Virginia Dental Journal

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Scientific Articles

Component News

Volume 56 February 1979 Number 1

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Virginia Dental Journal

MEMBER PUBLICATION
AMERICAN ASSOCIATION OF DENTAL EDITORS

Volume 56 February 1979 Number 1

CONTENTS Page

COVER

National Children's Dental Health Week

February 4-10, 1979

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GUEST EDITORIAL

A MIRROR, AN EXPLORER AND A BALL-POINT PEN*

** This excellent editorial, from the October 1978 issue of the* Journal of the American College of Dentists, *is reprinted with the kind permission of Robert I. Kaplan, Editor and the journal's editorial staff.*

How would you like to see a law passed that would permit dentists to turn over most of their traditional duties to auxiliaries, and leave all phases of prosthetic service, from start to finish, in the hands of dental laboratory technicians. Not much, you say. Well, pay close attention to the proposals of a group you may never have heard of, for if they are successful in their efforts, the time may not be far off when the only instruments left for the dentist to use in his practice may be a mirror, an explorer and a ball-point pen.

The latest challenge to the integrity of the dental profession and the autonomy of dental boards comes from the Council of State Governments' National Task Force on State Dental Policies. This organization has reviewed the Dental Practice Acts of the fifty states and has come up with two proposed pieces of legislation, which, if generally accepted, would bring about radical changes to dental practice as we know it today.

The first is a suggested dental practice act "premised upon the belief that assuring public health and safety is the basis—and the extent—of the state's power to regulate the health professions. The legislation provides for the protection of the public without imposing arbitrary limitations on the ability of the dental profession to meet the challenge of dispensing its services to as many people as possible." In specific terms, this sample dental practice act, which the Council is promoting, contains provisions for ownership of dental practices by nondentists, allows auxiliaries to perform extended restorative services far beyond those already allowed by many states and permits dental laboratory technicians to perform intraoral services "under the direct, indirect or general supervision of the dentists." As definitions of these terms, "Direct" and "indirect supervision" require that a dentist be physically present in the dental office. Under "general supervision", the dentist need not be present when the procedures are performed. In addition, such procedures "may also be performed at a place other than the dentist's usual place of practice."

The Dentist is defined as "that person who may perform any intraoral or extraoral procedure required in the practice of dentistry and to whom is reserved:

1. The responsibility for final diagnosis of conditions within the human mouth and its adjacent tissues and structures.
2. The responsibility for the final treatment plan of any dental patient.
3. The responsibility for prescribing drugs which are administered to patients in the practice of dentistry.

4. The responsibility for the overall quality of patient care which is rendered or performed in the practice of dentistry, regardless of whether the care is rendered personally by the dentist or a dental auxiliary."

It is not difficult to visualize a dentist of the future who will examine the mouth, write a treatment plan or a prescription, check preparations and restorations and leave everything else to auxiliaries and laboratory technicians.

The second proposal concerns the passage of a Health Occupations Policy Coordinating Act which would set up a Health Occupations Council, composed of health professionals and consumers. "The Council would coordinate certain functions currently performed by individual licensing boards by centralizing budgeting, office location, staffing, investigations and professional discipline. The act gives the Council broad powers to define roles and responsibilities in the provision of health services. The Council (would be) authorized to review and coordinate licensing board regulations, establish discipline and enforcement procedures, and resolve scope of practice questions". It would have the power to "grant limited waivers to existing practice acts to allow pilot projects to determine whether or not certain skills can safely be delegated to auxiliaries and new manpower groups".

If these proposals are ever enacted into law, we would have, in effect, a Superboard which would take away the power of existing state boards, make them subservient to it, and pass regulations which could be inimical to the interests of dentists in many states.

The Task Force is interested in receiving comments on the proposed legislation and will hold a public hearing at the Convention Center in Anaheim, California during the ADA annual session. The College has signified its interest in offering testimony in Anaheim.

We believe that both pieces of proposed legislation contain provisions for the abolition of many traditional regulations and restrictions established by State Boards for the benefit of the public, as well as the imposition of others which are open to serious question. It is time to speak out.

GUEST EDITORIAL

DENTISTRY'S DILEMMA, IS DENTISTRY'S CHALLENGE

by Douglas C. Wendt, D.D.S.

A growing problem in America today is the dental care for the elderly. Particularly those older people on fixed, low, incomes. They are caught up in the socioeconomic "crunch" of inflation. In 1976 there were 22.9 million Americans 65 years of age, or older. That is almost 11% of the population. Transformed into Virginia statistics, that means almost 500,000 elderly citizens. The median income of each of these citizens in 1975 was $3,655.00 per year. Their per capita health care expenditure was $1,360.00 in that year. Their dental care expenditure averaged $24.00! And they paid 34% of all health care expenses by private funds, and 93% of dental care by private funds.

These elderly people are proud, and they tend to feel that America and its opportunities have used them, and passed them by. They feel depressed, neglected, often alone, and they are somewhat resentful of their situation. Being mostly beyond their earning years, they are hard pressed to provide the essentials of life. They find dentistry fraught with economic barriers for them.

Dentistry is the only health profession to keep its fee scale below the cost of living index for the past 5 years or more, and we have been so commended by the President. However, inflation has seriously eroded the health dollar of the elderly, and cost becomes the primary factor in access to care of the elderly.

This is the time our profession must take stock of itself. Can we help these people without governmental intervention? Can we lead the way? Can we show the world the true meaning of professionalism, and do so by providing health service to the elderly at a reduced fee simply because we CARE about people? More than that, we will do it because our first obligation is to provide the best dentistry possible for the public. We are doctors whose sole purpose in practicing dentistry is for the benefit of the health and welfare of the individuals we treat.

