not reaching the new dentists. There are many students of diverse ethnic backgrounds who are not members of the VDA. We must do a better job of involving students in the Association, and welcoming them into our organization. There is no better way to teach the importance of the VDA than through the mentor program. I encourage you to make this a standing committee of the Association. The students of today are the leaders of the association tomorrow; we must take care of them and welcome them with open arms.

Access to care, is a hot topic in the Commonwealth as well as on the

National front. We are a Nation with the best dental care in the world; but there is a great chasm between those who receive care and those who do not. The answers to this problem are complex and will require a great deal of thought on just how to solve them. Regardless of the issues, we are the dental profession and we must step forward. As a profession, we are held at a higher standard than all others. We, by virtue of our license, are the only ones capable of delivering care and if we can not or will not deliver that care there are other groups and organizations that will attempt to deliver that care. When you are drowning, you want a life jacket and not necessarily a certified lifeguard to deliver it to you. In order to maintain the autonomy of practice that each of us enjoy, we each must do our share to help those that have no care. Each of us should, take at least five patients in the "Smiles for Children Program ". Each of us should participate in the DDS Program. Each of us should participate in a MOM Project. Each of us should donate to the Foundation. These are just a few small ways that each of us can give to those in need. While it may not be practical to donate to every cause, it is important for each of us to do something to make a difference.

While charity may help the problem, it is not a solution to the access issue. We are facing a manpower shortage in dentistry and there are only a few ways to fix this problem. We must choose which direction that the Association will proceed. We need to increase the number of Public Health dentists and lobby for these positions to be funded. In order to solve the problem beyond public health clinics, we can increase the number of practitioners or we can increase the efficiency with which we practice by delegating more duties to auxiliary personnel. We can also explore another type of provider to take care of this issue for us. I personally believe that anything that we do to divide the dental team will, in the long run, be detrimental to providing comprehensive care. It is my plan to continue the workforce task force and broaden its task to look at all options to find the best solution for dentistry. I encourage you to support the resolutions provided by the task force and provide any specific direction that you wish for the task force to take.

Whichever direction we take, it will take a concerted effort with policy makers to solve this problem. It has been said that no man's possessions, property, or fortune is safe when the Congress is in session. Therefore, it is critical that we maintain a strong Political Action Committee. Each of us should participate in the PAC two ways. First, make contact with your local legislators and let them know your feelings about the profession and how the VDA is working to help with the access issues. Secondly, donate to the PAC. It takes more and more money to run a campaign and it is even more critical that dentistry maintains its place at the table. In many states that do not have the relationship that the VDA has with the legislature; the practice of dentistry is marred with restrictions, and regulations not based on science; but based on the voice of radical environmentalists and special interest groups outside of dentistry.

An unintended consequence of the access to care issue is that any action or request for funding for social programs can seem self serving to the profession. Any attempt to block the practicing of dentistry by non-dentists may seem obstructional. Therefore it is critical to continue to build bridges with other organizations and coalitions. We must be a part of the solution and not distance ourselves from others because they have different opinions on how to solve the problems. In this issue, I feel that the VDA should take the high road and set policies on what is best for Oral Health Care for our patients and not necessarily what is in the best interest of dentistry. I feel that is the calling of a profession, to put our patients first and foremost above any personal gain. It is my opinion, and one unfortunately confirmed by national polls, that the profession of dentistry has slipped a few points as the most honest profession. As unfair as it may be, perception is reality in the media as well as in the legislature. We must, as a profession, rise above the temptations to compromise patient care for personal gain. Nationally and locally, we see over treatment on the rise. There are hundreds of seminars on "how to make a fortune in dentistry", the "Art of Selling Dentistry", and very few on how to improve techniques in patient care. I will work with the Editor of the VDA Journal as well as the Ethics and Judicial Affairs Committee to include ethical moments in the Journal as well as try to develop an ethics continuum to assist members in decision making processes. If we continue on the path of dentistry as a trade and dental services as a commodity; we will see others trade in that commodity. You only have to travel a few miles down the road to a Sam's Club to see whitening clinics operated by non-dental personnel with little training and no regard for proper aseptic technique. We must put our patients and their oral health first as well as do a better job of educating our members if we are to improve the ethical standing of the profession.

In closing, I am reminded of a story about two close friends Art and Walt and a discussion about 40 years ago. Walt was a dreamer and came knocking at Art's door one evening with an investment proposal. Walt and just purchased a huge tract of land and wanted to build a park and wanted to let his friends know and see if they were interested in helping out. Well Art seemed somewhat interested and got in the car with Walt. They drove to the airport and flew across the country. Once arriving, they got in the car and traveled for several hours until the roads ran out and nothing but dirt roads existed. It was at that point that Walt got out of the car and told his friend of his dream. He said, that this is the edge of my property, (as a short note, they were standing in the edge of a huge swamp, overgrown with what seemed like a vast wilderness), and I have invested all that I have on this land. I plan to build a park. It will be a place like no other and it is my dream that people will want to come to my park to relax and unwind after working so hard. He rationalized, that the harder people work the greater need for relaxation. Walt continued, there is plenty of land around here and if you want to invest, I think it will be a wise decision. Well, Art did not bite and the two friends went back home. As is the case, Walt found others to invest in his swamp land, and he did manage to build a huge park. Years later, Art told of his bad judgment and missed opportunity. Art or Art Linkletter's friend was Walt Disney, and the swamp land was in Orlando Florida, and his park was a Theme Park now called Disney World. Had Art invested at that time he could have bought land for less that one cent per acre. As you may have guessed, all of the land surrounding Disney sells for millions of dollars per acre.

We are all given opportunities in our life and in our profession. With every fire on the horizon, we are given opportunities to ignore them or invest in them to make a difference. The time is now for the VDA to not sit idly by but to move forward and improve our profession.

Thank you again for this opportunity to serve you and with your help as President of the Virginia Dental Association, we can move this Association forward and bring about a better profession for those that follow.

Resolutions:

1. The VDA should set a goal to maintain 50% of the annual budget in liquid cash reserves.
2. The VDA House of Delegates should direct the Board of Directors to change the Constitution and Bylaws to remove the mandate to geographically move the Annual Membership Meeting location around the Commonwealth.
3. As a profession, all VDA Policies should place patient health above personal gain.
4. Any program that attempts to answer access to care issues must not divide the dental team and must involve the dentist as the supervising care giver.

Attention ALL Members...

The Virginia Dental Association Board of Directors requires the association's Harassment Policy be published in the Virginia Dental Journal each year so that all members can familiarize themselves with it.

VIRGINIA DENTAL ASSOCIATION HARASSMENT POLICY

The Virginia Dental Association will not tolerate harassment of any employee, member, distributor, customer, or vendor because of that person's race, religion, creed, color, sex, age, national origin, sexual orientation, physical or mental disability, veteran's status, or any other status protected under applicable local, state, or federal law. Respect for the dignity of others should be the guiding principle for our relations with others.

All employees are responsible for assuring that the work place is free from sexual harassment. In addition, the Virginia Dental Association will not tolerate any action or conduct by VDA members involving employees or other members that could be viewed as sexual harassment. Specifically prohibited by this policy are unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. Prohibited conduct may be oral, written, visual, or physical in nature. More subtle forms of behavior, such as offensive posters, cartoons, fax, email, comments, and jokes of a sexual nature, may also constitute sexual harassment when they create or contribute to a hostile or offensive environment.

Harassment comes in two general types. One is pressure brought to bear by a superior upon an employee, involving sexual demands that become a condition of employment, or used to base decisions regarding the employee's pay scale or advancement. The other is the creation of a "hostile environment;" this type of harassment may often occur between peers.

This policy prohibits all such activities, whether engaged in by a superior, management employee, agent of the VDA, VDA member, fellow employee or non-employee of the VDA (who may be on VDA premises or who comes into contact with the VDA employees at any time for any purpose).

An employee or member of the Virginia Dental Association, including any supervisory or management employee who violates this policy, shall be subject to discipline by the VDA and said discipline shall include the possibility of discharge, depending on the nature and severity of the offense. In the event that a non-employee of the VDA violates this policy and the violation is brought to the attention of the VDA Executive Director, the VDA will take all necessary steps to assure that the said violations are stopped immediately.

The Executive Director is designated as the VDA complaint officer for purposes of the implementation and enforcement of this policy in relation to the staff. For VDA members or non-VDA employees, the complaint officers are the members of the VDA Board of Directors. VDA prohibits any retaliation against an employee who has made a good faith complaint under this policy or anyone who has cooperated in good faith in the investigation of a complaint. Any employee of the VDA who is subjected to sexual harassment in violation of this policy by any other person may make a formal complaint of such violation to the extent possible to the complaint officer(s). The complaint officer(s) shall be responsible for promptly investigating the complaint to the extent possible based on the information available about the circumstances. If the complaint is found to be justifiable, the complaint officer(s) will assure that the violation is stopped immediately.

In addition, the following actions shall be taken if a complaint against an employee is found to be justifiable:

1) First complaint, orally by other employee, will result in a verbal warning to the offending employee and noted in the employee's personnel file;

2) Second complaint must be in writing and will be held in the strictest confidence. This complaint will result in written warning, which will be placed in the offending employee's personnel file;

3) Third complaint, also issued in writing, again maintaining confidence, may result in termination if it is determined that a violation is valid and ongoing.

If a complaint against a VDA member or other non-VDA employee is found to be justifiable, the VDA President, acting as the complaint officer, shall take such action that he deems appropriate.

All complaints shall receive prompt, discrete investigation and result in prompt response. All complaints will be kept confidential to the maximum extent that the law permits. While investigations will be conducted discretely, VDA cannot promise complete confidentiality because pursuing an investigation may require or lead to disclosure of the identity of those connected to the complaint.

I have read, understood, and will comply with the VDA Harassment Policy as stated above.

Trustee's Corner

Dr. Ron Tankersley • 16th District Trustee

The Future

My tenure as your ADA Trustee ends this October. So, this will be my last Trustee Corner article. Previous articles discussed advocacy, dental education, dental practice, ethics, and the state of the ADA. These are all mutually dependent and important elements in securing our future. So, I will briefly try to put them in that perspective.

The ADA's ability to successfully advocate for the profession and the oral health of the public is among our most important assets. Today, there are many state and federal initiatives for healthcare reform, which are receiving increased public and corporate support. Unfortunately, we have no inherent immunity to proposed changes in health-care financing and delivery. So, our advocacy ability today is more important for our future than ever before.

Effective advocacy requires a high market share of dentists. But, today many dental graduates belong to ethnic minority groups; and, increasingly, younger dentists want to be employees, not traditional proprietors of dental practices. Often, these non-traditional dentists do not join the ADA because they do not understand our relevance to their futures. We need to educate them, value their perspective, and welcome them as full participants in our Association.

Dentists make up only a small percentage of the American population. Nevertheless, our advocacy efforts have historically been very effective, because we are recognized as the "authoritative" voice for quality oral healthcare. In fact, we used to be the "only" voice for quality oral healthcare. But, today we are in a competitive environment. Today's policy makers want pragmatic solutions to the access problem. Simply, protecting patients from harm is no longer adequate; they want help solving the problem. Other groups are eager to fill that void. If we are not proactive in developing better answers, those other groups will succeed in fragmenting our dental team and lowering the standards for providing dental care in this country.

To be successful in this competitive environment, we need "undeniable credibility". That requires dentists who are ethical, well educated, and highly skilled at critical thinking; and auxiliaries who are well trained, cost effective, and give us the flexibility to provide dental care to all patient populations, under the supervision of dentists.

Obviously, high ethical standards, state-of-the-art dental education, a comprehensive dental team, and a strong, inclusive Association are all mutually dependent and essential to our future. If all sectors of our profession work together to attain these common goals, dentists in the future will provide even better care, to more people, more cost-effectively, and with more job satisfaction. But, if we sit back and wait for others to make that happen, it won't!

Our courage and unity will be challenged over the next few years. But, we have a long proud history. If we work together, we can preserve those aspects of dental practice that work so well while developing innovative solutions for providing quality care to the underserved. Dentistry will remain "Healthcare that Works". It's up to you!

It has been an honor to serve as your Trustee to the ADA for the past four years. Your friendships, advice, and support have made this a journey of a lifetime for me. I will always be grateful for the experience. Based on that experience, I am confident that we can secure the future for our great profession. But, it will require dentists, like you, working together to make that happen. Please encourage your colleagues to help secure our future by active participation in the ADA, VDA, and your local component.

Virginia Dental Journal - Correction

Volume 85 Number 3 July, August & September 2008

Faces of Donated Dental Services (DDS) pg 36, incorrectly listed Michael James' dental care as being donated by Dr. Daniel Stockburger. The services were in fact donated by Dr. Robert A. Dreelin, DDS of Hampton, VA.

DDS greatly appreciates this and all donations of care and sincerely apologizes for the error.

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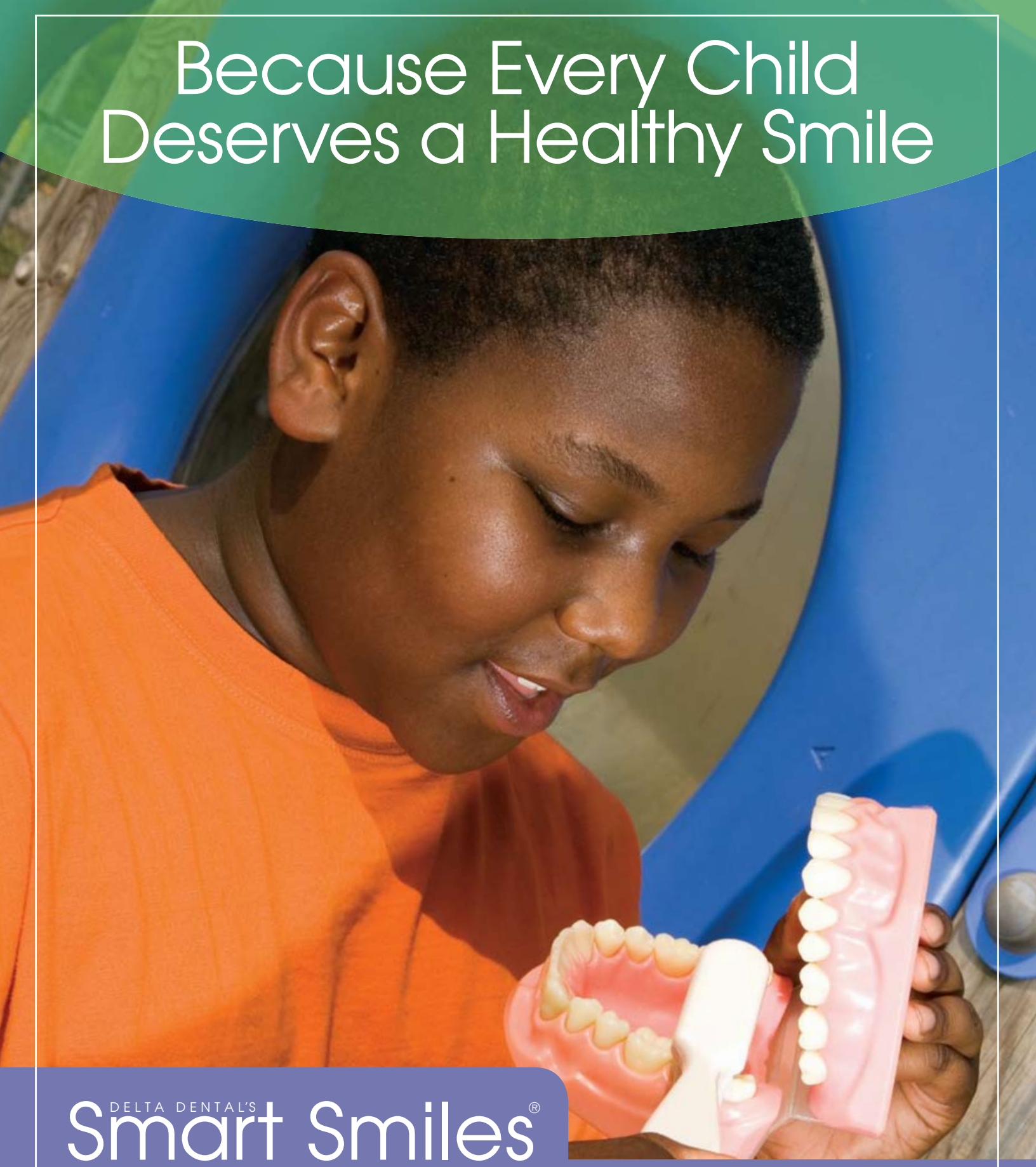

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Letter to the Editor

AEROSOLS AND PANDEMIC FLU

We in dentistry create aerosols by the bucketful in our offices, both from the air driven handpiece and the ultrasonic scaler. Research has shown a 3000% increase in background bacterial counts after using either one of them.[1] These aerosols are not innocuous. They have been challenging our immune systems, but we have ignored the danger of transmission of diseases via this route. This is evidenced by seroprevalence studies that have shown a higher level of antibodies for many viruses amongst dentists and dental students as compared to pre-dental students.[2] We are not taking the precautions that we should. So many diseases are ubiquitous in our society that it is hard to pinpoint which disease was caught from what source, but this study shows that at least some of our illnesses have their origins in our offices. When I started to research pandemic flu, I did it out of concern for my health and the health of my family. I was shocked to find that warnings about aerosols and disease in dentistry go back at least forty years. I now realize that we have not been doing enough to protect ourselves, our staff, and our patients from disease, and we are not doing enough to protect ourselves from the specter of a probable pandemic. At the present time Avian Flu (H5N1), the one we are worried about, has a mortality rate of 63%.[3] We need to initiate a strategy that both can protect us now and will allow us to continue to practice dentistry when a pandemic comes. How many weeks can you afford to close your doors? Unless you plan now, you will not be able to assure your staff that it is safe to come to the office, and you will not be able to convince patients to come to the office either. Procedures need to be put in place before the emergency and publicized to both your staff and your patients. Attempts at last minute catch up will be too little too late.

What can we do, and how do we do it? I cannot describe it all in this commentary, but basically we need to reduce the aerosols that escape into the air, and we need to protect ourselves from those that remain. Reduce aerosols by the use of High Volume Evacuation wherever aerosols are created. Most dentists have an assistant who suctions as they work, but what about the hygienist? The aerosols created by the ultrasonic scaler are mostly less than five microns in size.[4] Many of those float in the air for hours.[5] For some offices an assistant for the hygienist makes sense. For others a simple, inexpensive, attachment to the ultrasonic scaler (Safety Suction) will do the job.[6] If interested in this device, contact me for an article on its use.

What about protection from the aerosols that remain? Surgical masks, the ones most of us use, do not filter sufficiently. They are designed to protect the patients from our spitting on them, and to protect us from splatter, but not from aerosols. Protection from aerosols comes from NIOSH approved N95 respirators that are "fit tested".[7] Most of us have never heard of N95 respirators, nor of fit testing. N95s filter out 95% of aerosols down to 0.3 microns. Fit testing shows that you are wearing the right size respirator, and are wearing it correctly. however these respirators are not as comfortable as the inefficient masks we now wear. I have gotten used to wearing one continuously, for half a day at a time, because I am motivated and value my health. The Fairfax County Health Department has fit tested over three hundred physicians plus one dentist for N95 Respirators. How much is your health worth to you right now? How much do you want to stay in practice during a future pandemic? Old habits may be comfortable, but changes are in order.

{ Safety Suction and N95 respirators are not readily available. Suggested sources are: Safety Suction from Quality Aspirators at 1-800-858-2121. NIOSH approved 3M N95 Respirators sizes 1870, 1860, 1860s from Henry Schein, Inc. }

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An interview with...

Dr. Ralph Howell

VDA President 2008-2009

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

I would like to continue to improve upon all that the VDA has accomplished over the last several years. We as an association are in great shape from an organization's point of view; however, I would like for the VDA to reverse some of the trends that are seen nationwide in the ADA. I would like to increase the membership and the market share. We need build more bridges with other groups to improve oral health within the Commonwealth. Finally, we need to continue to develop new leaders within the association so that we can thrive in this ever changing environment.

What is the greatest challenge facing organized dentistry?

I think that the greatest challenge facing dentistry deals with the issue of access to care. This is a complex issue that many are looking to organized dentistry to solve the problem or at least be a part of the solution. If we do not make efforts to be a part of the solution outside "solutions" may be forced upon us.

What is being done to reach an understanding with dental hygienists' representatives?

A group of VDA leaders met with the officers of the Virginia Dental Hygiene Association to help them craft a new definition of Dental Hygiene in August. It is my hope that this definition will meet with the approval of the VDA House and will open the doors to a renewed alliance with Hygiene Association. I would like the team to work together to help solve dentistry's problems today.

Do you expect the 2009 General Assembly to be contentious? What are the issues that concern dentists?

I think that the greatest part of the dental profession is that we take the high road and advocate what is best for the public and not what is best for our own personal interests. If we continue that philosophy, I do not think the General Assembly will be contentious. However, the Commonwealth has some severe financial issues and great needs for roads and other capitol improvements. I believe that money for social problems, such as dental care, will suffer and we will face some challenges to have some programs funded.

Let's say I'm a recent dental school graduate. Why should I join the VDA?

I think that every dentist and every new graduate should be a member of the VDA. This is the only way that you as a professional can have any voice as to the future of dentistry. Without membership, the VDA has no voice with policy makers and no ability to control the destiny of our chosen profession.

About 70% of dentists in Virginia are VDA members. What can the VDA do to increase its market share?

We are not reaching the diverse population of our current graduating dentists and we are losing some current members. I think we need to increase our involvement with the dental students and become mentors to the younger dentists. We need to realize that there are many groups of "organized dentists" and the VDA needs to concentrate on the core values that are central to all practicing dentists. We need to extend a personal invitation to all who are not members. Membership recruitment and retention is not the job of a committee but a responsibility of membership.

Name the person who has influenced you most in your dental career.

As a dentist, my father, Leroy Howell, has been my greatest influence. His passion for dentistry and his compassion for patient care have set standards that I hope to achieve. Even after 50 years in the practice of dentistry, he has a smile on his face and never seems to tire from treating patients.

Do you have mentors? Who are they?

Within the VDA, Bud Zimmer has always been an example of an outstanding leader. He is always thoroughly prepared to deal with any task that presents itself. Terry Dickinson is a true visionary and has helped guide the VDA to national recognition as the Constituent Society. Finally, my Father has set the example as a mentor in my professional and personal life.

Who is your favorite author? Why?

I read so many different books and articles that it is hard to pick one particular author. I tend to read for preparation rather than for pleasure.

What would you like to be doing five years from now?

I hope to be able to practice dentistry and enjoy having both children out of college and graduate school.

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A Practical Approach to the Dental Management of Obstructive Sleep Apnea

By: Stephanie Chambers and Dr. Fred Certosimo

Introduction/Abstract

Obstructive sleep apnea (OSA) is a potentially life-threatening, sleep-related breathing disorder (SBD), yet a vast majority of those affected go undiagnosed and untreated.[1] A collaborative effort amongst dentists and physicians is necessary to assist sleep apnea patients obtain the proper treatment, a better quality of life and improved health. This article explains ways a dentist can better recognize and treat patients with sleep apnea. To accomplish this, it will be necessary to describe the available screening, diagnostic and sleep apnea devices, as well as the dentist's role in co-managing OSA patients. Surgical intervention is yet another treatment modality but is not within the scope of this article highlighting non-surgical therapies.

Different Types of Sleep Apnea

Affecting around 4 percent of adults[2], obstructive sleep apnea (OSA) is the most common type of apnea and involves repetitive complete or partial obstructions of the upper airway due to the collapse of the soft palate and/or tongue against the pharyngeal wall.[3,4] As a result of these obstructions, five or more episodes of either absent airflow (apnea) or diminished airflow (hypopnea) can occur per hour and can each last anywhere between 10 to 30 seconds.[3,4] The most common ramifications of such episodes include chronic, severe, loud snoring, frequent arousals due to hypoxemia, and hypersomnia due to the lack of refreshing sleep.[1,4] If OSA is left untreated, it can be associated with several health risks including: hypertension, coronary heart disease, nocturnal cardiac dysrhythmias, myocardial infarction, stroke and even sudden death.[1,3,4] It is the moderate to severe types of OSA that are linked to an increased risk of mortality and morbidity, while the long term outcomes of mild to moderate OSA are more ambiguous.[5] The less prevalent central sleep apnea (CSA), and mixed sleep apnea (combination of OSA and CSA), are other types of apnea which involve the central nervous system failing to control the mechanisms of breathing.[6] However, dentists should be most aware of OSA, as its pathophysiology might be best addressed by dental means.

Signs and Symptoms

Snoring affects 10-30% of the adult population.[7] Extremely loud snoring in 5 out of 100 people is often the first sign of OSA.[7] Since patients with OSA are seldom aware of their snoring or apneic episodes, dentists can question the sleep partner of the patient.[2] Obesity is another main predisposing factor for OSA, which is known to progressively worsen with advancing age and weight gain.[1,6] Along with snoring and obesity, dentists should also be cognizant of the several other potential risk factors, signs, symptoms and consequences of OSA so that potential OSA patients can be recognized, advised and referred to a physician or sleep specialist for a definitive diagnosis.[2]

Imagine: A 50 year old highly fatigued, irritable, obese patient walks into your office seeking treatment. After reviewing the medical history, you discover the patient has a history of symptoms that may be related to sleep apnea. Therefore, if such a patient denotes on the medical history form the associated risks or symptoms of OSA (i.e. hypertension, hypothyroidism, xerostomia), the dentist should be prepared to ask if they also suffer from morning headaches, irritability, impaired memory and concentration, and/or depression, as these questions could lead to a dramatic impact on a patient's future treatment and quality of life.[2,3,6,8] OSA patients may report poor work performances, occupational accidents and motor vehicle accidents, as untreated OSA patients have two to three times more accidents than in matched control drivers due to excessive day time sleepiness or hypersomnia.[3,8]

As dentists are the "maestros of the mouth", physicians may ask for our interpretation of lateral cephalometric radiographs of suspected OSA patients.[3] These radiographs may show signs that contribute to the propensity for developing OSA such as "an elongated soft palate, a large tongue, a retropositioned maxilla and mandible, an inferiorly positioned hyoid bone [and] a narrowed posterior airway space."[3] Dentists can also review their own routine panoramic radiographs for evidence of calcified carotid artery atheromas, as OSA patients are prone to developing these lesions.[3] A high arched palate, nasal septal deviation, a thick neck (collar size greater than 16-17), as well as enlarged palatine tonsils and/or uvula can also lead to an increased tendency of developing OSA and should be noted during routine head and neck exams.[6]

If it is suspected from the health history and routine clinical examination that the patient may have a sleep related breathing disorder, the dentist can use a simple Sleep Disorder Examination Form to assist in referring the patient to a physician for proper diagnosis.[9] As documented in the Ivanhoe et al. review article, this form includes a detailed oral examination section, questions pertaining to sleep position and snoring frequency and the Epworth Sleepiness Scale (ESS) questionnaire. The ESS is "used to determine the likelihood of the patient dozing off in a variety of common daily situations."[10] If the patient scores a 10 or higher out of 30 on the ESS, the dentist can be confident in their referral since ESS scores correlate well with the respiratory disturbance index recorded in overnight diagnostic sleep studies of OSA patients.[10,11]

Treatment

Once it is determined that the patient has the salient signs and symptoms of OSA, the dentist may confidently inform the patient of the possible presence of the sleep disorder and direct the patient accordingly to a SBD knowledgeable physician. The physician or sleep specialist will establish the type of tests or studies best suited for each patient to make a proper diagnosis of the sleep disorder. To make an appointment at a sleep center, the referral may need to come from a physician depending on the patient's insurance policy. Dentists can refer to www.sleepcenters.org to find more information and requirements for local sleep center referrals.

Polysomnography, or overnight sleep study, is the standard of reliability and accuracy for diagnosing the severity of the SBD.[5] Among other findings, this study will monitor sleep staging, cardiorespiratory data and the RDI (Respiratory Disturbance Index) or AHI (apnea/hypopnea index) .[5,9] AHI is "a calculation of the combined number of apneas and hypopneas per hour of sleep", whereas the RDI "is the average number of apneas plus hypopneas plus respiratory effort-related arousals per hour of sleep."[5] A task force commissioned by the American Academy of Sleep Medicine (AASM) has helped standardize the assessment of OSA by various sleep centers. AASM recommends that OSA be considered mild if the RDI is between 5 and 15 events per hour, moderate if between 15 and 30 and severe if over 30.[5]

The results from the tests help determine the appropriate treatment

modality.

If the physician determines that the patient qualifies for OSA treatment with an oral appliance (OA), they will refer the patient back to the dentist.[9] Though physicians are responsible for the ultimate treatment method, dentists should inform physicians of an OA treatment option upon their initial referral, because in certain cases "oral appliances are indicated for use in patients with mild to moderate OSA."[12] Dr. Dennis R. Bailey, a renowned contributor to the field of SBDs, has established a head, neck and airway evaluation for the dentist to complete upon referral from the physician. The purpose of this comprehensive evaluation is to identify the appropriate treatment modality and uncover supplementary conditions (i.e. TMD) that may either be associated with the OSA diagnosis, or have an affect on the outcome of the eventual treatment.[13] If it is determined that the patient's condition would benefit from the use of an oral appliance, then the dentist's diagnosis from the evaluation, along with the physician's sleep study diagnosis and patient desires, can all help decide which of the several mechanical devices is best suited for that particular patient. [13]

Treatment Modalities

Based on scientific literature published since 1995, the American Academy of Sleep Medicine (AASM) updated their practice parameters in 2005 to provide standards and guidelines for physicians and dentists to follow when treating OSA patients. AASM recommended treatment options for OSA range from behavioral or lifestyle changes (e.g. weight loss, sleeping on the side, elimination or avoidance of alcohol and sedatives three to four hours before bedtime) to OAs, CPAP (continuous positive airway pressure), and even surgery.[2,4] Many times lifestyle changes are successful and sufficient in reducing episodes of sleep apnea especially in mild cases of the disease.[2] For all levels of sleep apnea, especially the severe cases, an initial trial with nasal CPAP remains the gold standard of OSA treatment.[12] CPAP has proven in several studies to be "more efficacious than OAs in reducing the measures of respiratory disturbance (AHI and oxygenation)".[12] In fact, results from several "clinical, randomized trials demonstrate that AHI decreases (although not in every case) with oral appliances, and the AHI almost always decreases with the use of CPAP."[9] Although CPAP tends to have greater effectiveness[12], patients often have poor compliance with this form of treatment due to issues of mask discomfort and pump noise.[9] However, according to the AASM parameters, OAs are only suitable for patients with "mild to moderate OSA who prefer OAs to CPAP, or who do not respond to CPAP, are not appropriate candidates for CPAP, or who fail treatment attempts with CPAP or treatment with behavioral measures."[12] Conversely, for severe OSA patients in which CPAP is not used, effective or preferred, "upper airway surgery (including tonsillectomy, adenoidectomy, craniofacial operations and tracheostomy)" may override consideration of OAs.[12] New products that combine the design principles of CPAP and OA should also be considered.

There are over 38 different oral appliances[9] available to the dentist who is well trained in oral appliance therapy and the associated oral relationships.[12] Both groups of oral devices, the mandibular advancement device (MAD) and the tongue retaining devices (TRD), are devised to help open and stabilize the airway.[9] TRDs and MADs also minimize or prevent movement of the base of the tongue towards the posterior wall of the pharynx which could cause an obstruction.[9] Choosing between the two groups of devices is based on the individual patient's characteristics and preferences. For instance, TRD, which consists of a hollow bulb supported by trays that fit over the maxillary and mandibular teeth or edentulous ridges, is ideal for patients that are edentulous, have a complicated dentition, periodontal problems, a large tongue or TMJ disorders.[14] While TRDs utilize suction, the more frequently used MADs use the alveolar ridge or teeth for retention. MADs can be either fixed or adjustable and consist of form-fitting trays that fit over the maxillary and mandibular teeth (Figure 1,2). Initially, the fixed or adjustable MADs are positioned with the mandible about 60-75% of the distance from centric occlusion to full protrusion. (Figure 3).[9,14] Each of the available appliances (i.e. Klearway®, TAP3®) have specific requirements designated by the individual manufacturer to aid in proper fabrication or selection of the OA.

Upon insertion, dentists should advise patients of the use and care for their OA, as well as the possible side effects and their prevention. The most common mild and temporary side effects patients complain of range from excessive salivation and dry mouth to minor occlusal changes, sore teeth and jaws, but more serious side effects like TMD and irreversible tooth movement are possible .[4,9,15] Any discomfort in the teeth or TMJs should relieve itself within about an hour after removal of the device in the morning.[9] However if symptoms persist, then evaluation and possible adjustment of the OA is necessary. Depending on the type of OA, the device may also need to be titrated (adjusted) beginning several days after delivery if OSA symptoms (i.e. snoring, gasping for breath, choking, tiredness) are not eliminated or minimized to an acceptable level.[9] For the adjustments, the mandible is slowly adjusted either anteriorly or posteriorly, in increments of 0.25mm per night for two weeks.[9] The patient is then reexamined if the desired end results are not achieved. The patient is followed and the OA adjusted as needed until a decrease in side effects and symptoms is established.

After proper adjustment of the OA by the dentist, which may take weeks to months, the patient is referred back to the physician for a follow-up polysomnography.[9] The test is done with the final adjusted oral appliance in place to determine its efficacy.[12] Follow up testing is necessary since treatment results with OAs are highly variable and unpredictable, even leading to an increase in AHI in some patients.[12] After the oral appliance has been deemed efficacious and optimal fit has been established, patients being treated with oral appliances should have follow-up appointments with their dentist at 6 month intervals during the first year and at least annually thereafter.[12] To ensure satisfactory therapeutic benefit from the OA, the dentist should evaluate the occlusion, the integrity of the appliance, the health of the oral structures, monitor the patient for treatment compliance, and assess the patient for worsening OSA.[12]

Currently, no standardized criterion for successful treatment with the above modalities exists. However, suggestions as to what constitutes successful treatment are those that will most likely result in an "increase in life expectancy, a decrease in health problems and an improvement in the quality of life."[9] Presently, a successful endpoint is attained when there is "a 50% decrease in the AHI or RDI, an AHI or RDI less than 20, or when a satisfactory level of snoring has been reached and the AHI is less than 10 regardless of the beginning level".[9] Furthermore, a decrease or elimination of the symptoms of OSA to a level where TMJ or tooth sensitivity is controlled, can also be an effectiveness gauge.[9,12] These criteria are important for treating physicians and dentists alike as they help choose, and determine the efficacy of, different medical and dental modalities.

Conclusion

OSA continues to be a major public health problem associated with a wide variety of adverse health outcomes, yet studies indicate that an underestimation of the true incidence of OSA exists.[12,17] Thus it is in the patient's best interest that dentists be well-versed about OSA at least to extent where they can

recognize, properly advise and refer potential sleep apnea patients. While the level of involvement in OSA treatment rests primarily on the dentist's personal interest on the subject, if a dentist does choose to provide therapy with OA's, the AASM suggests that the dentist be well trained and knowledgeable in this field. Specifically, AASM recommends that the dentist be able to understand the different sleep testing modalities, interpret their results, as well as be adept in "the overall care of oral health, the temporomandibular joint, dental occlusion and associated oral structures".[12] The treating dentist should also understand the different OAs available, and be able to recognize and manage any side effects associated with the different devices.[18] While it is not required to become board-certified as a Diplomate of the American Board of Dental Sleep Medicine, doing so verifies to the community that a satisfactory level of education and experience has been completed.[19] There are several comprehensive resources available to those dentists who wish to gain further knowledge and accreditation in sleep apnea including The American Board of Dental Sleep Medicine (ABDSM) at www.abdsm.org and The American Academy of Sleep Medicine at www.aasmnet.org.

Figure 1 - Occlusal view of TAP3® Mandibular Advancement Device

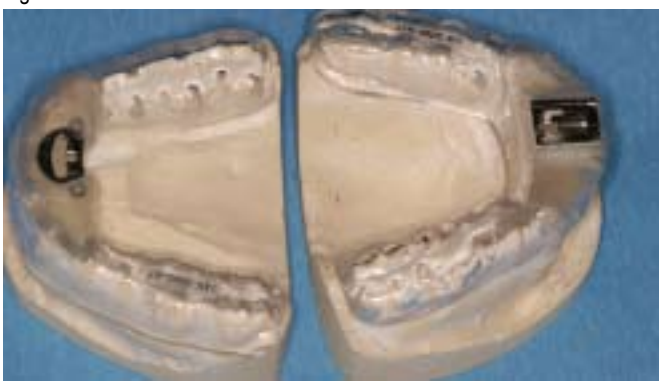
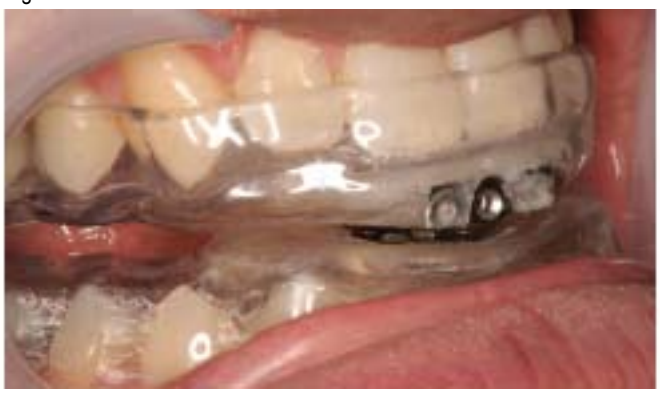


Figure 2 – Frontal view of TAP3® Mandibular Advancement Appliance

Figure 3 – Lateral view of TAP3® Mandibular Advancement Device



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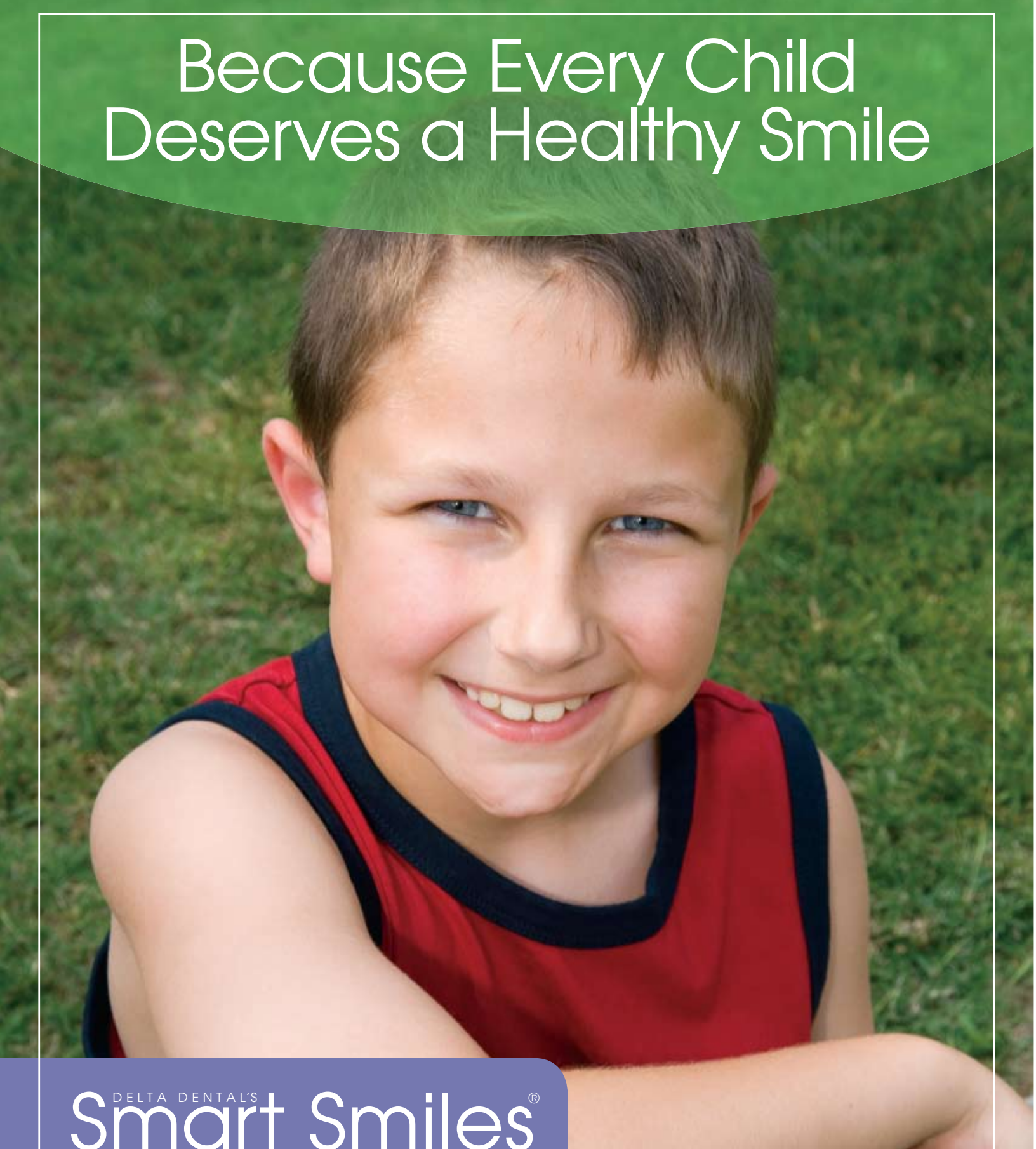

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Introducing:

PathologyPuzzler

with Dr. John Svirsky

Case number 1

Case History

A ninety-one year old African-American patient presented to a local oral surgeon with a lesion of the anterior mandible that both clinically and on radiograph showed expansion of the cortical plate. The occlusal radiograph (figure 1) showed an expansile radiolucent lesion with trabeculations measuring approximately 2.5 cm by 1.75 cm in greatest dimensions. Adjacent to and connected to the primary ballooning lesion was another expansion showing a broad base of attachment measuring .8 cm by .7 cm. Areas of radiolucency were also present central within bone. In the Panorex (figure 2) there appears to be multiple round ovoid areas of radiolucency within the anterior mandible.

Questions:

1) Which of the following would you consider in your differential diagnosis?

A. Ameloblastoma
B. Calcifying Epithelial Odontogenic Tumor
C. Central giant Cell Granuloma
D. Aneurysmal Bone Cyst
E. Odontoma
F. Odontogenic Keratocyst
G. Central Ossifying Fibroma
H. Calcifying Odontogenic Cyst

2) What is the next step to make a definitive diagnosis?

A. Brush biopsy
B. Incisional Biopsy
C. Excisonal Biopsy
D. Do nothing and observe

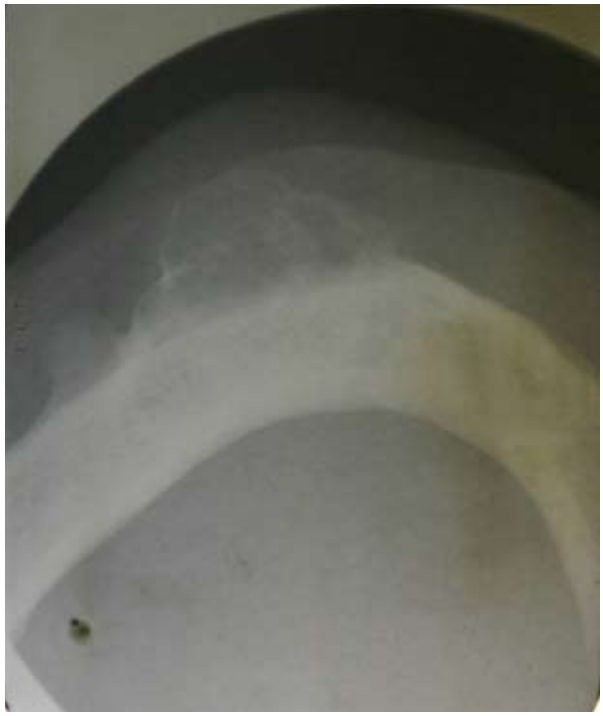

Figure 1

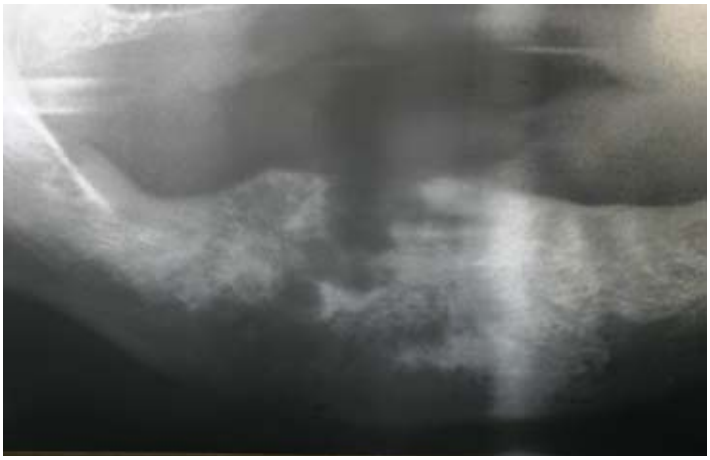

Figure 2

See answers on page 59

Oral Surgery Abstracts

Aspirin and bleeding in dentistry: an update and recommendations

Michael T. Brennan, DDS, MHS, Richard L. Wynn, PhD, and Craig S. Miller, DMD, MSc,
Oral Surg Oral Med Oral Pathol Oral Radiol Endod 2007;104:316-323

Aspirin is one of the most commonly used over-the-counter medications in the United States due to its antipyretic, anti-inflammatory, and antiplatelet activities. The antiplatelet activity of low-dose aspirin is used in the prevention of myocardial infarction, ischemic stroke, and vascular death. This article discusses the biochemistry of aspirin, the thrombotic risks associated with discontinuing an aspirin regimen, and offers new recommendations for continuing an aspirin regimen during invasive dental procedures.

Low dose aspirin is proven to reduce the risk of nonfatal myocardial infarction by 30%, nonfatal ischemic stroke by 30%, and vascular death by about 17% in patients who are at high risk for atherosclerotic disease. A daily dose of aspirin in the range of 75 to 100 mg (1 baby aspirin contains 81 mg) is recommended for the long-term prevention of serious vascular events in high-risk patients. Currently, it is accepted that the cardioprotective benefits of low-dose aspirin outweigh the potential for untoward bleeding episodes in at-risk patients with cardiovascular disease.

Many patients on an aspirin regimen may also take clopidogrel (Plavix), another antithrombotic medication. A recent Science Advisory from the American Heart Association, American College of Cardiology, Society for Cardiovascular Angiography and Interventions, American College of Surgeons, and the American Dental Association recommended continuing aspirin and clopidogrel therapy for minor dental surgical procedures in patients who have coronary artery stents or delaying treatment until the prescribed antiplatelet regimen is completed, and warned of the significant thrombotic risks of discontinuing therapy. Patients with acute coronary syndrome who discontinued daily aspirin use are reported to have worse short-term outcomes than individuals not previously on aspirin therapy. Patients who regularly take aspirin and cease taking the medication are more susceptible for myocardial infarction. The mean delay between aspirin withdrawal and the acute coronary event was 10 +/- 1.9 days (range 4-17 days).

This article recommends not discontinuing the use of daily aspirin before routine dental extractions including multiple teeth. Studies indicate that the amount of bleeding anticipated during oral surgical procedures in patients on aspirin is controllable by standard local hemostatic measures such as suturing, direct packing with gauze, resorbable gelatin sponge, oxidized cellulose, or microfibrillar collagen. Low-dose aspirin therapy should be continued when routine dental extractions are performed, unless specific extenuating circumstances exist. In such cases, discontinuation should be limited to 3 or fewer days as increased risk for thrombotic events increases when discontinuation is between 4 and 30 days. The thrombotic risks of discontinuing aspirin and Plavix outweigh the potential bleeding complications with continuing therapy. Due to the effect of aspirin on COX-1 and COX-2, patients who take higher doses of aspirin (i.e., 1 gram or more per day) do so for the analgesic and/or anti-inflammatory properties, and do not have antithrombotic concerns. In these patients, aspirin use could be discontinued before dental extractions or surgery, as they are not at known risk for thrombosis.

Corey Burgoyne, DMD, Resident, VCU Oral and Maxillofacial Surgery

CO_2 Laser Evaporation of Oral Lichen Planus

P.S. van der Hem, M. Egges, J.E. van der Wal, J.L.N. Roodenburg
International Journal of Oral and Maxillofacial Surgery 2008; 37: 630-633

Oral lichen planus is a relatively common disease affecting 1-2% of the general population. The disease may be present anywhere in the oral cavity; however, the buccal mucosa, the lateral border of the tongue and the gingiva are the most common sites. Oral lichen planus can be divided into six types; the erosive, atrophic, and bullous forms are often associated with a burning sensation that may cause severe pain. Traditional treatment consists of various drugs, including antifungal ointment, retinoids, and local and systemic corticosteroids. The aim of this study was to retrospectively evaluate the effectiveness of the CO_2 laser in the management of oral lichen planus in patients with complaints of pain, and to look at the recurrence rate compared with other treatment modalities. From 1975 to 2003, a group of 21 patients with 39 oral lichen planus lesions which caused pain, even after conservative therapy, were treated with CO_2 laser evaporation. During a follow-up period of 1-18 years, 21 patients were pain free (85%) and 6 patients (15%) experienced painful recurrence after treatment. After retreatment with CO_2 laser evaporation there were no complaints of pain. There was complete epithelialization after treatment and retreatment in three weeks in all cases. In patients whose condition is unresponsive to topical corticosteroids, CO_2 laser evaporation may yield long-term remission of symptoms, and may even be the treatment of choice in patients suffering from painful oral lichen planus.

Dr. Gabriel Fritz, Resident, VCU Oral and Maxillofacial Surgery

Oral Bisphosphonate-Induced Osteonecrosis: Risk Factors, Prediction of Risk Using Serum CTX Testing, Prevention, and Treatment

Robert E. Marx, DDS, Joseph E. Cillo, Jr, DDS, Juan J. Ulloa, DDS
Journal of Oral Maxillofacial Surgery; 2007; 65: 2397-2410

The purpose of this study was to quantify the risk and time course involved with oral bisphosphonate-induced osteonecrosis of the jaws. Performing oral and maxillofacial surgical procedures on patients taking oral bisphosphonates has been a hot topic in recent years due to the increased awareness of the disease process and more patients being prescribed oral bisphosphonates for osteopenia and osteoporosis. This study prospectively looked at thirty cases of exposed bone that fit the American Association of Oral and Maxillofacial Surgeons Task Force definition of osteonecrosis. Each patient was asked for a detailed history of oral bisphosphonate use, including duration, dose, frequency, comorbidities and indication for use. They were also asked about the initiating event, presence or absence of pain, previous treatment for exposed bone and response, and whether the oral bisphosphonate was discontinued. Clinical examination noting size, location and presence of infection was determined. Each patient was scheduled for a fasting morning CTX (C-terminal telopeptide) prior to starting the study. The mandible was the site of 96.7% of the cases, with 50% occurring spontaneously without a recognized initiating event. Incidence and severity increased linearly with duration and dose. Concurrent steroid use with prednisone or methotrexate exhibited the lowest CTX values. A six-month drug holiday showed significant improvement in CTX values above 150 pg/ml (the critical value determined to be associated with the lowest risk). This study recommends 1) a CTX test if there is a history of three or more years of oral bisphosphonate use and 2) a CTX test for all patients taking oral bisphosphonates and concomitantly using corticosteroids or chemotherapy. The value of 150 pg/ml or greater is associated with minimal risk. A value less than 150 pg/ml warrants a drug holiday of four to six months before a repeat CTX test is done. If the patient presents with infection, conservative treatment with 0.12% chlorhexidine and penicillin is all that is initially required. For patients allergic to penicillin, levofloxacin is the antibiotic of choice.

Adam McCormick, DDS , Resident, VCU Oral and Macillofacial Surgery

Maxillary osteosarcoma associated with a dental implant

H.S. McGuff, DDS; J. Heim-Hall, MD; F.C. Holsinger, MD;
A.A. Jones, DDS; D.S. O'Dell, DDS; A.C. Hafemeister, BS

Journal of the American Dental Association; 2008; 139: 1052-1059

The purpose of this article is to report a case of maxillary osteosarcoma associated with a dental implant and review current knowledge of implant-related sarcomas in the mouth. The incidence of malignant neoplasms associated with dental implants is rare - 49 reported cases of sarcoma associated with orthopedic hardware in the last 50 years. Not much is known about dental implants and the host reaction to and integration of the foreign object. In the US almost one million dental implants are placed annually. With increasing

use of dental implants, the risks and benefits should be weighed and carefully explained to patients.

This case report reviews the only known report of sarcoma associated with a dental implant. A 38 year-old woman presents with a low-grade chondroblastic osteosacoma in the right maxilla eleven months after receiving a maxillary right dental implant. Periapical preoperative implant placement radiographs were taken. After a differential diagnosis an incisional biopsy, CT scan, and x-rays were taken of the right maxilla. After a working diagnosis was formed, the patient received two initial courses of chemotherapy followed by resection of the infrastructure: maxillectomy, a partial hard palatectomy, and a lateral pterygomaxillary dissection by a head and neck surgeon. She was followed closely for the next 47 months.

The pathological findings showed a malignant neoplasm with pleomorphic, hyperchromatic spindle-cell proliferation. Numerous mitotic figures were apparent. A diagnosis of chrondroblastic osteosarcoma was made. Initial courses of chemotherapy failed due to complications of fever, neutropenia, fatigue, anemia, thrombocytopenia, nausea, vomiting, mucositis, dehydration, and stage II chronic kidney disease. Surgical resection showed good prognosis due to a negative margin of resection and low-grade (T1 N0 M0) of tumor. Thus the patient did not require subsequent chemotherapy.

These results are useful to the dental profession because the use of endosseous implants continues to expand. All dental professionals should be aware of the risks and complications, no matter how rare. The author believes that the association of the implant with the development of the osteosarcoma may be coincidental given the patient's history of localized osteonecrosis related to implant placement, persistent chronic osteitis and the accumulation of low-dose radiation explores related to multiple radiographic imaging studies of the area. There has been much research on implanted biomaterials in orthopedic literature, but very little in dental literature. More research needs to be done to fully explore the oncogenic potential of implants and their component materials.

Dr. Nazir Ahmad, Resident, VCU Oral and Maxillofacial Surgery

Effect of Botulinum Toxin-A in Myofacial Pain Patients With or Without Functional Disc Displacement

Cem Kurtoglu, DDS, PhD, Osman Hayri Gur, DDS, PhD, Mehmet Kurkcu, DDS, MSc, PhD, Yasar Sertdemir, PhD, Fusun Guler-Uysal, MD, and Hakan Uysal, DDS, PhD, Journal of Oral Maxillofacial Surgery Vol. 66: 1644-1651, 2008

This study evaluates the effects of botulism toxin-A in the treatment of patients who have myofascial pain with or without functional disc displacement. Tempromandibular disorders are considered a major cause of pain in the orofacial region, and can be quite debilitating. This prospective, randomized, double-blinded, placebo-controlled study was performed at the Clinics of Temporomandibular Disorders of the Cukurova University Dental Facility. Botulism toxin-A (BTX-A) has been proposed to be effective in treating oromandibular dystonia, torticollis, TMD, bruxism, and hypertrophy of the masseter muscles. In this study, 24 patients were enrolled that had myofascial pain, with or without internal derangement of TMJ disc, and who had no resolution of symptoms after conservative therapy. Electromyograms (EMG) and the Research Diagnostic Criteria for Temporomandibular Disorders (RDC/TMD) were used to evaluate patients. The protocol includes demographics, patient characteristics, an axis I diagnosis, and an axis II profile. Axis II assesses and classifies pain intensity, pain-related disability, depression, and non-specific physical symptoms. Exclusion criteria were age less than 14 years, a history of allergic reaction to BTX-A, pregnancy, and lactation. Subjects were given bilateral injections of BTX-A or saline (regardless of unilateral or bilateral pain); three points in 2 masseter muscles and 2 points in 2 anterior temporalis muscles. Those subjects were evaluated at baseline, and at 14 and 28 days. The differences in EMG values at rest position between the study and the placebo groups were significant for the left and right masseter and right temporal muscles on day 14 (p values <0.01), but that was not evident at baseline and on day 28. The differences in EMG values at maximal clenching between the study and placebo groups were significant for all muscles at each time interval. Comparisons of pain, disability, and psychological status showed no statistical difference over time for the placebo or study groups. The study concluded that patients with myofascial pain, with or without functional disc displacement, can achieve a positive effect using BTX-A.

Christopher Durham, DDS, 2nd Year Oral and Maxillofacial Surgery Resident, VCU Medical Center

Dexmedetomidine versus Midazolam for Sedation in Outpatient Third Molar Surgery

Yakup U¨ stün, DDS, PhD., Murat Gündüz, MD., Özgür Erdog˘an, DDS., and M. Emre Benlı˙dayi, DDS. Journal of Oral and Maxillofacial Surgery; 2006; 64:1353-1358

The purpose of this study was to compare the use of dexmedetomidine with the use of midazolam during intravenous conscious sedation in third molar surgery. Dexmedetomidone is a highly selective alpha (2)-adrenoreceptor agonist suggested for intravenous sedation and postoperative analgesia. It is unique in that it provides no respiratory depression while lowering heart rate and blood pressure. Outpatient surgery has been a mainstay in oral and maxillofacial surgery practice for many decades. Sedation techniques vary according to the operator with a common goal at hand - a safe anesthetic. This study looked at twenty healthy patients with symmetrically impacted third molars who were to have these teeth removed under sedation. In a double blinded, randomized fashion, these patients were divided into two groups, one to receive dexmedetomidine as a sedative in the first surgery (the D group) and the other to receive midazolam (the M group). The patient had two of the four third molars extracted at the first appointment. At the second appointment, each patient was sedated again, this time with the drug that was not administered in the first appointment. The intraoperative sedation level, patient cooperation, and postoperative performance were scored and any pain reaction during the local anesthetic injection was recorded. Visual analog scales were additionally used for the subjective assessment of pain and patient satisfaction. Amnesia was evaluated by the patients' ability to recall the objects shown during the operations and the local anesthetic injection. Patient preferences were recorded during the interview at the end of the second operations. The mean heart rate and blood pressure measurements were significantly lower in group D. There was no significant difference in the respiratory findings. A significantly higher number of patients showed pain reactions in group M. Sedation level, postoperative performance, and VAS (Visual analog scales) pain scores were not statistically significant, whereas the differences in cooperation score and VAS for patient satisfaction were significant. Adequate amnesia was obtained in group M, however, no amnesia was demonstrated in group D. Sixty-five percent of the patients indicated a preference for dexmedetomidine sedation.

Kevin Bond, DDS, Resident, VCU Oral and Maxillofacial Surgery

The Effect of Mandibular Third Molar Presence and Position on the Risk of an Angle Fracture

Joyce T. Lee, DDS, MD and Thomas B. Dodson, DMD, MPH
Journal of Oral and Maxillofacial Surgery
2000; 58:394-398

The purpose of this study was to assess the relationship between the presence and position of mandibular third molars and angle fractures. A retrospective cohort study was performed with a sample composed of patients admitted to the Emory University department of oral and maxillofacial surgery for the treatment of mandible fractures between January 1993 and April 1998. The source of the data was the medical records and radiographs of the patients, and a total of sample size of 367 was analyzed. The position of the third molars was categorized using the Pell and Gregory classification system. Horizontal position ranged from Class I, where adequate space was available between the second molar and anterior border of ramus, to Class III where the majority of the third molar was located within the ramus. Vertical position was classified as Class A if the highest portion of the crown was at or above the occlusal plane, Class B if it was between the occlusal plane and the cemento-enamel junction (CEJ) of the adjacent second molar, and Class C if it was below the CEJ of the second molar. Patients with fractured mandibles and lower third molars present had a 1.9-fold increase in the risk of angle fractures compared with patients without third molars. When taking third molar position into account, it was found that mandibles with the most impacted third molars (position IIIC) had a 50% decrease in angle fracture risk compared with those with third molars in position IA.

Mike Coleman, DDS, Chief Resident, VCU Oral and Maxillofacial Surgery

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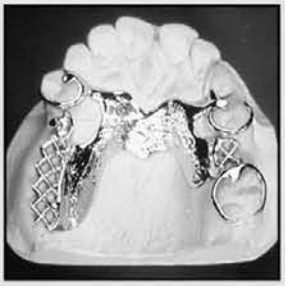

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A YEAR IN IRAQ

Dr. Silverman looks back

Editor's Note: *Dr. Ronald D. Silverman, a member of the VDA for 33 years, recently retired as Major General in the U.S. Army. From July 2006 to August 2007 he served as the Army's top medical officer in Iraq, and was responsible for the complete spectrum of healthcare for 160,000 service members supporting Operation Iraqi Freedom. He was the first dentist to oversee all medical care for a combat theatre, and was the third-ranking officer in Iraq. The VDA Journal contacted Dr. Silverman at his dental office in Alexandria, and he agreed to talk about his experience.*

VDA Journal: Tell us about your career path.
Dr. Silverman: I joined ROTC at the University of Wisconsin as an undergrad, and graduated from dental school at Temple University. After four years on active duty, I opened a general practice in Alexandria. I remained in the Army Reserve while in private practice, and considered my career "routine" until my appointment as a general.

VDA Journal: How does a dentist become the top medical officer in a combat zone?
Dr. Silverman: Being a dentist, or any other specialty, does not exclude you from a command position in the Army. What's required are good leadership and administrative skills, and the experience to put these in place. I was the senior medical officer in Iraq, and the first dentist in history to command all medical personnel in a combat zone.

VDA Journal: You spent a year in Iraq. How was that received by your patients?
Dr. Silverman: Actually, I was gone for two years. I was in charge of the 3rd Medical Command (3d MEDCOM) first, then we were deployed to Iraq for thirteen months. My partner was fantastic – he was able to take care of patients while I was gone. My patients were great too; sending e-mails, letters, care packages. I heard from them almost daily while I was gone.

VDA Journal: Did you treat dental patients in Iraq?
Dr. Silverman: Only four – as a sideline. I treated some friends as a favor. My job there was not dental. We ran the world's largest trauma center, and took care of all branches of the service from six hospitals.

VDA Journal: Has combat experience changed the way you interact with patients? If so, how?
Dr. Silverman: In Iraq, as a commander, you look at everything from a "macro" point of view. How can we provide care for soldiers for their entire tour of duty? We had the highest survival rate in the history of warfare – 90% of wounded soldiers. In dental practice, it's a "micro" environment, dealing with each individual patient. It took me some time to adjust. It gives you a new perspective on life. Thank God we're here; and thank God for what America has.

VDA Journal: Why should dental students consider a career in the military?
Dr. Silverman: It will give them an opportunity to work and train with mentors that you would never have in private practice. They'll be able to see parts of the U.S. and the world they would never see otherwise. Soldiers come from very diverse backgrounds; dentists will learn to appreciate their culture and point of view. In Iraq, the dental clinics have the best of everything – equipment and supplies. They can do any procedure; well, not many implants are done.

VDA Journal: How does private practice experience help in your military career?
Dr. Silverman: In the Army, it's a matter of dealing with people. It's the same way in practice. When you operate a dental practice, you have to deal with supplies, payroll, personnel issues, management issues. You can apply this same problem solving experience to the military on a larger scale. You learn to make decisions and then live with the consequences.

VDA Journal: How do today's soldiers compare to those serving at the start of your career?
Dr. Silverman: I started during the Viet Nam era. There was the draft – we got soldiers of many different educational backgrounds, and different levels of motivation. Some were motivated and some weren't. Today it's a volunteer Army, and the soldiers are more motivated and take their job more seriously. They're more dedicated – they want to be there. That includes the officers. And they're highly skilled in the technical aspects. These young men and women are doing a fantastic job – they're dedicated and motivated.

VDA Services – Supporting the Association, Working for You

Dr. Roger E. Wood, President, VDA Services

As you know, there are many benefits to being a member of the Virginia Dental Association. There is the legislative strength of the Association, the excellent CE and social offerings of the Virginia Meeting, volunteer opportunities of the MOM and DDS and so many others. In my year as President of VDA Services, it has come to my attention that many members are not aware of another great benefit of membership: the peer-reviewed vendors that are part of the VDA Services program. While hundreds of members have taken advantage of some of these programs, there are hundreds more who are not familiar with VDA Services.

In 1996 the Virginia Dental Services Corporation (VDSC) Board was formed to evaluate and recommend various products and services to the members of the VDA. Recommendations are made after careful evaluation by the dentist-volunteers that serve on the Board, and in some cases, non-dues revenue is generated based on member's use of the different vendors. In 2006, the VDSC launched a brand for all of the endorsed products and services and they are all now categorized under the VDA Services umbrella. Currently there are 17 vendors that are recommended by VDA Services ranging in scope from insurance, to payroll services to gloves for your office (for a complete listing of the VDA Services vendors please see the list opposite this article).

Through VDA Member's use of these various programs, VDA Services has been able to financially support a number of VDA programs. In total, VDA Services has provided $1,450,897 to the VDA and its related entities. These funds have been used to sponsor the Virginia Meeting, CE at each Component Society, the MOM Projects, the VCU School of Dentistry and to help keep VDA Member dues as low as possible. VDA Services has been proud to provide so much support to the Association and it is our goal to increase our support for the VDA's programs.

If each VDA Member was to start using just one VDA Services vendor, the impact on your Association could be huge. When you review the list of vendors, you will see that many of the products and services are ones that you already use in your office. The difference being that when you use a VDA Services vendor, you are helping to support the VDA. You also have the backing of the Board and a place to turn should a problem ever arise.

I urge you to review the list of vendors and contact them to find out what they have to offer. Many offer discounts and special programs available only to members that can help your bottom line in addition to supporting VDA Services. Should you have any questions about VDA Services, please do not hesitate to contact me, any of the VDA Services Board Members or Elise at the VDA Central Office.

Your support of VDA Services is greatly appreciated – we are proud to serve the Members of the VDA!

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The "IT" Factor in Healthcare

By: Dr. James Schroeder
Previously published in *Campus Connections* - CJW Hospital

What is the IT Factor? You know it when you see it in action or personally experience it. Perhaps it is implied in a mission or value statement in a hospital or other healthcare facility. Maybe you observe it when people interact with each other in delivering a healthcare service. When you are on the receiving end of it, or a loved one receives it, you are warmed, pleased and grateful. On the contrary, when it is missing, you sense a cold wind blowing through the interaction and are left with a feeling of despair or anger. Often in healthcare, if you do not have it, your team members wish you had stayed home from work and your patients are happy they missed the experience you deliver.

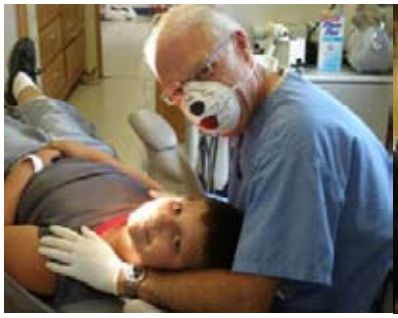
A small word with only two letters, it can be a deal breaker when left out of the healthcare experience. The first component of the IT Factor dynamic is competency: knowledgeable; highly skilled; cutting edge; excellence in profession; sound judgment. Education, laws, medical boards, peer supervision and certification all regulate a standard, demanding a high performance the public expects. Enormous investments are made to sharpen an individual's ability to stay abreast of new information and the technological explosion taking place in the heath care industry. People recognize excellence when they see it.

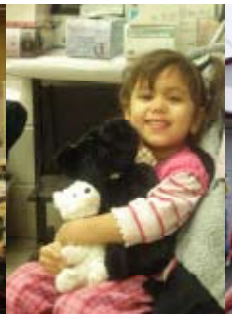
The second component of the IT Factor can be found in a different shape and form; Character. It plays an important part in the patients' perception of their experience. Often found in mission and value statements, it is not regulated by laws and often overlooked in the curriculum of health care providers. Amidst the explosion of knowledge and technology, a person's character will deliver the heath care experience and change the perception of others. Our ability to listen, be polite, show kindness and impart empathy will leave no guess work that we care about people. Doing so requires humility, compassion, and respect. Laws, regulations and educational curriculums are not focused on developing a standard competency of excellence for this component. However, it is not an option, if we are committed to deliver exceptional service to people in need.

IT: a dynamic word that carries a powerful meaning. High competencies, understanding respect, compassion; Do you have IT?

Missions of Mercy
Virginia Dental Health Foundation

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






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

Join the MOM Team!

I would like to volunteer at:

Grundy MOM 2008
- ☐ Saturday, October 4, 2008
- ☐ Sunday, October 5, 2008

Emporia MOM 2008
- ☐ Saturday, November 1, 2008

Goochland MOM 2009
- ☐ Saturday, January 24, 2009

NOVA MOM 2009
- ☐ Friday, March 13, 2009
- ☐ Saturday, March 14, 2009

Eastern Shore MOM 2009
- ☐ Saturday, April 18, 2009
- ☐ Sunday, April 19, 2009

Wise MOM 2009
- ☐ Friday, July 24, 2009
- ☐ Saturday, July 25, 2009
- ☐ Sunday, July 26, 2009

Roanoke MOM 2009
- ☐ Friday, October 16, 2009
- ☐ Saturday, October 17, 2009

I prefer to do:

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

NAME _____

SPECIALITY _____

ADDRESS _____

CITY / STATE / ZIP _____

PHONE NUMBER _____ EMAIL _____

***LICENSE NUMBER REQUIRED _____

PLEASE NOTE: A COPY OF YOUR CURRENT BOARD OF DENTISTRY LICENSE MUST ACCOMPANY YOUR REGISTRATION! (VDA FAX # 804-261-1660).

For more information on the Mission of Mercy projects and to register online please visit us at www.vadental.org. Contact Barbara Rollins at VDA: 804-261-1610; email: rollins@vadental.org; FAX 804-261-1660.

Hope you can join us!

Missions of Mercy
Virginia Dental Health Foundation

WISE MOM... An Addiction

By: Bonnie Leffingwell, RDH
Richmond, VA

Every year during the middle of summer thousands of people come together in an outdoor setting for what is officially called Missions of Mercy (MOM) in Wise, but actually is an amazing spirit of kindness and love. My name is Bonnie and I have been a practicing hygienist in the Richmond area for the last 26 years. The 2008 visit was my fourth or fifth MOM project in Wise and I can't stop. Since I am in dentistry this is the area where I witness most of the kindness during the long weekend. This is the second year my 21 year old daughter, Annie, has been to Wise and she is as hooked as I am. She started Dental Hygiene school at VCU the following week and was really charged up. Wise will do that for you.

Let me set the scene - beautiful mountains and trees, winding roads and tents full of people. Most volunteers wear scrubs or t-shirts and everyone calls you by name, if they can see your nametag. Many slide their tags around their backs as they lean over and help patients. Cloud coverage is at a premium and the fans are a blessing. It is still hot and sweaty, but the volunteers (Dentists, hygienists and assistants) all walk with a purpose and extend the help needed for 12 to 14 hours each day. With a smile and the slumped look of a tired person, they smile as if to say, "Yes, isn't this a good tired?" The patients are hot, tired, and rumpled as many have slept in cars or tents or driven hours over winding roads because the realize they need the medical and dental treatment being offered. Almost all thank you before you begin the often painful treatments. Yes, we know that these procedures hurt and that the patient's mouth will be sore for days and they still are so appreciative. The patients are happy to receive, but the volunteers are happier to give. It is the spirit of the entire weekend and the feeling stays with you.

The days start for some of the volunteers, especially the Lions Club, at 2:30 a.m. so that breakfast can be served to the volunteers each day. Bacon, eggs, pancakes, sausage gravy, coffee and juice are served to all with a hug and a smile. Light banter and a quick breakfast fuel us for the day with an equally delicious lunch provided. The Lions are our favorite people there! Not only are the volunteers fed, but also the patients. Meals, snacks, and water are passed out to all waiting for services. The children are given toys and kind people keep them company throughout the long day. Their parents appreciate it so much. The afternoon continues much as the morning with the temperature rising along with the giving. Everyone is hot and tired, but would not dream of giving less then their best. As the day closes after 12 to 14 hours, another patient is squeezed in before the clean up begins.

We all hit the sack early and no one has to be rocked to sleep. It is the satisfied sleep of hard work and peacefulness of being a part of something so wonderful. The spirit of giving and love is so palatable at Wise it is an easy addiction to have. I am so glad to have this kind of addiction. See ya next year.

Thank you to over 350 dental volunteers who made the 2008 MOM possible!

With your help 1,353 patients received free dental care valued at $1.3 Million!

2000-2008
Wise MOM Statistics

Patient Exams:	10,646
Cleanings:	2,468
Restorations:	11,113
Extractions:	26,860
X-rays:	3,367
Root Canals:	284
Dentures:	151
Value of care:	$6.6 Million

Making it happen...

Dr. Mike Abbott
Carol Abbott
Susan Abbott-Stark
Ahmad Abdelrahm
Dr. Anne Adams
Amy Adams
Rhiannon Aesy
Dr. Shaman Al-Anezi
Matt Aldred
Dr. Steve Alouf
Hamzeh Alqublan
Zaid Alsamir
Dr. Dave Anderson
Dr. John Andre
Sara Aron
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Martha Bushong
Dr. Andrew Carey

Melissa Carpenter
Peggy Carwile
Sheldon Cash
Zeeshawn Chagtai
Stephanie Chambers
Rami Chayah
Rami Chayah
Kristy Childress
Kristy Childress
Kris Clair
Jamie Clair
Dr. Michael Clark
Jessica Clark
Ally Clay
Dr. Greg Cole
Dr. Tom Cooke
Jill Cooke
Vanessa Cooper
Stacy Cornett
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Christina Cox
Emily Craft
Oscar (Bear) Crafton
Erika Crawford
Robin Cummings
Michelle Cunningham
Ashley Cunningham
Dr. Charles Cuttino
Jaime Cyprowski
Dr. Jeffrey Cyr
Dr. Neal Davis
Becky Davis
Sandy Davis
Dr. David DeViese
Dr. Terry Dickinson
Cherryl Dickinson
Heidi Dix
James Dix
Dr. Tuyet Do
Darren Dorfman
Dr. Sarah Dowdy
Dr. Ronald Downey
Jim Doyle
Sonny Duong
David Durham
Chuck Duvall
Linda Duvall
Sandra Easley
Megan Ellis
Dr. Thomas Eschenroeder
Jason Faulkner
Casey Feiling

Dr. Robert Field
Theresa Field
Dr. Robert Findley
Justin Findley
Pat Finnerty
Audrey Gamulo
Justin Gerard
Monica Gibbs
Kristen Gilliam
Adam Goddard
David Grayson
Greg Greenstein
Jordan Greenstein
Shelagh Greenwood
Ashley Hall
Bill Hall
Lee Hall
Mike Hanger
Ashley Hanson
Lauren Harris
Cheryl Harris
Dr. Debra Haselton
Bridget Hengle
Heidi Hessler-Allen
Lisa Hickman
Dr. Corrine Hoffman
Susan Hoppenjans
Dr. Nathan Houchins
Stacy Houchins
Neda Hovaizi
Gaines Howell
Ginger Howell
Dr. Wallace Huff
Jennifer Hunt
Omar Hussain
Grant Hutchens
Qasum Jaffri
Golnaz Jalali
Michelle Johnson
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Susan Jones
David Jones
Chris Joyce
Sumana Kafle
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Beth Worley
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Dr. Reginald Young
Patrick Young
Jenny Young
Linda Zack
Stan Zack
Dr. Greg Zogby

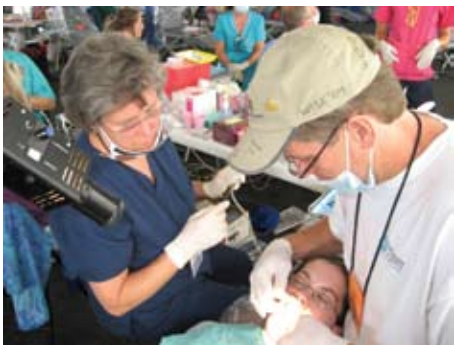
Where There's A Need

A Conversation With M.O.M. Volunteer Joyce Estes

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

Dental assistants are trained in a number of ways. Some enroll in community colleges and technical centers; others receive on-the-job training. Joyce Estes was trained by the assistant she replaced – her daughter. Her oldest daughter had worked as a chair-side assistant for Dr. David M. DeViese, a Madison, Virginia, general dentist, but was leaving to attend college. He asked if she could recommend someone for the job; without hesitation she answered "My mom!" Logic dictated she train her replacement, and thus began a long and rewarding career for Joyce, who twenty-five years later remains a much-valued staff member at Dr. DeViese's office. Along the way Joyce acquired a habit she finds hard to break: donating her time and talents to the Missions of Mercy and many other volunteer projects.

Growing up in Madison County, which lies on the east slope of the Blue Ridge, and includes part of Shenandoah National Park, Joyce graduated from high school and raised four children. Her family has expanded to include twelve grandchildren, and to complete the cycle in the dental office, her oldest granddaughter now works for Dr. DeViese during the summers away from college. She says many persons in the community can't afford routine dental care and seek only emergency treatment. Work hours are often extended to care for patients in pain. This, coupled with volunteer service at a free clinic in Madison, and scheduled visits to a nursing home to treat residents, made her aware of the access-to-care issue years ago. Her interest in the Missions of Mercy was kindled by a mailing from the VDA for the Wise County project in 2000. She gave the form to her boss, and they agreed: let's do this.



Joyce assists Dr. Bryan Brassington

Joyce Estes at Wise M.O.M. Project 2008.

Having participated in twenty M.O.M. projects, Joyce has seen many improvements in the delivery of care since the first one eight years ago. From more supplies and better equipment, to more volunteers and less "down time" (due to better maintenance) previously difficult working conditions are now much easier. This allows her and the doctors she assists to focus on the care of patients and "make patients happy." The M.O.M. projects "get better every year", she says. In addition to helping patients, some of the benefits of participation include learning new materials and techniques – using products that, according to Joyce, are unfamiliar to many doctors and assistants. She says assisting "many good doctors who do things differently" has proven to be an advantage.

When asked what makes M.O.M projects so special – why she continues to volunteer – she says "Each of us has been blessed in his or her own way. This is just my way of contributing, or 'giving back'. It's better than money." Dr. DeViese, according to Joyce, has always supported her efforts, reimbursing for out-of-pocket expenses, even when he couldn't attend a project. For those who haven't yet participated, but maybe considering it, she says, "Try it – you'll have a good feeling when you're done. It's all about helping people feel good about themselves, helping them keep their teeth and making people smile."

Emporia M.O.M. Project Scheduled

A new Missions of Mercy project will be held – Saturday, November 1, 2008, in Emporia, Virginia. It will target Brunswick, Sussex, Southampton, and Greensville counties in Virginia (including the city of Emporia); also, patients are expected from adjacent counties in North Carolina. Greensville County High School gymnasium will be the site of the one-day event, with clinic hours from 8:00 a.m. to 5:00 p.m. Dr. Harold Neal, project organizer, says volunteers are needed not only to treat patients Saturday, but also to set up clinical equipment and screen patients beginning at noon, Friday, October 31. There will be 35 chairs available for oral surgery, operative dentistry, and hygiene. Volunteer dentists and hygienists are still needed as a large turnout is expected. Use the form on the previous page to sign up for this project.

Lodging will be available for volunteers staying overnight. A block of rooms has been reserved at the Hampton Inn in Emporia, at a rate of $79 per night. Please mention this event when making a reservation. For hotel accommodations, call (434) 634-9200. A dinner for volunteers is planned for Friday evening, and registration will be available online at www.vadental.org, or by phone, (804) 261-1610. Breakfast and lunch will be provided Saturday for all volunteers. An information packet including directions will be mailed prior to the event.

This project is sponsored by the Virginia Dental Health Foundation and the Greensville Memorial Foundation.

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Medicaid Dental Services Program is in Good Hands

Interview with Pat Finnerty, Director of DMAS

By: Laura Givens

Pat Finnerty has had an extensive career, mostly in positions related to state Government, which has led him to his current role as Medicaid Director of the Department of Medical Assistance Services (DMAS) in Richmond. The Medical Assistance Services program is financed by state and federal funds. DMAS coordinates the delivery of health services to Virginians of limited or non-existent means.

Immediately prior to being appointed as Director of DMAS, Finnerty was involved with the Joint Commission on Health Care (JCHC), first as a Senior Analyst and then as the Executive Director of the staff. JCHC is a health policy body of the General Assembly.

"My whole career has been in state Government," states Finnerty. "I actually started my first full time position with the State Police working in a couple different capacities there in an administrative kind of role and then moved to the Department of Planning and Budget. My first involvement in health care issues was at the Department of Human Resource Management directing the State Employees' Health Benefits Program. We managed health insurance for all state employees and retirees."

Finnerty was appointed as DMAS Director in 2002 by then Governor Mark Warner. This is a job that requires a certain endurance in providing services for over 700,000 Medicaid recipients. Underscoring the difficulties involved in this important role is the fact that the average Medicaid Director serves 18 months in the position. Pat Finnerty has already exceeded this average. He was reappointed for a second term by Governor Tim Kaine in 2005.

Since Medicaid reimbursement is a challenge across the country, it was quite an undertaking for Finnerty when he took the position as DMAS Director here in Virginia. "I think initially restoring some credibility with outside groups – providers, legislators, advocacy groups and others – was a challenge for the agency. The challenge was trying to re-establish some productive working relationships with the people we have to work with to do business," states Finnerty.

Finnerty also indicates that a continuing challenge for the Medicaid Director in every state is the struggle to hold down costs. "We have to be as efficient as we can and at the same time respond to demands from different interest groups who want more people covered or providers who understandably are saying we need to pay more," he explains.

The challenges DMAS faces are inevitable because of the large number of Medicaid recipients. Finnerty specifies that there are currently around 715,000 Medicaid recipients in the Commonwealth of Virginia. The number of children enrolled in the state Medicaid program known as FAMIS-Plus, and its sister program called FAMIS is around 450,000. "All of those children are eligible for the dental program. They get comprehensive services. Based on the reports that we get from our contractor, Doral Dental, we estimate that approximately 45% of those eligible for dental services received a service in the past year," states Finnerty. Although expressing dissatisfaction with this percentage, Finnerty notes that it is a 55% increase since the *Smiles for Children* dental program started in 2005.

About the significant increase in Medicaid recipients, Finnerty explains: "Because of the changes we made in the dental program and the new dentists participating, we have more dentists for people to see. So now we are getting close to 50% of those kids getting care. We want it to continue to grow."

With Medicaid being a double digit part of the state budget, it seems inevitable that there will always be efforts to control the amount of state funds going into Virginia's Medicaid program. Finnerty notes the program's funding is subject to General Assembly approval.

"Medicaid is an entitlement program. If someone is eligible, you must enroll them. There are certain services that you must provide by federal law. Since it is an entitlement program, I don't foresee any hard cap on expenditures," states Finnerty. Though he does not foresee a cap on the funding, Finnerty concedes that, "Given the economy we are facing today, we are always challenging ourselves to be as efficient as possible."

There may be a constant challenge to be efficient, but the strong relationship between DMAS and the Virginia Dental Association (VDA) has benefited both dentists and the Medicaid program, witness the increase in dentist participation and the number of Medicaid recipients receiving dental care. Finnerty and Dr. Terry Dickinson, the VDA's Executive Director, have worked together to secure additional Medicaid dental service funds and to remove Medicaid dental services from the managed care arena.

"Dr. Dickinson has been an amazing partner," states Finnerty. "He has been great to work with and is really a critical factor to the success of this program. We, of course, work closely not only with Dr. Dickinson but with VDA members. All of the VDA presidents also have been very supportive and helpful."

Another integral part of making the program work is the DMAS Dental Advisory Committee, which is comprised of dentists from all over the state. Finnerty acknowledges the value of the members on the committee by stating that they "… have been helpful in crafting the program in a way that makes it easy for them to participate."

DMAS has had a 75% increase in dentists participating in the *Smiles for Children* program since its inception in 2005, due largely to the changes Finnerty has made with the help of participating dentists. Although DMAS is pleased with the number of dentists involved and its working relationship with the VDA statewide, the Department continues to work to increase dentists' involvement.

"Governor Kaine recently sent a letter to all licensed dentists in the state recognizing their contributions to the program. The letter thanked those who are participating but also asked for more participation," states Finnerty, who is encouraged by the gradual climb in dentists involved in the program. "The number has never gotten to a certain level and stopped. It is gradual, but it is constantly increasing. We are thrilled with the response, and hopefully we can continue to grow the program so that even more kids are served."

continued on page 33

The Virginia Dental Political Action Committee (VADPAC) *Update*

VADPAC established a **goal of $375,110** for this year and we are not there yet. **We need your contributions to raise $59,981 and meet our goal!** Below is a breakdown of the various VDA Components and what they have done to date.

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

Component	Total Members in Component	% Contributing to Date	2008 VADPAC Goal	Amount Contributed to Date	Percent of Goal Achieved	Per Capital Contribution	Amount Needed to Reach Goal
1	294	59%	$47,835	$40,785	85%	$235	$7,050
2	160	63%	$24,310	$24,377	100%	$244	$0
3	84	54%	$12,500	$10,775	86%	$244	$1,725
4	462	47%	$69,465	$48,728	70%	$223	$20,737
5	219	43%	$33,900	$23,985	71%	$255	$9,915
6	131	60%	$19,850	$22,830	115%	$289	$0
7	202	54%	$30,105	$26,800	89%	$245	$3,305
8	934	60%	$137,145	$116,849	85%	$253	$20,296

TOTAL CONTRIBUTED = $315,129

If you have not already made a voluntary contribution and can do more, please contribute. Without making a voluntary contribution, you are relying on your colleagues to make the difference. Please add your name to the list. Contact Laura Givens at 804-261-1610 or givens@vadental.org to make your contribution today!

Are you asking yourself, in which component to I practice? The map below indicates how the State of Virginia is broken up into eight components.

continued from page 31

Serving children and bringing them comprehensive dental care is the main goal of the *Smiles for Children* program and its participating dentists. "We all have our eyes on the same prize," states Finnerty. "We want to give kids dental care, and we want to do it in a way that makes it easy for dentists to participate. We all have that goal, and I think that is the key reason why we have been successful."

Though there are always bumps in the road and challenges for DMAS to face, Finnerty's leadership of the state Medicaid program has been undeniably successful. This was recently proven when Finnerty was asked to chair a national oral health Technical Advisory Group (TAG), which works with the federal Centers for Medicare and Medicaid Services (CMS). Some TAGs already exist, and there has been an effort in the last year to create one for oral health. With its establishment by federal regulators, Finnerty was selected to lead the group.

"One of the reasons they came here is because we have received quite a bit of national attention," states Finnerty. He believes this is mostly due to the efforts of the VDA membership. "Thanks to their efforts in working with us and the General Assembly," he states, "We are able to make this program work as kind of a model of how to do this."

Pat Finnerty emphasizes his appreciation for the VDA's support and asks for your continued participation with the program. There is always room for improvement, and Finnerty recognizes this by stating, "I hope that the VDA continues to participate and we'll continue to make this program even better." With Finnerty's dedication as Director of DMAS, as well as his newly appointed position as chair of the oral health TAG, the future for this program is in good hands.

Governor Warner Fundraiser in Richmond

June 2, 2008

Former Governor Mark Warner and VDA members supporting his Senate candidacy were hosted by Dr. John Doswell and his wife Mary at a June 2 event held at their Richmond home. From the left: Dr. John Doswell, Dr. Jim Revere, Governor Warner, Dr. Roger Wood, and VDA lobbyist Chuck Duvall.

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RIVERSIDE TARGETS ORAL CANCER

Reprinted with permission from *Daily Press*
Page: C9 **By VERONICA GORLEY CHUFO**
vgorley@daileypress.com 757-247-4741

Summary: The health system seeks to raise awareness that the illness has been linked to a sexually transmitted disease.

Oral cancer rates are going up, even though tobacco use is down.

And new studies link oral cancer to a strain of the human papillomavirus, a sexually transmitted disease better known as HPV.

So, dipping chew is out, but oral sex is in. But a new technology now being used on the Peninsula aims to help reduce deaths from the disease.

Early detection is key to treating oral cancer. For that reason, the Riverside Foundation, the charitable arm of the Riverside Health System, on Wednesday donated high-tech detection devices to three health clinics and the Virginia Dental Society's Missions of Mercy.

"There have been high death rates of oral cancer because often you don't find it until it's too late," said Carrie Schmidit, director of Riverside's cancer service line. "When caught early, there's a much better chance of doing something about it."

The device is a called the VELscope (Visually Enhanced Lesion Scope) oral cancer screening system. The devices are produced by a Vancouver, Canada, company and cost a little more than $4,000 apiece, Schmidt said.

The device shines a bluish light into the mouth of a patient. The light reflects back a greenish color if the tissues are normal. Tissues that are damaged will appear black.

If the dentist sees a black spot, that doesn't necessarily indicate oral cancer. It signals the need for a biopsy or for an appointment with an oral surgeon, Schmidt said.

The Oral Cancer Foundation estimated that about 34,000 people in the United States would be diagnosed with oral cancer in 2007, making it the second year in a row that the occurrence rate increased.

Dr. McKinley Price (VDA Board of Directors) & Dr. Terry Dickinson (VDA Executive Director) receive VELscopes from Carrie Schmidt (Services Line Director for Cancer at Riverside).

Oral cancer will cause more than 8,000 deaths, killing roughly one person an hour.

Of the 34,000 newly diagnosed patients, half will be alive in five years, according to oralcancerfoundation.org.

Riverside donated the devices to local free clinics in hopes of improving access to potentially life-saving detection.

VELscopes were given to the Lackey Free Family Medicine Clinic in York County, Peninsula Regional Dental Clinic in Hampton, Old Towne Medical Center in James City County and the Virginia Dental Association's Mission of Mercy mobile dental clinic.

Historically, oral cancer has affected six men to every one woman, but that gap has narrowed to two men to every woman.

It occurs twice as often in blacks as in whites. Survival statistics are also lower for blacks, at 33 percent, versus 55 percent for whites.

Oral cancer had been closely associated with tobacco use, including chewing tobacco and cigarettes.

But new studies show the HPV-16 strain, which can cause cervical cancer, is also a known cause of oral cancer, particularly cancers at the back of the mouth, according to the Oral Cancer Foundation.

Riverside hopes to stir up awareness that oral cancer is linked to HPV.

"There's a societal change that's happening in our young people that has significant ramification for health," Schmidt said. "If we're really about the health of our community, if we're really about not-for-profit health, then this is what we have to do."

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Microflex Micro One
Powdered Latex
$4.08 a box

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Removing the "Shield" that Minimizes New Patient Flow
By Dr. Richard Madow and Dr. David Madow

New patients are the lifeblood of dental offices. Successfully handling the initial phone call from potential new patients is critical to establishing these important relationships. Patients calling your practice for the first time may be dealing with numerous obstacles that are unknown to you. They may be fearful, or think the treatment will be too expensive, or perhaps they had a negative experience at another practice. It is your goal to put the patient at ease and address their concerns. Unfortunately, many practices put up an imaginary "shield" that prevents the patient from ever scheduling or keeping that first appointment.

How the "Shield" works

A "shield" is an unnecessary barrier or obstacle that causes practices to lose potential patients. Here are some examples of how a "shield" is used during a potetial new patient call:

- Being inflexible in screening new patients. A potential patient calls and asks, "How much do you charge for a cleaning"? The dental team will not provide a quote over the phone, and instead, insists they come in for an exam and x-rays first. The potential patient only wants a cleaning, so the call is released. No appointment was made, the new patient is lost.
- Putting the caller on hold. The dental team is very busy. A potential new patient calls the office and is immediately placed on hold without an on-hold message, so they simply hang up. No appointment was made, the new patient is lost.
- Pre-judging a patient by their insurance. If the first (or second) question asked is the type of insurance the potential patient has, the patient might think the only thing the office cares about is being paid, rather than expert dental care. Or the potential patient might not have insurance or an insurance plan that is accepted by the practice, and gets embarrassed for having to admit they don't. No appointment is made, the new patient is lost.

Overcoming the "Shield" with the ALASKA System

In each of these situations, as during most telephone calls, there is a certain flow to the conversation. Correctly responding to that flow and using the appropriate communication techniques are important to handling the call successfully. We created the ALASKA System to teach dental teams how to properly communicate with callers, helping to secure the maximum number of new patient appointments.

- A – Answer the phone quickly and correctly, and don't immediately put callers on hold.
  - Answer within 2 rings. If the phone is ringing more than twice, it's time to add another person to the front office team.
  - Try to answer the phone with: "Dr. Jones' office, this is Linda speaking. I can help you." – Identify the office, give your name, and say that you can help them. This projects confidence.
- L – Listen to what the caller is saying.
  - Don't judge or predetermine need or try to quickly get off the phone so you can get back to more "important" tasks. Listen and respond to the person's needs.
- A – Analyze what they are saying to uncover hidden barriers or concerns.
  - Do they want an appointment but are fearful of pain? Are they concerned about the cost?
- S – Solve their problem-- this is your chance to shine.
  - If they call you with a problem, "I need a new dentist." – Help them set the first appointment.
  - If they call with a concern, "My last dentist said I need a lot of expensive work, but I don't have a lot of money." – Explain how your practice makes treatment more affordable by offering a no interest payment program like CareCredit, and explain how it works.
- K – Kindness, say something nice to the caller
  - Assure them they've made the right decision, "You're going to love Dr. Jones, he is so gentle!" – Treat them like a friend. Be nice and kind first, then professional and businesslike.
- A – Action, take action by asking them when they'd like to come in.
  - Offer several choices for appointment times and dates that are available, "Would you like to come in today at 2:30? Or on Thursday at 1:00?" – Seize the opportunity to appoint the patient whether they've asked for an appointment or not.

Remember, when a potential patient calls, the dental office's main goal is to secure an appointment. Properly Answering, Listening, Analyzing, and Solving their problem will help that person feel important. Treating them with Kindness and taking Action by setting up their appointment will reinforce to them that they've made the right decision by calling you. Using the ALASKA System is a great way to help your patients feel good about their experience, and look forward to their first appointment.

Author Bio:
Dr. Richard Madow and Dr. David Madow founded The Madow Group in 1989, an education and marketing company dedicated to helping dentists and their teams become more successful in their practices. They are internationally recognized by dental teams for their exciting seminars such as "How to Love Dentistry, Have Fun, and Get Rich," "TBSE (The Best Seminar Ever)", and "How to Love Dentistry, Have Fun, and Get Rich—Even More." The Madow Group can be contacted at 1-888-88-MADOW or www.madow.com.

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Access– the VDA Responds to a Crisis

By: Dr. W. Vincent Dougherty, III • Chair, Access to Care/Work Force Task Force

Access to care is the "hot button" issue of our times. In early 2007 the VDA, under then President Dr. Anne Adams, had the foresight to develop a Task Force on Access to Care. The primary charge was to identify problems in Virginia that prevent access to care; define the target population and how they could be served; and develop more prevention and a corresponding workforce capable of delivering the care.

The well-publicized death of Deamonte Driver has caused the number of proposals to increase exponentially. We always hear that if we do not develop solutions, the solutions will be legislated upon us. This is truer now than it has ever been, especially with the upcoming national Presidential election.

The state of Virginia has budget shortfalls we hear about everyday. They are looking for answers that will not adversely affect their budget. The American Dental Hygiene Association is touting what they perceive is a solution to access to care with an Advanced Dental Hygiene Practitioner.

The entire current dental equation of government programs, workforce model, education of the workforce, dental education for patients, and volunteer programs will be challenged and will change with the new times. We want to have our foot in the door in deciding these changes so that the practice of dentistry will serve the patient in the best way possible.

The practice of dentistry in Virginia has changed and will continue to change. Dental licensure by credentials and administration of local anesthesia by hygienists were both adopted. "Dental Assistant II" has become law although the curriculum and the dental procedures they will perform have not been finalized.

The Access to Care/Work Force Task Force has worked diligently to come up with solutions. Many possible remedies have been discussed at length. Volunteer programs are an important part of our role in access to care. They are essential in providing our communities with quality dental care.

The VDA has already done great things with our Missions of Mercy project. Our Executive Director, Dr. Terry Dickinson, could not have initially imagined how successful this project would become. Over thirteen million dollars in services have been provided to those in need. This project has formed an allegiance and camaraderie among dentists. A sense of pride has developed and we realize great things can be done by working together. Many children have left our Give Kids A Smile Program with smiles on their faces. Teachers who have brought their students to these projects have expressed sincere appreciation. For those of you who prefer to give back to the community in your own setting, Donated Dental Services has been well received. The VDA Journal continues to publish pictures of these successful programs.

The VDA, under President Dr. Gus Vlahos, has been successful in increasing Virginia dental Medicaid reimbursement rates. The Medicaid insurance process was streamlined by adding a third party insurance company. This was accomplished by having a close working relationship with FAMIS (Family Access to Medical Insurance Security). The result is the number of dentists accepting Medicaid grew in one year by over 60%.

The task force does not feel the VDA will be able to solve the entire problem. However we certainly want to be a part of the solution.

Related dental issues were discussed at length including the public health care system, education and nutrition, redistribution of the work force from over-supplied areas, and a potential mid-level provider. Resolutions, on which many of you have voted, were put forth to the House of Delegates. I am hopeful the majority of these have passed.

One resolution gives VDA support to the Department of Health as the primary support mechanism for children's dental health, which includes population-based prevention programs, fluoridation and surveillance, as well as clinical services. As the number of dentists and state/federal funding for public health have decreased, the access to care issue has become more acute. The obvious course of action would be to reverse this trend. Unfortunately, this is where budgets fall short.

Another resolution is to conform to American Dental Association policies stating a child should see a dentist six months after the first teeth appear. This would provide education to the child and parents, and, with prevention programs, offset the increased incidence of childhood caries.

Two other resolutions were submitted to the House of Delegates imploring all of us to volunteer at a minimum level. The minimum levels were spelled out in the resolutions. If the resolutions pass and all VDA dentists abide by the recommendations, we could certainly "put a dent" in this problem.

The final resolution dealt with a mid-level provider. This individual would have education and skills above any current allied team member. Potential principles of what the VDA would want with a mid-level provider were submitted to the House of Delegates. This is the starting point to determine our stand on this issue.

The ADA is advocating a "Community Dental Health Care Coordinator", which differs from our mid-level provider proposals. This resolution probably stirred the most debate among delegates. This debate is welcome as the future of dentistry will be affected.

I am hopeful many younger dentists will become involved in these discussions. They are the ones that have the brightest future ahead of them. Let us all guide the change!

Chesterfield County Recognizes Volunteers

The Chesterfield component of "Give Kids a Smile!" Access to Dental Care Initiative was the main group honored on June 6, 2008 at Chesterfield County Public Schools Business Partner Appreciation reception. The breakfast reception was held at Chesterfield County Technical Center and gave recognition and thanks to business partners and organizations assisting county schools. This "GKAS!" event is sponsored by Southside Dental Society, the Virginia Dental Association and Chesterfield County Public Schools, and is in its seventh year. Ms. Robin Byrd organized the event and Ms. Martha Frickert, CCPS director of "Communities in Schools" program narrated a Power Point® presentation, showing numerous photographs of "GKAS!" in action and explaining the program to an audience of more than one hundred that included School Board members, county school administrators and representatives from business partner organizations. Dr. Samuel Galstan accepted a plaque on behalf of Southside Dental Society and members of Southside Dental Society participating in the program this year also received plaques.

Virginia Dental Association
Governance Meeting
September 12-14, 2008
Newport News, VA

Delegate Philip A. Hamilton (R-Newport News) featured speaker. Pictured with Dr. Terry Dickinson.

Marilyn B. Tavenner, Secretary of Health & Human Resources, Commonwealth of Virginia - featured speaker. Pictured with Dr. Terry Dickinson.

Dr. Leroy Howell received his 50 Year Members Certificate. Pictured with his son Dr. Ralph Howell.

Dr. Ralph Howell takes office as VDA President. Pictured with his daughter Dani and wife Tammy.

Dr. Herbert R. Boyd, Jr. received his 60 Year Members Certificate. Pictured with Dr. Gus Vlahos.

Board of Directors - Actions in Brief
September 12, 2008

The following items were considered:

1. A motion was made and seconded to approve the Definition of Dental Hygiene and Dental Hygienists:

   Definition of Dental Hygiene and Dental HygienistsApproved by Virginia Dental Hygienists' Association Executive Board on 8-18-08

   §54.1-2700. Definitions.
   As used in this chapter, unless the context requires a different meaning.

   'Board' means the Board of Dentistry

   'Dental hygiene' means that portion of dentistry that includes patient assessment and the rendering of educational, preventive, and therapeutic dental services. Dental hygiene shall include the duties specified in regulations of the Board and not otherwise restricted to the practice of dentistry.

   'Dental hygienist' means a person who has graduated from a dental hygiene program in an institution of higher education accredited by the Commission on Dental Accredi tation of the American Dental Association and who is licensed to practice dental hygiene. A licensed dental hygienist performs dental hygiene and duties as specified in regulations by the Board not otherwise restricted to the practice of dentistry.

   The Board of Directors approved the above resolution with a recommendation the House of Delegates vote yes.

2. A motion was made and seconded to approve the Dept. of Health Profession's bill to amend and reenact §§ 54.1-2722 of the Code of Virginia, relating to the practice of dental hygienists as presented.
   Be it enacted by the General Assembly of Virginia.

   1. That §§ 54.1-2722 of the Code of Virginia are amended as follows:

   § 54.1-2722. License; application; qualifications; practice of dental hygiene.

   A. No person shall practice dental hygiene unless he possesses a current, active, and valid license from the Board of Dentistry. The licensee shall have the right to prac tice dental hygiene in the Commonwealth for the period of his license as set by the Board, under the direction of any licensed dentist.

B. An application for such license shall be made to the board in writing, and shall be accompanied by satisfactory proof that the applicant (i) is of good moral character, (ii) is a graduate of an accredited dental hygiene program offered by an accredited institution of higher education, (iii) has passed the dental hygiene examination given by the Joint Commission on Dental Examinations, and (iv) has successfully completed a clinical examination acceptable to the Board.

C. The Board may grant a license to practice dental hygiene to an applicant licensed to practice in another jurisdiction if he (i) meets the requirements of subsection B of this section; (ii) holds a current, unrestricted license to practice dental hygiene in another jurisdiction in the United States; (iii) has not committed any act that would constitute grounds for denial as set forth in § 54.1-2706; and (iv) meets other qualifications as determined in regulations promulgated by the Board.

D. A licensed dental hygienist may, under the direction or general supervision
of a licensed dentist and subject to the regulations of the Board, perform services that are educational, diagnostic, therapeutic or preventive. These services shall not include the establishment of a final diagnosis or treatment plan for a dental patient. Pursuant to subsection U of § 54.1-3408, a licensed dental hygienist may administer topical oral fluorides under an oral or written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine.

A dentist may also authorize a dental hygienist under his direction to administer Schedule VI nitrous oxide and oxygen inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia. In its regulations, the Board of Dentistry shall establish the education and training requirements for dental hygienists to administer such controlled substances under a dentist's direction.

For the purposes of this section, "general supervision" means that a dentist has evaluated the patient and prescribed authorized services to be provided by a dental hygienist; however, the dentist need not be present in the facility while the authorized services are being provided.

The Board shall provide for an inactive license for those dental hygienists who hold a current, unrestricted license to practice in the Commonwealth at the time of application for an inactive license and who do not wish to practice in Virginia. The Board shall promulgate such regulations as may be necessary to carry out the provisions of this section, including requirements for remedial education to activate a license.

E. Notwithstanding any provision of law or regulation to the contrary, a dental hygienist who holds a license or permit issued by the Board of Dentistry may provide educational and preventative dental care in public health or community free clinics, schools and head start programs in Virginia Dental Health Professional Shortage Areas, as designated by the Virginia Department of Health. The dental hygienist providing such services shall practice pursuant to protocol developed by the Department of Health. Nothing in this section shall be construed to authorize independent practiced by a dental hygienist.

2. That the Department of Health shall seek consultation and information from all relevant parties, including agencies of government, in its development of regulations and policies to implement the provisions of the act.

The Board of Directors approved the above resolution with a recommendation the House of Delegates vote yes.

3. The following motion was made and seconded:

Background: Costs of investing and regulating offending licensees by a regulatory board should be at least partly paid for by the guilty party.

Resolution: To accept a draft of amendment 54.1-24XX, General Assembly Code of VA, but allow the Board of Directors to amend with the addition of (1) limitation on assessed fees and (2) to specify that the moneys collected are returned to the specific board.

The Board of Directors approved the above resolution with a recommendation the house of Delegates vote yes.

The following items were approved:

1. A motion that the leaders of the VDA will meet with the leaders of VCU to find a solution to increasing the number of Virginia students at the VCU School of Dentistry
.
2. The following resolution approved by fax vote August 21, 2008 was reaffirmed by roll call vote:
Background: A letter was received from the Virginia Health Care Foundation requesting that the VDA sponsor the speaker for the upcoming Dental Summit in December. The VHCF was the original funder of the MOM Project and has been a big supporter of the VDA's efforts to increase access to care.

Resolution: In the event the VDA Services does not choose to sponsor the speaker (Dr. John Neal) at the Virginia Health Care Foundation's Dental Summit December 15, 2008, the VDA would pay the requested $2500 speaker's fee and be a sponsor of the program. In the event the VDA pays the fee, the funds would come from the Board of Directors discretionary fund line item.

Board of Directors - Actions in Brief
September 14, 2008

The following item was considered:

1. The following motion was made and seconded:

Background: There have been and will continue to be problems when the Nominating Committee chair (immediate past president) runs for an elected position and there fore is ineligible to conduct the committee meeting or to give the report. Also, now with online and absentee ballot voting, the voting process begins before the Nominating Committee gives their report at the opening session of the Governance Meeting.

Resolution: Sunset the Nominating Committee

The Board of Directors approved the above resolution with a recommendation the House of Delegates vote yes.

The following actions are reported as information only:

1. The following appointments for 2008-2009 were approved:
    1. Parliamentarian – Dr. Charles E. Gaskins III
    2. Journal Editor: - Dr. Richard F. Roadcap
    3. Executive Director – Dr. Terry D. Dickinson
    4. Legal Counsel – David Lionberger, ESQ. and Scott Johnson, Esq.
2. The following members of the VDSC Board of Directors for 2008-2009 were approved: Roger E. Wood, President, Fred Coots, Jr., Frank C. Crist, Jr., Wallace Huff, Bruce Hutchison, Lanny Levenson, Vice President, Jeffrey Levin, Kirk Norbo, Harvey Shiflet, III, Les Webb, Jr., Edward Weisberg, Robert A. Levine, Rodney Klima, Andrew J. Zimmer (Advisory), Ted Sherwin (VDA Liaison).
3. The following were appointed to serve as the 2009 Awards Subcommittee: Benita Miller (Chair), Mike Abbott and Jamie Krochmal

Minutes of the 139th Annual Business Meeting
Saturday, September 13, 2008

The 139th Annual Membership Meeting of the Virginia Dental Association was held at The Marriott Newport News at City Center, Newport News, VA. Saturday, September 13, 2008.

President Gus C. Vlahos called the meeting to order.

The flag pledge was recited.

The following deceased members were remembered:

Richard B. Barrick (1) Past Pres.
Jack C. Dilaura (1)
Hugo A. Owens (1)
Apollon G. Orphanidys (2)
Donald F. Bunn (4)
John R. Burton (4)
Hugh B. Douglas, Jr.
Francis M. Foster (4)
Timothy J. O'Malley (4)
Maurice W. Phillips (4)
Irvin H. Schmitt, Jr. (4)
George J. George (5)
James E. Johnson (5) Past Pres.
Dan W. Culbertson (6)
Harold L. Ringley (6)
Oliver L. Burkett (7)
Fred C. Hamer (7)
Robert E. Miller, Jr. (7)
Albert F. Brendes. (8)
Donald L. Clark (8)
James B. Early, Jr. (8)
Kenneth G. Hughes (8)
Peter A. Morabito (8)
William B. Powell (8)
Francis J. Samaha (8)
Irving H. Wagman (8)
Charles Wissler (8)

The following were inducted into the VDA Fellows in 2008:

W. Todd Bivins (1)
Sharon Y. Colvin (1)
Rod M. Rogge (1)
Sharon C. Covaney (2)
William L. Davenport (2)
William T. Griffin (2)
Kent Herring (2)
Richard F. Roadcap (3)
Alfred J. Certosimo (4)
Karen S. McAndrew (4)
Donald G. Trawick (4)
Jason S. Crist (5)
Ronald G. Downey (7)
A. Garrett Gouldin (8)

The following received Life Member Certificates in 2008:

Bruce L. Bosworth (1)
Leonard R. Cervoni (1)
William R. Cox, Jr. (1)
Howard S. Dorfman (1)
Arthur L. Glick (1)
James J. Kail (1)
Theodore R. Smith (1)
Stanley P. Tompkins (1)
Donald W. Cherry (2)
Arthur H. Diamond (2)
John P. Doley (2)
Lanny C. Hinson (2)
James I. Gilbert III (5)
Ronnie L. Brown (6)
H. N. Davis (6)
Thomas W. Littrell (6)
Donald R. Brown (7)
John Helleberg (7)
David C. Jones (7)
William H. Mason (7)
Charles E. Strickler (7)
Walter Bechtold (8)
S. W. Brown (8
William R. Parks (2)
Lawrence R. Sarmiere (2)
Ronald L. Tankersley (2)
Hugh C. Dowdy, Jr. (3)
James R. Lance (4)
Arthur P. Mourino (4)
Thomas E. Spillers (4)
Seaborn M. Wade, Jr. (4)
Richard S. Wilson (4)
Raymond C. Baker, Jr. (5)
Robert S. Branham (5)
Donald G. Cairns (5)
Albert A. Citron (8)
Jerome A. Covel (8)
James S. Dryden, Jr. (8)
Arnold S. Fariello (8)
Raymond J. Finnerty (8)
Richard J. Godlewski (8)
William H. Hillmann, Jr. (8)
Leonard A. Jones, Jr. (8)
Anthony A. Nasif, Jr. (8)
Chris C. Pappas (8)

The following received 50 Year Certificates in 2008:

Calvin L. Belkov (1)
William S. Cabell (1)
Jack S. Hurley (6)
Charles D. King (6)
Arnold M. Hoffman (1)
R. L. Howell, Sr. (1)
Howard L. Kesser (1)
George R. McGuire (1)
Norman P. Moore (1)
Paul Burbank, Jr. (2)
James A. Boyd (3)
John P. McCasland (3)
Llewellyn T. Flippen (4)
Gordon A. Hearne (4)
Edward H. Radcliffe (4)
Richard D. Wilson (4)
Richard L. Fisher (5)
Jessie W. Mayhew, Jr. (5)
William R. Henley (6)
Robert G. Moore (6)
Brownie E. Polly, Jr. (6)
Gene P. Reasor (6)
Harold P. Remines (6)
Robert M. Lawrence, Jr. (7)
Eldridge D. Anderson (8)
Joseph O. Johnson (8)
George R. Keough (8)
Alvan M. Morris (8)
Jerome I. Rock (8)
John S. Rushton (8)
Nathan S. Spitler (8)
Roy E. Stanford, Jr. (8)
William Wallert (8)
Lawrence L. Ziemianski (8)

The following received 60 Year Certificates in 2008:

Odilon P. Delcambre (1)
Vernie C. Lawrence (1)
Herbert R. Kolb (2)
Herbert R. Boyd, Jr. (3)
William H. Fitzgerald (3)
Charles Lott (4)
Walter S. Claytor (5)
Paul E. Halla (8)
Irving J. Imburg (8)
Kenneth S. McAtee (8)
Gerald J. Rose (8)

Jay Knight, VADPAC Chair, announced the following VADPAC awards:

Category A – Small Component Membership
Percentage of members who contributed to VADPAC — Component 2
Percentage of Commonwealth Club Members — Component 7

Category B – Large Component Membership
Percentage of members who contributed to VADPAC — Component 1
Percentage of Commonwealth Club Members — Component 1

President, Gus Vlahos, announced the following election results:

President-Elect – Alonzo M. Bell

ADA Delegates – Anne C. Adams, Alonzo M. Bell, M. Joan Gillespie, Kirk M. Norbo. (All will serve three year terms.)

ADA Alternate Delegates – David C. Anderson, Ralph L. Howell, Jr., Bruce R. Hutchison, Michael J. Link, Elizabeth C. Reynolds. (All will serve two year terms.)

Roger Wood, President of VDA Services, addressed the membership. VDA Services has given $1,450,897 to the VDA and related entities since 1997. He also reminded the members to use the endorsed products.

The out-going component presidents were recognized.

The VDA officers, ADA delegation members and component presidents were installed.

Gus Vlahos presented in-coming VDA President, Ralph L. Howell, Jr., with the president's pin.

Ralph Howell presented Gus Vlahos with the past president's pin, the VDA Torch Bearer Award and the ADA Constituent President's plaque.

The meeting was adjourned.

37th HOUSE OF DELEGATES - ACTIONS IN BRIEF
SEPTEMBER 12-14, 2008

1. Adopted: The VDA supports funding for the Dept. of Health as a primary support mechanism for children's dental health to include population based health promotion and prevention programs, fluoridation and surveillance, as well as clinical services. The VDA will support a legislative initiative to increase funding for public health Dentists in Virginia and include this initiative in our legislative agenda.

2. Adopted: A recommendation that VDA Policy would encourage dentists and medical practitioners to recommend a child's first dental visit within six months of the eruption of the first deciduous tooth and no later than 12 months of age in accordance with ADA policy.

3. Adopted: A recommendation that the VDA urges and recommends that, at a minimum, all Virginia dentists either: (Policy)
   A. Accept Medicaid Take Five Program
   B. Volunteer on a yearly basis for two days with VDA's Mission of Mercy, Give Kids a Smile, local Volunteer Clinics, or pro bono services.
   C. Be an active DDS provider

4. Adopted: A recommendation that the VDA urges the VCU School of Dentistry to recommend that all graduating students at a minimum either: (Policy)
   A. Accept Medicaid Take Five Program
   B. Volunteer on a yearly basis for two days with VDA's Mission of Mercy, Give Kids a Smile, local Volunteer Clinics, or pro bono services.
   C. Be an active DDS provider

5. Adopted: A recommendation that the VDA Board of Directors should continue to explore the concept of increasing access to care through consideration of the following:
   A. Any mid-level provider must improve access to care.
   B. They would work in a dental team under the direction of a dentist.
   C. To improve access, the mid-level provider would be limited to serving in designated or underserved areas, public clinics, or practices caring for under served patients through Medicaid.
   D. The educational requirements and dental skills needed would be beyond the level of any current allied dental team member.
   E. To make a meaningful difference in access to care, some consideration must be given to providing local anesthesia and basic restorative services.
   F. The delegation of duties would be based upon applicable dental regulation and on the comfort level of the supervising dentist with the mid-level provider's education and experience.
   G. Irreversible procedures will be performed by a dentist.
   H. The Board will report annually to the House of Delegates.

6. Adopted: A recommendation that the VDA endorses the development of accredited dental assistant apprenticeship programs. (Policy)

7. Approved: The following wordage to the Department of Health Professions' bill to amend and reenact §§ 54.1-2722 of the Code of Virginia, relating to the practice of dental hygienists.

   Notwithstanding any provision of law or regulation to the contrary, dental hygienist employed by the Dept. of Health who holds a license or permit issued by the Board of Dentistry may provide educational and preventative dental care in the Cumberland Plateau and Lenowisco Health Districts, Federal Health Professional Shortage Areas (HPSA), as designated by the Virginia Department of Health. The dental hygienist(s) providing such services shall practice pursuant to a protocol developed by the Cumberland Plateau and Lenowisco Health District medical directors and dental hygienist, the Director of the Dental Division of the VA Dept. of Health, and two representatives of the VDA. A report of these activities, including their impact upon the oral health of he citizens of these districts, shall be prepared and submitted by the above individuals, to the VA Sec. of Health and Human Services. Nothing in this section shall be construed to authorize or establish the independent practice of dental hygiene. The provisions of this section (E) of 54.1-2722 shall sunset automatically one year after enactment.

   The Department of Health shall seek consultation and information from all relevant parties, including agencies of government, in its development of regulations and policies to implement the provisions of the act.

8. Adopted: A recommendation that the four (4) student delegates of the VCU School of Dentistry shall have the right to vote for officers of the VDA.

9. Referred to the Board of Directors: A recommendation to accept the draft of amendment 54.1-24XX, General Assembly Code of VA, but allow the VDA Board of Directors to amend with the addition of but not limited to (1) limitation on assessed fees and (2) to specify that the moneys collected are returned to the specific regulatory board. (The Board has permission to move forward and use all information to craft what is needed.)

10. Referred to the Board of Directors: A recommendation that the Annual Meeting (Governance Meeting) shall be held in Richmond, Va. beginning in 2011. Future Governance Meetings will be limited to two days.

11. Adopted: A recommendation that the VDA create a task force with the purpose to:
(a) Work to insure that the 10 additional students added to the dental class at the VCU School of Dentistry starting in 2008 be in-state students (giving a minimum of 65% in-state students), and that, within each dental class, at least 15 students be from southern and western Virginia to improve access to care in these areas, as stated in our lobbying efforts in the General Assembly in 2006, and (b)Work towards a goal of increasing the percentage of in-state students to 80% in the dental class to improve access to care.

    The task force shall consist of five VDA members: four appointed by the VDA President and distributed geographically in the state and the fifth being the immediate past VDA President who will serve as Chairman. The Dean of the Dental School shall be an ex-officio member. The task force shall serve for a period of one year and report back to the 2009 VDA House of Delegates. If needed, the HOD will authorize the task force to continue for a second year.

    The task force will work with VDA members, the administration of the School of Dentistry, the administration of Virginia Commonwealth University, our lobbyist, members of the General Assembly and other interested parties to bring about its stated purpose.

    The task force shall be called the School of Dentistry Task Force.

12. Adopted: The following Policy change: (Change in budget request submission date.)

    VDA Policy # 12 under Committees:
    12. All committee budget requests will be submitted by March 1 to the Council on Finance.

13. Adopted: The following Bylaw change: (Removal of the budget request submission date in.)

Article VII, Section 4.C.
C. At the direction of the Board of Directors, each committee shall submit a proposed itemized budget request for the next fiscal year in accor dance with VDA Policy

14. Adopted: The following Bylaw change: (Additional duties.)

Article VII, Section 7.1.b
1. Council on Finance.
b. Duties: This Council shall serve in an advisory capacity to the Board of Directors and the Secretary-Treasurer (1) evaluate the proposed expenses and revenue resources from the Board of Directors budget report and recommend the dues necessary to fund Association expenses and programs for the following year; (2) maintain up-to-date information on financial data; (3) make recommendations to the Board regarding the investment of reserve funds of the Association; (4) promote and to award appropriate funds for the support of dental auxiliary students and (5) finalize the budget for review by the Board of Directors.

15. Adopted: A recommendation that the VDA Board of Directors will assign one of its members to attend Virginia Board of Dentistry meetings.

16. Adopted: the following Bylaw changes: (Fifth member and additional duties added to Council on Sessions.)

Article VII, Section 7.2
2. Council on Sessions
a. Membership: This council shall consist of five members, one appointed each year by the President to serve a five year term. The Immediate Past chairman of the Council shall serve the fifth year. The designated Local Arrangements Committee Chair Person, shall be appointed by the current President Elect in consultation with the Council on Sessions, shall be an ex-officio member for one year prior to becoming the Local Arrangements Chair Person. No member shall serve more than two consecutive terms.

b. Duties: This council shall serve in an advisory capacity to the Board of Directors and the Executive Director and shall (1) facilitate the Virginia Meeting; (2) plan for future meetings including meeting format and speakers; (3) plan the Virginia Meeting, including location, in accordance with the Bylaws; (4) The Council shall appoint an Advisory Committee to provide input on the appropriateness of speakers and will include individuals who represent the targeted audience; (5) prepare a budget for the Virginia Meeting; (6) appoint a sponsorship chair as an advisory member of the Council.

17. Adopted: The following Bylaw change: (Amends duties of the Local Arrangements Committee)

Article VII, Section 8.2.b
b. Duties: This Committee shall (1) oversee exhibit operations; (2) organize social events associated with the meeting; (3) arrange transportation and housing for speakers and VIPs attending the meeting and (4) perform any other duties necessary for the successful performance of the meeting

18. Defeated: A recommendation to add a new #15 to VDA Policy listed under Committees:

15. In order to be in compliance with relevant continuing education certification requirements, the Council on Sessions will incorporate input on continuing education courses from communities of interest.

19. Adopted: The following Bylaw change: (add the word “maintain”)

Article I, Section 7.A
A. Virginia Dental Association annual dues for active members shall be established by the House of Delegates. Any proposal to change or maintain the dues shall be submitted to the House of Delegates…

20. Adopted: A recommendation to approve the 2009 proposed budget with a $10.00 dues increase (dues actually billed $370.00) reflecting the $9.00 DR offset and the projected loss taken out of reserves.

21. Adopted: A recommendation that the President of the Virginia Dental Association may appoint the chair and/or vice-chair of any standing committee should the committee be unable to do so. (Policy)

22. Adopted: A recommendation that the HOD approve the concept of a standing committee on mentoring and refer it back to a task force appointed by the President to establish criteria.

23. Adopted: A recommendation to accept the Task Force on Direct Reimbursement’s recommendations as VDA Policy:

1. Allow more membership involvement with Direct Reimbursement by educating the membership through brochures and education programs at the component level.
2. Make the Budget process similar to all other VDA committees and make the DR Committee directly accountable to the membership.
3. Direct the Board and the DR Committee to look at other agencies to serve as TPA’s and Brokers for Direct Reimbursement and Direct Assignment.
4. Look at developing an incentive program for Brokers to make the Program more economically viable as a business model.
5. Expand marketing to the general public through member’s offices by involving member dentists in the process.
6. Develop strategies to make the DR program self sustaining in the next five years.

24. Adopted: A recommendation to rescind VDA Administrative Policies 3,5,10 and Dental Benefits Policy 3.

Administrative:

~~3. The VDA supports a Direct Reimbursement program for Virginia with dues increase of $30 per year for financing the program. (Rescinded for the budgetary year 2002.) -1995~~

~~5. A Direct Reimbursement Budget will be developed and administered separately from the VDA Operational Budget. (Rescinded for the budgetary year 2002.) -1997~~

~~10. Annually, beginning with the budgeted year 2005 the last completed fiscal year's DR Budget surplus funds, if any, shall be considered as an income item for the next proposed DR Budget, which added to the dues request shall equal $30 per member. -2003~~

Dental Benefits:
~~3. The VDA supports a Direct Reimbursement program for Virginia with dues increase of $30 per year for financing the program. -1995~~

25 Adopted: A recommendation that Policy #8 under Administrative be rescinded.
~~8. The VDA will share the VDAA's registration fees for the Annual Meeting with the VDAA on a 50/50 basis with minimum shared revenue of $1,000. 2000~~

26. Adopted: A recommendation that that a liquid Reserve Fund will be established with a goal of 50% of the annual operating Budget of the Virginia Dental Association (Policy);
and
that Virginia Dental Association Policy #12 under Administrative be rescinded.
~~12: A liquid Reserve Fund will be established with a goal of 40% of the annual operating expenses. 2006~~

27. Adopted: A recommendation that an annual report, including the calculation of VDA "reserves" on December 31st, will be included with the budget worksheets as information for the Board of Directors and House of Delegates.

28. Adopted: A recommendation that the VDA President appoint a task force to evaluate the merging of The Virginia Meeting with the Governance Meeting.

29. Adopted: The following Definition of Dental Hygiene and Dental Hygienists
Approved by Virginia Dental Hygienists' Association Executive Board on 8-18-08

§54.1-2700. Definitions.
As used in this chapter, unless the context requires a different meaning.

'Board' means the Board of Dentistry

'Dental hygiene' means that portion of dentistry that includes patient assessment and the rendering of educational, preventive, and therapeutic dental services. Dental hygiene shall include the duties specified in regulations of the Board and not otherwise restricted to the practice of dentistry.

'Dental hygienist' means a person who has graduated from a dental hygiene program in an institution of higher education accredited by the Commission on Dental Accreditation of the American Dental Association and who is licensed to practice dental hygiene. A licensed dental hygienist performs dental hygiene and duties as specified in regulations by the Board not otherwise restricted to the practice of dentistry.

The following is reported as information only:

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

Component 3	Samuel W. Galstan
Component 5	Craig B. Dietrich
Component 8	Neil J. Small

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

3. The following were approved for Life Membership in 2007: Bruce L. Bosworth (1),Leonard R. Cervoni (1), William R. Cox, Jr. (1), Howard S. Dorfman (1), Arthur L. Glick (1), James J. Kail (1), Theodore R. Smith (1), Stanley P. Tompkins (1), Donald W. Cherry (2), Arthur H. Diamond (2), John P. Doley (2), Lanny C. Hinson, William R. Parks (2), Lawrence R. Sarmiere (2), Ronald L. Tankersley (2), Hugh C. Dowdy,Jr. (3), James R. Lance (4), Arthur P. Mourino (4), Thomas E. Spillers (4), Seaborn M. Wade, Jr. (4), Richard S. Wilson (4), Raymond C. Baker, Jr. (5), Robert S. Branham (5), Donald G. Cairns (5), James I. Gilbert III (5), Ronnie L. Brown (6), H. N. Davis (6), Thomas W. Littrell (6), Donald R. Brown (7), John Helleberg (7) David C. Jones (7), William H. Mason (7), Charles E. Strickler (7), Walter Bechtold (8) Albert A. Citron (8), S. W. Brown (8, Jerome A. Covel (8), James S. Dryden, Jr. (8), Arnold S. Fariello (8), Raymond J. Finnerty (8), Richard J. Godlewski (8), William H. Hillmann, Jr. (8), Leonard A. Jones, Jr. (8), Anthony A. Nasif, Jr. (8) Chris C. Pappas (8).

4. The following were approved for Honorary Membership in the Virginia Dental Association: Virginia S. Donne, Sonya Farris, Vernon Shafer, Jr., Richard Shafer and Gerald Zeno.

Dr. Tu Tran, DDS Dr. Thien Pham, DDS & Associates

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Civil rights leader Dr. Hugo Owens Sr. dies in Chesapeake

Dr. Hugo Owens Sr. in a July 2000 interview. (Virginian-Pilot file photo)

By: Denise Watson Batts
757-446-2504, denise.batts@pilotonline.com
The Virginian-Pilot - reprinted with permission.

How Hugo Owens Sr. loved a good fight. And a good laugh. Owens, who died Tuesday night at age 92, will be remembered as a brash and dapper man who didn't mind getting dirty to dismantle Portsmouth's segregation institution by institution. He then helped lead Chesapeake in its early years as one of the city's first black councilmen.

He died of natural causes at the Chesapeake home of his son, Hugo A. Owens Jr. The elder Owens had not been himself since his wife, Helen, passed away in April. The couple had been married 66 years but had been together longer than that, the son said.

In recent years, Owens would, in his humble way, describe himself as "just an old, broke-down dentist" who enjoyed spending days at a Chesapeake middle school named after him, reminding students that they couldn't let anyone or anything stop them, a lesson he'd lived by for decades.

"All these people talked about all these crazy things Hugo is doing," Owens said, with a laugh in a February interview, remembering his social activism in the 1950s and '60s.

"People would say that they didn't have time to get involved. It's that they didn't have that spine in their backs to challenge!"

Former Old Dominion University President James V. Koch met Owens when he was appointed to the university's board of visitors in 1990 and then was named the board's first African American rector in 1992. Koch described Owens as a Nelson Mandela of Hampton Roads.

"He endured unfair treatment and the like. But he was determined and emerged the moral victor," Koch said. "He was a proud man but not a boastful guy. He really cared about his fellow human beings."

Owens never lacked courage, something he said he learned from his parents and from growing up in Norfolk County. His parents were college graduates, around the turn of the century, a rarity for their time. Both were educators, and his father later worked with the postal service.

Their youngest of five children was born Jan. 21, 1916, and they named him after the presidents of their alma maters, James Hugo Johnston Sr. of present-day Virginia State University, and Samuel Armstrong of what is now named Hampton University.

His uncle, Portsmouth lawyer George Melvin, a militant before his time, was another of his heroes. Melvin would come home bloody some evenings because he'd been beaten for refusing to sit in the back of segregated streetcars. Some judges called him names from the bench, Owens said, as if it would dissuade Melvin from appearing in court. It never did.

Owens' father would bring home Saturday Evening Posts and Ladies' Home Journals, and the young Owens would read about endocrinology. He thought the study of hormones was fascinating. "Can you imagine a little dumb guy from Deep Creek talking about endocrinology?" he said.

After graduating from I.C. Norcom High School in Portsmouth, he went to Virginia State College, but there was no endocrinology. So he took biochemistry, but there were no jobs for blacks in that field, either.

So he had to teach. He taught in Maryland and Portsmouth, and then got drafted into the Army during World War II. It was while Owens was stationed at Fort Eustis that his wife noticed a bulletin offering specialized training, including dentistry.

Owens opened a practice in Portsmouth in 1947. He became involved in the evolving civil rights movement, which mushroomed after the end of the war as black veterans returned home to find the freedom they fought for still was denied to them. He held organizational meetings at his dental office or one of the local churches.

Owens filed his first lawsuit in 1950 to integrate the city parks after he'd taken his daughter to see the ducks and he and his daughter were run off by a groundskeeper. He and three others sued to gain access to city golf courses, and won. Then in 1960, Owens helped win a lawsuit to desegregate the city's libraries. Around 1964, he joined a group of doctors and dentists to desegregate Portsmouth General Hospital.

Owens often said that his busy, sometimes frightening fight against Jim Crow was driven by what he held most dear: his family, particularly his three children, Paula, Patrice and Hugo Jr.

In a 1984 interview he said, "As my kids grew up, it annoyed me when I had to lie to them about why they couldn't eat in the five-and-10 or why they couldn't go to the movie theaters."

Owens moved back to Norfolk County in 1962, the year before the area merged with South Norfolk and formed Chesapeake. He thought he could be effective in public office, and in 1970, Owens became one of the first two blacks elected to the Chesapeake City Council.

Former Chesapeake Mayor William Ward, who served as Owens' campaign manager, said the victory paved the way for other African Americans. "He inspired other people like myself to pick up the mantle," Ward said.

During Owens' 10 years on the council, he served eight as vice mayor. He'd become known as "Doctor Debonair" by then, developing a reputation for a quiet demeanor and for pressing for more citizen involvement, to lessen the public's distrust of "the government."

"Just because I'd been a hell, fire and brimstone man in Portsmouth, a lot of people figured I'd be that way as a councilman," Owens was quoted saying in a 1979 article. "But I fooled them; I used the calm and negotiating approach at the table."

He also became known as a councilman of all people.

A 1979 editorial stated, "He has not been 'the black city councilman' as some blacks might have had him to be. Instead, he's attempted to be a councilman for all the city, blacks and whites."

Owens retired around 1990 and continued his civic work, garnering various awards and honors. In 1996, ODU named its African American Cultural Center in his honor.

In 1997, Hugo A. Owens Middle School opened in the Deep Creek section of Chesapeake, not far from Owens' childhood home.

Funeral arrangements are still being finalized, Owens' son said.

Ethics Workshop Conducted by VCU

The VCU School of Dentistry conducted an interactive workshop on August 27 in conjunction with its annual Mirmelstein Ethics Lecture. Participants included leaders of the Virginia Dental Association, the Virginia Board of Dentistry, and faculty leaders and administrators from the school. Our guest speaker was Dr. Charles Bertolami, Dean of the NYU College of Dentistry.

"Once again, for the second straight year, because of the generous contributions of the Virginia chapters of the Pierre Fauchard Academy, the American College of Dentists, and the International College of Dentists, we invited a nationally known expert in the teaching of ethics to help with the workshop and talk to our students on the following day. Dean Bertolami always has unique and provocative insights," said Dr. Ron Hunt, Dean of the VCU School of Dentistry. "We were fortunate to have him return this year."

Dean Hunt opened the workshop with an update on local and national efforts to improve the teaching of ethics and professionalism. Then Dean Bertolami provided additional thoughts on the environment currently facing teachers of ethics. Then the participants held discussions on how to set expectations for ethical decision making and role modeling professional behavior.

The Public Gets What the Public Wants: Dr. Charles Bertolami's 2008 Mirmelstein Ethics Lecture to VCU Students

By: Martha Bushong, MS

In last year's Mirmelstein lecture Dr. Charles Bertolami spoke about the importance of self-reflection and role-modeling as ways for students, and dental professionals to gain insight into ethical behavior. This year he described the external and environmental factors that influence public perception of dentistry and are forcing change.

"Dentistry's theme used to be 'Doing Well, Doing Good'." said Dean Bertolami. "Students come to dental school because they want to reap the social and financial rewards (do well), but they also want to alleviate pain and help needy people (do good)." Recently, however, the theme has changed to become "The Public Gets What the Public Wants". A combination of pressure from corporate influence and rising public expectations have caused political action and challenges to the image of dentistry.

Dr. Bertolami used examples from the media, advertising, and popular culture to illustrate his message. He set the stage with background information and demographic data that showed population trends were related to dental school applications and admissions. Since 1950, peaks and valleys in the number of live births changed the dental labor force and caused market fluctuations in the supply of and demand for dentists.

He told the story of Deamonte Driver, a child in Maryland who died because of an untreated abscessed tooth and pointed out that anecdotes are more powerful than data. Driver's story gained national media attention and raised public awareness about the tragic outcomes when children lack adequate dental care. The public outrage at the situation prompted legislation and compels dentists to think and behave differently.

Market capitalism and corporate decision-making also are forcing changes in dentistry. Hollywood celebrities and politicians with overly white teeth have "the look" the public wants. Advertisers are only too willing to promote a plethora of products and procedures that can help them achieve it.

Dr. Bertolami concluded by juxtaposing examples of newspaper headlines about the status and material wealth of dentists with other examples that heralded inadequate care for millions and cheating scandals in dental schools. These examples influence public perception of dentistry and dentists tremendously.

The convergence of these forces makes it essential for students to learn how to think critically and act with compassion and integrity. Dr. Bertolami urged students to honor the profession by becoming both "learned" and "caring".

Work in Progress: Efforts of the ADA, ADEA, and VCU to Strengthen Ethics and Professionalism in Dental Education

Ronald J. Hunt, D.D.S.
Dean, VCU School of Dentistry

Ethics and Professionalism at VCU

Courses in Ethics

In life and in practice as health care providers and teachers, ethics and professionalism transcend our interactions with others. Our lives and interactions have context and ethical behavior occurs in that context. Ethical behavior doesn't stand alone. At the VCU School of Dentistry, therefore, instead of offering programs with free-standing courses in ethics or professionalism, we integrate the content into many other courses across the curriculum, just as we integrate instruction in behavioral sciences, patient management, special needs, and geriatric dentistry.

For example, ethical treatment of patients and professional interactions with them is discussed in the D1 and D2 Clinical Skills courses and the D2 Periodontics course. We emphasize the importance of high quality personal interactions, respect, empathy, patient empowerment and motivation, obtaining informed consent, and defining patient problems. The annual Mirmelstein lecture is a requirement for D1 and D2 students, and may cover any variety of topics under the general theme of ethics.

In the D3 Treatment Planning Seminar, once again we address ethics by having students investigate and respond to eight simulated but realistic ethics/professionalism scenarios that can occur in dental education or dental practice. Students discuss these scenarios in small group seminar settings with a faculty member facilitator. The interactive discussions provide opportunities for reflection on the situations, what the ethical response to the situation looks like and why.

In the D4 Practice Management course, expert speakers lecture on the legal and ethical issues in risk management. Students must complete an on-line self-study course and post-tests through the Fortress Liability Company. The course emphasizes informed consent, risks associated with referrals, treating beyond your comfort level, and terminating care. Care is focused on what is in the best interest of the patients. In addition, a speaker covers the ADA's Principles of Ethics and Code of Professional Conduct regarding waiver of copayment, overbilling, and treatment dates. Each year the dental school hosts the ADA Success Seminar, which includes an ethics component.

The D3 and D4 Patient Management and Professional Conduct courses impact ethical practice and professional behavior most directly. In these courses students complete self-paced self-study, and post-tests through the American College of Dentists website. Topics include introduction to ethics, professionalism, and ethical decision-making and four case-based ethical dilemmas in dentistry.

In addition to the web-based instruction, the course evaluates each student's daily clinical performance in four different areas: 1) timeliness and continuity of care, 2) patient relations, 3) patient record management, and 4) professional conduct. Students must pass each semester in order graduate.

Policies on Ethical Behavior

At VCU School of Dentistry a number of well-defined policies codify ethical and professional behavior for students and faculty. The clear articulation of these policies provides the basis for setting expectations and mechanisms for dealing with breaches in ethical behavior if and when they occur.

First, the VCU School of Dentistry Code of Professional Conduct covers professionalism standards for all students and faculty. Second, our Technical Standards for Dental Education Programs include a relatively new standard on ethics and professionalism. A general standard specifies a student must maintain the standards of conduct for ethics and professionalism as set forth in the American Dental Association's Principles of Ethics and Code of Professional Conduct and VCU School of Dentistry Code of Professional Conduct. If a student fails to meet this standard it can prevent promotion to the next year or graduation. Finally, the school also participates in the VCU Honor System for dealing with instances of individual ethical breaches in test taking, projects, or other class activities.

The 2007 Mirmelstein Ethics Workshop and Follow up

Last year's Mirmelstein Ethics Workshop generated six initiatives for an enhanced curriculum at the school (see box). We have made progress on the first two suggestions - student peer evaluation and student discussion and self-reflection.

In the academic year 2007-08 Dr. Jim Burns, Assistant Dean for Clinical Education, implemented programs of student self-assessment and student peer assessment. In each of their clinical competencies, students must not only obtain faculty evaluation, they must evaluate their own performance. Faculty and students use the self-assessment process both formatively, i.e., to guide learning, and summatively, i.e., to evaluate performance and incorporate it into the student's grade.

The student peer assessment is formative exercises in which students rate classmates on nine behaviors that indicate ethical and professional attitudes. The tenth item is a checklist where students circle five adjectives they believe best describe the classmate being evaluated. This information is kept confidential and provided only to the classmate evaluated. The use of this instrument reflects the belief that feedback from trusted sources can inform and influence future behavior in a formative way. Students responded to these assessments positively and this year the process will be repeated.

In spring 2009, to augment our integrated approach to teaching ethics, we will launch the first free-standing course, directed by Dr. Carolyn Booker, Assistant Dean for Students. It will be held in the D2 year, after the students have had their introduction to dentistry and are beginning patient care. The format for this one-credit hour course will be interactive case discussions with faculty members.

Efforts of ADA and ADEA

In the past year two national dental organizations, the American Dental Association and the American Dental Education Association, formally responded to some cheating scandals in several dental schools in the previous academic year.

In October 2007, the ADA House of Delegates created a joint subcommittee of members of the Council on Dental Education and Licensure (CEDL) and the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) to develop strategies to address this problem and report back to the 2008 House of Delegates. Its membership included guests from other agencies, too. Dr. Kirk Norbo, from Leesburg, Virginia, represents CEBJA on this joint subcommittee and I am a guest member representing ADEA.

The CEDL/CEBJA subcommittee calls for broad-based wide ranging actions in both dental education and dental practice. The actions include additional dental accreditation standards, ethics programming at ADA meetings, and increased collaboration with the American College of Dentists and the American Society for Dental Ethics.

Initiatives from 2007 Mirmelstein Ethics Workshop

- Student discussion and self-reflection
- Student peer evaluation
- Setting clear expectations
- Consistent role modeling
- Faculty development on methods
- Involving private practitioners

In March 2008, the ADEA House Delegates created a Task Force on Code of Professionalism in Dental Education. This task force includes representation from academics and organized dentistry, including CEDL and CEBJA. Rather than create a another code of mandated standards, the task force developed a set of values-based professional behaviors that they believe everyone in the dental profession, educators and clinicians, should exhibit. The ADA subcommittee responded positively to the efforts of the ADEA task force on ethics, applauding its values-based educational approach.

We need to remember ethical breaches are not limited to the dental education environment. Members of the Virginia Board of Dentistry certainly know about many ethical breaches they have encountered among dentists who have long since graduated from our dental school or others. Nonetheless we in dental education must do what we can to steer our students and graduates in the right direction, set appropriate expectations, show students how to make ethical decisions, and be good role models.

The growth and stature of our profession depend on the progress we make regarding this work.

Component News

Component 3
Dr. Mike Hanley - Editor

Heat pestilence drought crop failure and a continuing shortage of commas when you really need one pretty well sum up the last three month in Component III. We do have one new member, Melanie Wexel. Melanie is a recent graduate in Orthodontics at the University of Florida. She has the good fortune to now be working with Wright Pond in Colonial Heights. He is presently working on her speed ---speaking, that is. She is nowhere near the 450 words per minute that Dr. Pond can utter. Welcome, Melanie! One of the customs we have in Component III is to get new members to raise their hands when we are looking for officers. So…..our new officers for the year are: Melanie Wexel, Treasurer, Paul Brinser, Secretary, Shannon Bowman, President Elect, Ellen Oertel, President. No trouble with that glass ceiling in our component!

Thank you to our outgoing president, Earl Shufford. You did an outstanding job! We also say thank you to our outgoing Counselor, Reed Boyd. For many years (could it be 8?), he has been the first to arrive and the last to leave at State Meetings. He represented us well; never one to mince words or NOT have a strong opinion on everything. Enjoy your retirement, Reed. Taking up the task is Sam Galstan. He is already involved in everything, so this should be an easy transition. Thanks in advance, Sam.

On the 7th of November, at the Country Club of Petersburg, Ellen Byrne will be speaking. Don't have the topic, yet; but you know you will learn a lot of useful information. Look for more information in the mail.

As of this writing, we still could use help at the MOM project in Emporia. Thanks to a grant from the Greensville Memorial Hospital Fund and others, 35 chairs will be available. Harold Neal and the dentists in Emporia are working very hard to make this successful. There is a huge need in Southside Virginia area. Please help if you can. Check the VDA website for more information. I'll report on its success next issue.

Random thoughts:
VADPAC is down right now and the need is immediate. Please consider a contribution to VADPAC before the elections. Save the 1st Friday in February (6th) for GKAS. Chesterfield County had a Partner Appreciation Day and presented Sam Galstan a certificate for the SouthSide Dental Society's partnership in GKAS. People are noticing our efforts! February 19th "Back In the Day" will try again to entertain us. (Remember the electricity went out after their 1st song?!). The next day will be our annual OSHA update. More on that later…

I spoke of the new, how about the old: Buck Rutledge has retired. After 42 years, he is ready to head out to the pasture. A close personal friend of G.V. Black, he has seen dentistry evolve from using leeches to that "new fangled" curing light he purchased last year. Buck is an avid golfer who should be shooting his age soon. With the sale of his practice and his Civil War pension, he should have plenty of new golf balls. Congratulations and good luck, Buck.

And finally, speaking of Dr. Ellis – he's told us that he has been invited to the Ryder Cup. After checking into this, I found that he's really in a competition speed driving a yellow box truck full of furniture to the West Coast!

Component 4
Dr. Gregory Cole - Secretary

Component 4 will begin our fall meetings with a wine tasting dinner September 4th and the installation of our new Component president, Dr. Lanny Levenson. On October 24, 2008, we will welcome Dr. Gordon Christensen back to Richmond for a two-session program entitled "New Aspects of Fixed Prosthodontics (morning) and New Aspects of Restorative Dentistry (afternoon)". This will be held at the Richmond Marriott Hotel.

The Richmond Dental Society will also sponsor the 2nd Annual CE & Ski Weekend at Wintergreen on February 6-8, 2009. Speakers for this event are still being finalized at this time, but will be announced shortly.

For more details about these programs, please contact Linda Simon at (804) 323-5191. Have a great Fall 2008!

Component 8
Dr. Chris Spagna - Editor

The NVDS is pleased to report that not only did we have fantastic weather for our annual golf outing at Stonewall GC in June, but we raised over $7000 for the Northern Virginia Dental Clinic. They however, weren't the only "winner". Through the tireless efforts of Tom Wilson, the clinic director, most every participant went home with some sort of really nice door prize, from wine to dinner certificates to golf accessories. Except for a few of the scores, it was a truly great event!

In its second year, the Ellen S. Flanagan Memorial Fund continues to successfully raise money for charitable interests such as Missions of Mercy, Give Kids a Smile, and the NVDS Clinic. To date, we've already collected $10,000 in ticket sales for our raffle, whose drawing will be held at our Annual Business Meeting on September 3rd.

The Northern Virginia Dental Society continues to grow, as we had 35 attendees at our new member orientation held on August 27. They, as I'm sure all our members, are anxiously looking forward to the stellar CE Progams line-up for 2008-2009. Haven't heard yet who's coming in town to speak … well check out the new NVDS website!

For those of you who haven't already checked it out at www.nvds.org, the revamped page is more comprehensive, more interactive, and more user-friendly than before. There is an extensive section specifically tailored for the general public. Here they can find information on local dentists, basic dental health, referring agencies, dental careers, as well as links of interest to sites such as the ADA and the VDA. Interactive features include the ability to view for example, TV news clips recognizing the NVDS's community involvement. Prospective members can download application forms. And members who missed the last NOVA Newsletter can read past issues or even register for upcoming CE courses. The members only section is password protected and contains information reserved solely for our membership. Here, members can get all sorts of contact information, they can view the current Calendar of Events, and can register online for various volunteer opportunities. In addition, they may check out the index of the NVDS's lending library - a collection of audiovisual aids and handouts made available to members free of charge to help with oral health presentations.

But that's just the tip of the iceberg! Login to see for yourself what we've been working on ... we're sure you'll mark it as one of your saved page "Favorites".

Membership Counts - The Value of Unity

By Dr. Robert A. Candler, Chair, Membership Committee

"We must hang together or we shall certainly hang separately. " This quote attributed to Benjamin Franklin accurately described the situation of our Founding Fathers in 1776. It also describes the current condition of dentistry. Only by being together in our ADA tripartite structure do we have the unity of voice that allows us to guide our honored and esteemed profession through the challenges we confront. When we neglect to remind our colleagues of the importance of supporting organized dentistry we do ourselves a disservice. When we let our membership lapse we contribute to loss of the independence of dentists generally. Our current model of practice has resulted in the highest standard of care for our patients, delivered in an economic and efficient manner. Only through the actions of our ADA do we have assurance that the materials, equipment and procedures we use are safe, effective and appropriate. Only through the intervention of the ADA and VDA do we have on effective voice with legislators and third-party payers. Only through our strength in numbers and the contributions in time and money from membership would we have been able to bring some of the worst abuses of the large dental benefit plans under control and continue with monitoring to prevent more abuse of the doctor patient relationship. The demands of government regulation are eased by the ADA regulatory compliance manual and OSHA rules would be more onerous without the input of our dental society. Even the education of new dentists would suffer without the hard work done by organized dentistry. Meeting the challenges of our ever changing world would be impossible without the resources we have as a group, united, rather than a collection of individuals, each on their own. The unbiased and scientifically founded continuing education we receive through the efforts of ADA sponsored research and programs allows us to stay current and continue to master the demands put on us to render sound, safe, and considerate treatment for the community we serve.

3 Steps for Recruiting

1. Identify Non-Members
2. Invite them to Join
3. Answer questions and meet objections with encouragement.

This letter, being published in the VDA Journal, will of course be read by members. The challenge is to bring in the colleagues we know who are not part of our society. The doctors who refer to us and to whom we refer, the ones who take part in our study clubs and the ones who are our friends and neighbors must be given an invitation and reason to belong and support their profession. Not belonging only weakens all of us and each of us individually suffers. Remain a member and be an ambassador for organized dentistry.

Every VDA component has a membership committee and they are your resource for recruitment and retention. Along with our paid staff they will be able to help if you will help them by identifying non-members, making that invitation to join and meeting resistance or objections with answers and encouragement.

New Dentist Conference 2008

By: Dr. Chris Payne

This year's ADA 22nd New Dentist Conference was held in New Orleans in June 2008. You may have received a brochure in the mail or read an article in the ADA Journal about the meeting. For many of you, this conference may have passed under your radar. As I found out, it is a unique venue for CE, networking, getting advice about dentistry and having an enjoyable time doing it. If you're ten years or newer to the profession, consider putting next year's meeting on your calendar.

The keynote address this year was presented by Dr Houland who was serving as Dean of LSU School of Dentistry when Hurricane Katrina hit. He told of the challenges in the aftermath of the storm, the lessons learned and the determination to rebuild. The situation demanded a reevaluation of all parts of the curriculum to have the seniors graduate on time. There were many stories of courage and sacrifice. In the end, it seems the seniors did well on their boards despite the difficulties of setting up in an offsite location and living in FEMA housing. Some even stayed on a cruise ship. An emphasis was placed on the clinical aspects of the dental experience which has influenced the curriculum to date.

The conference followed with some valuable CE courses. Practice Management courses included "Secrets for Success" with Steve Anderson and "Preparing for Practice Ownership" by Matsco. Clinical Courses included "The Perfect Smile" by Dr Corky Wilhite, "Dental Implants" by Dr Dean Morton and two days of courses from the ADA - Pankey Connection: "Case Sequencing" and "Predictable Restorative Dentistry". The presentations were high quality and a great value. The $295 registration fee included all the courses, as well as some lunches, a breakfast and a social.

ADPAC sponsored a dinner cruise aboard the Steamboat Natchez on the New Orleans Riverfront Friday night. There were plenty of opportunities then and throughout the conference to meet with new dentists from around the country. Many of us are in similiar situations and stages in our careers, have similiar goals or difficulties, and can gain insight and swap stories. Dr Ron Tankersley attended the conference, as well as several other ADA representatives, who talked one on one with many of the attendees about the concerns of new dentists.

New Orleans made a great venue for the New Dentist Conference. The meeting is a great chance for some fun, education and meeting new dentists. Next year's meeting is May 2009 in Miami. Some of the Pankey Courses at this meeting may be held at the Pankey Institute. The low registration fee is a bargain for the value. If you haven't been to one before, consider putting next year's conference on your schedule.

Welcome New Members

September 2008

Northern Virginia Dental Society

Dr. Forough Akrani graduated from VCU School of Dentistry in 2005. Dr. Akrami is practicing in Burke, VA.

Dr. Julie Baveja graduated from the University Of Maryland School Of Dentistry in 2003. She then completed her GPR in 2004 and went on to receive her Certificate in Pediatric Dentistry in 2006. Dr. Baveja is currently practicing in Vienna, VA.

Dr. Clarissa Bellard graduated from Universidad Paulista in 2001. Dr. Bellard then attended Forum Health Hospital where she received her GPR Certificate in 2008. Dr. Bellard is currently practicing in Fredericksburg, VA.

Dr. Stephanie Bomar graduated from the University of Pennsylvania in 2004. She then completed her GPR in 2005. Dr. Bomar is currently practicing with Dr. Aunon in Centreville, VA.

Dr. Paul Harris graduated from UMAB Baltimore College of Dental Surgery in 2000. Dr. Harris is now practicing in Annandale, VA.

Dr. Kouros Hedayati graduated from VCU School of Dentistry in 2008. Dr. Hedayati is practicing in the Northern Virginia area.

Dr. Mohsen Izadi graduated from Howard University in 1990. Dr. Izadi is currently practicing in Vienna, VA.

Dr. Rana Khattak graduated from Creighton University in 1992. Dr. Khattak is currently practicing dentistry in Fredericksburg, VA.

Dr. Sean Kim graduated from West Virginia University School of Dentistry in 2007. Dr. Kim is currently practicing in at Fredericksburg Smile Center.

Dr. Chien-Ying Lee graduated from the University of Maryland with her Certificate in Pediatric Dentistry in 2008. Dr. Lee is practicing in Fredericksburg, VA.

Dr. Sumayra Mohiuddin graduated from VCU School of Dentistry in 2008. Dr. Mohiuddin will be practicing dentistry in the Northern VA area.

Dr. Howard Ngo graduated fromVCU School of Dentistry in 2007. Dr. Ngo then completed his GPR at Palmetto Health Richland in Columbia, SC. Dr. Ngo is currently practicing with Dr. Peter Cocolis in Springfield, VA.

Dr. Pratik Patel graduated in 2007 from SUNY at Buffalo, School of Dental Medicine. She then completed her GPR at Lehigh Valley Hospital in 2008. Dr. Patel is currently practicing in the Northern VA area.

Dr. Steve Pleickhardt graduated from Georgetown University in 1985. Dr. Pleickhardt is currently practicing in Gainesville, VA

Dr. Cyrus Ramsey graduated from University of Pennsylvania in 2003. He then attended Case Western Reserve University where he received his DMD MD in Oral and Maxillofacial Surgery in 2008. Dr. Ramsey is now practicing with Fairfax Oral and Maxillofacial Surgery in Fairfax, VA.

Dr. Shahram Sabet graduated from Shahid Beheshti Dental School in 1996. He then attended Howard University College of Dentistry where he received his AGD in 2001. Dr Sabet is currently practicing in Vienna, VA.

Dr. David Sarment graduated from the University of Michigan School of Dentistry in 1994. He then attended the University of PA where he received his Certificate in Periodontics. Dr. Sarment is practicing in Alexandria, VA, with Sarment and Associates.

Dr. Shohreh Shahram graduated from New York University School of Dentistry in 2008. Dr. Shahram is currently practicing in Woodbridge, VA. and Silverspring, MD.

Dr. Michelle Klima Toms graduated from VCU School of Dentistry in 2008. Dr. Toms is currently practicing dentistry in Manassas, VA, with Dr. Elaine Sours.

Dr. Kevin Toms graduated from VCU School of Dentistry in 2006. Dr. Toms then completed his GPR at VCU Health Systems at McGuire VA Medical Center in 2008. Dr. Toms is practicing in the Northern VA area.

Dr. John C Yi graduated from VCU School of Dentistry in 2000. Dr. Yi is currently practicing in Alexandria, VA.

Piedmont Dental Society

Dr. Shane Claiborne graduated from VCU School of Dentistry in 2003. He then completed a 2 year GPR in 2005. Dr. Claiborne is currently working at Central Virginia Family Dentistry in Lynchburg, VA.

Dr. James James, III graduated from VCU School of Dentistry in 2006. Dr. James is currently practicing in Roanoke, VA with Dr. William Deyerle.

Dr. Andy Mancini graduated from UNC at Chapel Hill where he received his AEGD certificate. Dr. Mancini is currently practicing in Roanoke, VA.

Dr. William E Morris graduated from UNC School of Dentistry in 1978. Dr. Morris is currently serving at President of the Academy of Operative Dentistry as well as Vice President of the Dental Foundation in North Carolina. Dr. Morris is practicing at Smith Mountain Lake, VA

Tidewater Dental Association

Dr. Mohamed Attia graduated from Alexandria University in 2002. He then completed a GPR at Howard University in 2007 and GPR II at Carolina Medical Center, NC in 2008. Dr. Attia is practicing in Norfolk, VA at the Foleck Center.

Dr. Steven Hatch graduated from VCU School of Dentistry in 2008. Dr. Hatch is currently practicing with LWSS and Associates in Virginia Beach.

Dr. Jill Merrell graduated from Tufts University School of Dental Medicine in 2007. Dr. Merrell is currently in the Norfolk area.

Dr. Spencer Shelley graduated from VCU School of Dentistry in 2008. Dr. Shelley is currently practicing in Onley, VA

Dr. Lauren Singor graduated from VCU School of Dentistry in 2008. Dr. Singor is currently practicing with LWSS and Associates.

Dr. Mindy Streem graduated from Harvard School of Medicine in 2005 and then received her MS and Certificate in Orthodontics from the University of Michigan in 2008. Dr. Streem is currently practicing in Chesapeake, VA.

Richmond Dental Society

Dr. Tawfiq Alkilani graduated from the University of the Pacific in 2008. Dr. Alkilani is now practicing in Colonial Heights, VA and living in Richmond.

Dr. Mary Baechle graduated from University of Texas Dental Branch at Houston in 1998 and then completed her AEGD there in 1999. Dr. Baechle is practicing at VCU Dental Faculty Practice in Richmond, VA.

Dr. Sarah Baicy graduated from Tufts School of Dental Medicine in 2007. Dr. Baicy is currently practicing with Drs. Mark Kowal and Allen Macilwaine in Glen Allen, VA.

Dr. Corey Burgoyne graduated from the Medical University of South Carolina in 2004. Dr Burgoyne then attended VCU School for Oral and Maxillofacial Surgery where she received her Certificate in 2008. Dr. Burgoyne is practicing with Commonwealth Oral and Facial Surgery.

Dr. Michael Catoggio graduated from VCU School of Dentistry in 2008. Dr. Catoggio is currently practicing in Richmond, VA.

Dr. William Coker graduated from VCU School of Dentistry in 2008. Dr. Coker will be working in the Richmond area.

Dr. Patricia Daley graduated from the University Of Mississippi College Of Dentistry in 1987. Dr. Daley has since completed certification in Prosthodontics, GPR, and Geriatric dentistry. Dr. Daley is currently practicing at Ft. Lee, VA.

Dr. Michael Holbert graduated from the University of North Carolina in 2003 and then

received his Certificate in Orthodontics in 2008. Dr. Holbert is currently practicing in Richmond, VA.

Dr. Tiffany Nightengale graduated from the University of Louisville in 2006. Dr. Nightengale had been a tripartite member in Fort Wayne, IN, and will be now practicing in Richmond, VA.

Dr. William Pack graduated from VCU School of Dentistry in 2008. Dr. Pack is currently practicing in Ashland, VA.

Dr. Israel Puterman graduated from Boston University School of Dentistry in 2002. He then attended Loma Linda University where he received his Certificates in Periodontics and Implant Dentistry. Dr. Puterman is practicing with Drs Passero and Feeney in McLean, VA.

Dr. Isabel Rocha graduated from VCU School of Dentistry in 2008. Dr. Rocha is currently practicing in the Richmond area.

Dr. Ardalan Sanati graduated from New York University in 2008. Dr. Sanati is currently practicing in VA and MD.

Dr. Justin Scott graduated from Tufts School of Dental Medicine in 2007. Dr. Scott is currently practicing in Williamsburg, VA.

Dr. Marvin Sagun graduated from VCU School of Dentistry in 2008. Dr. Sagun is currently practicing in the Virginia Beach area.

Dr. Justin Tebbenkamp graduated from VCU School of Dentistry in 2008. Dr. Tebbenkamp is currently practicing in the Richmond area.

Dr. John Truitt graduated from VCU School of Dentistry Dept of Oral and Maxillofacial Surgery in 2008. Dr. Truitt is now practicing in Midlothian, VA, with Richmond Oral and Cosmetic Surgeons.

Dr. Stefanie Yung graduated from VCU School of Dentistry in 2007 Dr. Yung is working with Dr. Genevieve DeVera in Midlothian, VA.

Southside Dental Society

Dr. Melanie Wexel graduated from VCU School of Dentistry in 2004. Dr. Wexel then went on to complete a one year Fellowship and three year Residency where she received her MS and Certificate in Orthodontics from the University of Florida. Dr. Wexel is currently practicing in Colonial Heights with Dr. Pond.

Southwest VA Dental Society

Dr. Jay Bass graduated from VCU School of Dentistry in 2008. Dr. Bass is currently practicing with Dr. John Robertson in Blacksburg, VA.

Dr. Tyler Burningham graduated from Tufts School of Dental Medicine in June 2008. Dr. Burningham is currently practicing in Radford, VA

Dr. Michael Hull graduated from Tufts University, School of Dentistry in May 2008. Dr. Hull is now practicing dentistry in Abingdon, VA with Brown Dental Associates.

Dr. Stephen Shelburne graduated from VCU School of Dentistry in 2008. Dr. Shelburne is currently practicing in Pennington Gap, VA.

Shenandoah Valley Dental Association

Dr. Matthew Kim graduated from VCU School of Dentistry in 2008. Dr. Kim is currently practicing in Harrisonburg, VA. with Dr. Charles Hall.

Dr. Christina P. Mills graduated from VCU School of Dentistry in 1994 and then completed her AEGD in 1995. Dr. Mills is currently practicing in Culpeper, VA.

Dr. James Solomon graduated from Temple University School of Dentistry in 1986. He then attended Baylor University Medical Center where he received his degree in Oral and Maxillofacial Surgery. Dr. Solomon is now practicing with Central Virginia Oral and Facial Surgeons in Charlottesville, VA.

Peninsula Dental Society

Dr. Corinne Hoffman graduated from VCU School of Dentistry in 2008. Dr. Hoffman is currently practicing in the Williamsburg area.

In Memory...

Dr. Harold Ringley	Southwest VA Dental Society	Coeburn	January 26, 2008
Dr. Dan W Culbertson	Southwest VA Dental Society	Gate City	April 10, 2008
Dr. Richard Barrick	Tidewater Dental Association	Portsmouth	June 18, 2008 **Past President & VDA Fellow**
Dr. Peter Morabito	Northern VA Dental Society	Potomac, MD,	June 28, 2008
Dr. Maurice Phillips	Richmond Dental Society	Fredericksburg	July 12, 2008
Dr. William Powell	Northern VA Dental Society	Culpeper	July 12, 2008
Dr. Apollon Orphanidys	Peninsula Dental Society	Newport News	July 17, 2008
Dr. Timothy O' Malley	Richmond Dental Society	Richmond	July 24, 2008
Dr. Hugo Owens	Tidewater Dental Association	Chesapeake	July 29, 2008
Dr. John Ray Burton	Richmond Dental Society	Richmond	July 30, 2008
Dr. George J. George	Piedmont Dental Society	Culpeper	Date unknown
Dr. Donald L. Clark	Northern VA Dental Society	Alexandria	August 17, 2008

Dr. Francis Joseph Samaha of Arlington died February 15, 2008, at the age of 79. Dr. Samaha retired from the U.S. Air Force as a full Colonel, began his private practice of Periodontics in McLean, Virginia and retired in 1995. His military honors include the Legion of Merit and the Air Force Commendation Medal, amongst others. Dr. Samaha was a 1951 graduate of Georgetown University School of Dentistry, and completed his residency in Periodontics at Tufts University in 1956. In addition to his active participation in organized dentistry, he was the author of numerous scientific publications and held faculty positions at Georgetown University, Tufts University and the University of Maryland dental schools. He was a fellow in the American College of Dentists, and a past president of the Northern Virginia Dental Society. In 1998 he received the Lifetime Achievement Award from the NVDS. Survivors include his beloved wife, Gina A. Samaha, and children Rev. Jeffrey F. Samaha of Maryland, Gary M. Samaha of Atlanta, Lisa Marie Samaha, D.D.S., of Newport News, Richard G. Samaha, M.D., of Williamsburg and Nina M. Samaha of New York.

FOR THE DENTAL PATIENT . . .

THIS IMPORTANT DENTAL MESSAGE BROUGHT TO YOU BY:

Oral moisturizers
Products that can help relieve dry mouth

Saliva coats and lubricates tissues in the mouth. It helps cleanse the mouth and begins the digestive process as you chew. Speaking, chewing and swallowing all are made easier when the mouth is moist. When saliva glands do not work properly, the mouth becomes dry. Artificial saliva is a product that is used to help relieve dry mouth. It is available in an aerosol or a liquid that is squirted into the mouth.

WHAT IS DRY MOUTH?

Dry mouth results from an inadequate flow of saliva. Drying irritates the soft tissues in the mouth, which can make them inflamed and more susceptible to infection. Severe dry mouth can promote the growth of harmful organisms. Without the cleansing and shielding effects of adequate salivary flow, caries (tooth decay) and periodontal (gum) disease become much more common. Constant dryness and the lack of protection provided by saliva contribute to bad breath. Dry mouth also causes full dentures to become less comfortable because there is no thin film of saliva to help them adhere properly to oral tissues.

HOW DOES ARTIFICIAL SALIVA DIFFER FROM REAL SALIVA?

Artificial saliva is not a perfect substitute for natural saliva, which is complex physically and chemically. Although more than 99 percent of saliva is water, saliva also contains buffering agents, enzymes and minerals that keep teeth strong and play a crucial role in maintaining a healthy mouth. Artificial salivas typically contain a mixture of buffering agents, cellulose derivatives (to increase stickiness and moistening ability) and flavoring agents (such as sorbitol). However, they do not contain the digestive and antibacterial enzymes and other proteins or minerals present in real saliva. Research is under way to try to develop artificial salivas that more closely mimic natural saliva. Artificial saliva can be used as often as needed. Saliva substitutes are swallowed quickly and, therefore, the moistening and lubricating action has limited duration. Repeated applications may be needed. Although saliva substitutes will not cure dry mouth, they can provide temporary relief of some symptoms. Artificial saliva does not require a prescription, but it may be difficult to find on store shelves. Check with your pharmacist if you don't see it displayed with other oral hygiene products.

HOW DOES ARTIFICIAL SALIVA RECEIVE THE AMERICAN DENTAL ASSOCIATION SEAL OF ACCEPTANCE?

A company earns the American Dental Association (ADA) Seal of Acceptance for its product by producing scientific evidence that the product is safe and effective. The Seal is your assurance that the artificial saliva has been evaluated by an independent body of scientific experts—the ADA Council on Scientific Affairs— for safety and effectiveness. Look for the ADA Seal statement on the product's packaging or label. The statement explains why the ADA has given the Seal to the product. You also can be assured
that all claims on packaging and container labeling have been reviewed and approved by the ADA. Products with the prestigious ADA Seal must say what they do and do what they say.
For more information, visit "www.ada.org/goto/seal" ■

Prepared by the ADA Division of Communications, in cooperation with The Journal of the American Dental Association and the ADA Division of Science.

"For the Dental Patient" provides general information on dental treatments to dental patients. It is designed to prompt discussion between dentist and patient about treatment options and does not substitute for the dentist's professional assessment based on the individual patient's needs and desires.

Dr. Terry Dickinson honored by National Rural Health Association

By Stacie Crozier, ADA News; 39(12): page 25 - printed with permission

New Orleans—Helping thousands of rural Americans receive much-needed dental care through Mission of Mercy projects has earned Dr. Terry Dickinson the Rural Health Practitioner of the Year award.

Dr. Dickinson received the award at the National Rural Health Association's annual conference here May 9.

The Virginia Dental Association executive director was honored for his leadership in developing and sustaining Mission of Mercy projects in Virginia, Kentucky, West Virginia and Tennessee since 2000, plus a MOM dental clinic in New Orleans for Hurricane Katrina victims in 2006.

MOM projects under his direction have provided more than $9 million in free dental care to more than 23,000 underserved rural citizens.

"I am extremely honored to receive this most prestigious award," said Dr. Dickinson. "I accept it on behalf of all the health care heroes who serve those most in need."

Dr. Dickinson said he was glad to see that dentistry was highlighted at the NRHA meeting.

"It says a lot about how far we've come in showing that dentistry is an important piece of the overall health picture."

The NRHA is a nonprofit organization working to improve the health and well-being of rural Americans and providing leadership on rural health issues through advocacy, communications, education and research. Its members include individuals and organizations that share the common bond of an interest in rural health.

NRHA President Paul Moore and Dr. Terry Dickinson. Photo courtesy of National Rural Health Association.

Oral health was one focus of the NRHA annual meeting May 7-10. Two ADA representatives, Dr. A. J. Homicz, a member of the ADA Council on Access, Prevention and Interprofessional Relations, and Dr. Steven P. Geiermann, ADA senior manager, Access, Community Oral Health Infrastructure and Capacity, attended the meeting.

HAVE YOU NOTICED?

The Virginia Dental Journal has been featuring "For the Dental Patient" for the last several issues. This feature is offered by the ADA to help dental professionals educate their patients on important dental issues.

What do you do with this?
The patient page is formatted so that you can copy the page and either send it out to your patients or have it as a reference in you office.

The Virginia Dental Journal is striving to make this publication relevant and useful to today's dental professionals. Check out the new "Pathology Puzzler" on pages 19 & 59.

We value your feedback and ideas. Send them to:

Dr. Richard Roadcap - Editor or jacobs@vadental.org
7525 Staples Mill Road
Richmond, VA 23228

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Classifieds

Practices For Sale/Lease

OFFICE FOR LEASE-
LYNCHBURG, VA

Office for lease June 2008 with possible sale later. Excellent condition and location. Previous general dentist moved after a 10 year lease. 1250 sq. ft. Plumbed and wired for 4 treatment rooms. Built in cabinets and desks in business office, private office, laboratory-sterilization area and supply-darkroom. The 3 treatment rooms have cabinets and sinks.

Contact: Cleve H Porter, Jr., DDS
TELEPHONE: 434-384-2688.

PRACTICE SALE!
Fairfax County, VA – Location, Location! General family practice. 1200 s/f, great opportunity! Rev. $350K. Call Donna 800.988.5674

PRACTICES FOR SALE

CHRISTIANBURG, VA
PERIO #8515 Located near Virginia Tech.
Gross $667,363; 4 days
4 operatories; 1,585 sq. ft. office space
Additional plumbed but unequipped operatory.

PETERSBURG-FT. LEE AREA
#8163 Rolls Royce factory and new regional hospital are being built 1/2 mile from office. This will result in 60,000 new residents!
Gross $395,817; 4.5 days
5 operatories; 2,000 sq. ft. office space
Additional plumbed but unequipped operatory.

SOUTH CENTRAL VIRGINIA
#8270 Gross $740,522; 4.5 days
4 operatories; 1,770 sq. ft. office space

For information on any of these practice sales, call ADS South, Dr. Jim Howard at 910-523-1430. For information on associate positions, call Vikki Howard at 910-523-1949.

PRACTICES FOR SALE
We have many practices for sale in Pennsylvania. Please contact us at www.ADStransitions.com or toll free 888-237-4237 and ask for Nancy. We are also seeking opportunities for associate dentists that want to become a partner in both general and specialty dental practices.

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

PRACTICE BUYERS WANTED
For great practices in the Virginia area. We have many practices available for sale in the Virginia area. Are you tired of being an employee in a dead end job? Call us for a FREE CONSULTATION to find out about these opportunities. THE MCNOR GROUP, 888-273-1014 x 103 or johnf@mcnorgroup.com, www.mcnorgroup.com

Miscellaneous

SELLERS WANTED
We have qualified buyers with 100% funding approval that want to buy a practice in Virginia. The baby boomers are starting to sell and this is a great time to transition your practice. We get excellent prices and sell the practice in a timely, healthy manner. THE MCNOR GROUP, 888-273-1014 x 103 or jjohnf@mcnorgroup.com, www.mcnorgroup.com

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We are the only transition consulting company in the area that has a Certified Valuation Analyst CVA as a principal that focuses exclusively on the transition of DENTAL PRACTICES. Please see the article by CVA Karen Norris on page 82 of the April 07 issue of Dental Economics on this subject or call or email us for a FREE CONSULTATION and a copy of the article. If you are selling, buying, creating a partnership or just want to find out the current value of your practice contact THE MCNOR GROUP, 888-273-1014 x 103 or johnf@mcnorgroup.com, www.mcnorgroup.com

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PathologyPuzzler

answers revealed

Answers: 1) A, C, D
2) B

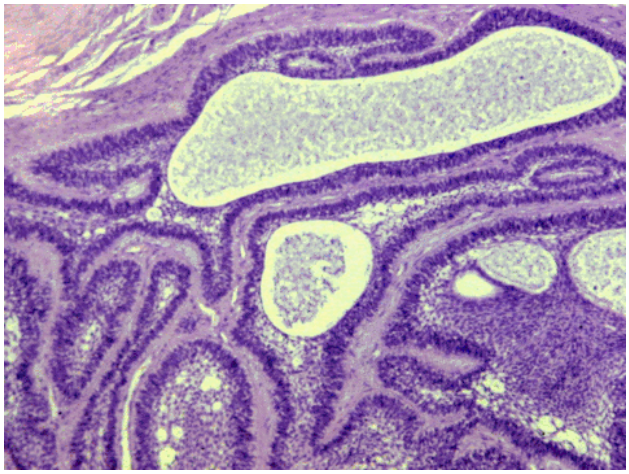
Discussion:

Based on the expansile nature and radiolucent character of the lesion, the differential diagnosis favors a central giant cell granuloma and ameloblastoma. An aneurysmal bone cyst, although rare, could also be a possibility. The calcifying epithelial odontogenic tumor, the calcifying odontogenic cyst, the odontoma and the central ossifying fibroma would all produce radiopacities within the radiographs with a lesion this size and are therefore not correct. The best procedure to diagnose the lesion is an incisional biopsy.

The advanced age of the patient was not compatible for any of the three entities although "tumors do not read textbooks" and "statistics are for dead men, the patient is a case of one." There are not many entities to include that show this appearance. Odontogenic keratocysts do not usually expand. Being expansile and in the anterior mandible, central giant cell granuloma would be the favored diagnosis.

A biopsy was performed and the final diagnosis was ameloblastoma. Due to the patient's age and reasonably localized growth, conservative removal was the recommended treatment.

Figure 3



The ameloblastoma is the most clinically significant odontogenic tumor. They are usually slow growing, locally invasive and persistent. They occur 70% of the time in the posterior mandible (molar-ramus area). As in this case, they usually present as a painless expansion of the jaws.

The histologic findings showed a desmoplastic variant of ameloblastoma (figure 3). The typical reverse polarization was minimally present. The patient has responded well to the therapy.

This case was submitted by Dr. Andrew Ferguson of Richmond, Virginia.

Have a case you would like to submit?
Contact Dr. John Svirsky via email: jasvirsk@vcu.edu

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