Dentistry in Virginia has found a way to help these elderly people. A new program conceived by dentists and proposed by dentists is now ready to be launched, and needs dentist volunteers to implement it. It is the VDA Denture Help Program. Every dentist interested in providing a high quality denture service at a reduced fee can volunteer to provide such a service for the number of patients he wishes. You will soon be receiving a letter explaining details of the program, and a return post card. On the card, we ask that you indicate your willingness to provide help in your own community, in your own office, and at your own convenience.

This is our first step. We will then know the numbers of dentists willing to provide this service. Existing Senior Citizen groups will be asked to screen those in need, and possibly appoint the patients with the volunteer dentist.

This program is just a beginning. We are not advocating the encouragement of the "something for nothing" philosophy which is dominating our society today—but are proposing a means for these low income citizens of this proud land, to pay for the kind of dental care which will not just put teeth in their mouths, but provide an essential health care of nutritional good health, and disease detection through oral care and supervision.

ARE YOU WILLING TO SHOW YOU CARE? We can no longer just talk about this problem. It is time, perhaps, to be reminded of something Ralph Waldo Emerson once said; "The reward of a thing well done, is to have done it". Lets do it!

CALENDAR OF EVENTS

(Mark your calendar now for these future meetings)

VIRGINIA DENTAL ASSOCIATION COMMITTEE MEETINGS
June 1, 2, 3, 1979—Cavalier Oceanfront, Virginia Beach

VIRGINIA DENTAL ASSOCIATION 110th ANNUAL MEETING
September 12-15, 1979—Omni International Hotel, Norfolk

AMERICAN DENTAL ASSOCIATION 120th ANNUAL MEETING
October 21-25, 1979, Dallas, Texas

LETTERS TO THE EDITOR:

Dear Doctor Burke:

It has come to our attention again recently that several out-of-state dental supply firms are advertising in a dental trade publication that they charge no sales tax on any orders.

Because this seems to be a recurring problem, we would appreciate your communicating the following information to your members:

"Virginia has no jurisdiction over out-of-state mail order firms which have no place of business in this State; consequently, most out-of-state firms operating in this manner have not elected to register for collection of the Virginia tax. Section 1-109 of the Virginia Retail Sales and Use Tax Rules and Regulations provides that "persons not registered to collect the use tax are not authorized to do so. In such case the consumer is liable therefor and must file a consumer's use tax return for the month of purchase." Forms for such returns may be obtained from the Department of Taxation, Sales and Use Tax Division, P. O. Box 6-L, Richmond, Virginia 23282.

Section 1-33 of the Virginia Retail Sales and Use Tax Rules and Regulations indicates that "a dentist is the consumer of all tangible personal property which he purchases for use in the practice of his profession and is required to pay tax at the time of purchase, except that dentures or other prosthetic devices, when prepared by a dental laboratory or other supplier pursuant to a work order of a dentist, may be purchased by the dentist from the dental laboratory or other supplier under a certificate of exemption. With the exception of dentures and other prosthetic devices purchased by a dentist from a dental laboratory or other supplier . . . pursuant to a work order of the dentist, all sales of tangible personal property to dentists, including dental supplies of every kind, equipment, furnishings and other property such as materials which a dentist may fabricate into dentures or artificial teeth for his patients, are subject to the tax since the dentist is classified as the user or consumer of such property and materials."

Based on the above, it can be seen that if a dentist does not pay the sales or use tax to his suppliers, he must report and pay the 4% Virginia use tax on all nontaxed purchases of tangible personal property except dentures and other prosthetic devices purchased from a dental laboratory or other supplier pursuant to a work order of the dentist. Consumer's use tax return, Form ST-7, is required to be filed by the twentieth of the month following the month in which the nontaxed purchase(s) was/were made.

It is requested that you apprise the members of your association of the application of the sales and use tax to their purchases and also inform them that they may avoid the required bookkeeping inherent with the filing of consumer's use tax returns by dealing only with out-of-state vendors who are registered to collect the Virginia tax, and do so by separately stating the

tax on their invoices as required by law (Virginia Code, Section 58-441.18).

Obviously, it would be to the advantage of any dentist continuing to deal with nonregistered out-of-state vendors to request each such vendor register for collection of the tax as a convenience to his Virginia customers. If sales into Virginia are substantial, the implication of the possible loss of such sales to other in or out-of-state vendors who are registered to collect the tax may be just the catalyst needed to effect voluntary registration of such nonregistered vendors. The Department will also contact any nonregistered out-of-state vendor making sales to your members if they (the dentist) will furnish the complete name and mailing address of the vendor as well as the nature of the merchandise and the amount of the sale to Mr. Henry L. Curry of this office.

Your cooperation in this important matter will be appreciated as well as helpful to your members and the Commonwealth. If there are any questions, or if we can offer assistance in any way, do not hesitate to contact us."

Frank W. Lewis, Director
Sales and Use Tax Division
Commonwealth of Virginia

January 2, 1979

Doctor George Burke
Editor, V.D.A. Journal
Virginia Dental Association
2015 Staples Mill Road
Richmond, Virginia

Dear George:

Component IV recently held the first of the all-day programs co-sponsored with the Virginia Dental Association. The day was a great success with the largest attendance we have ever had.

However I would like to share with other V.D.A. members, 2 areas which have produced discomfort and inconvenience to those who have endeavored to administer a great program:

1. The large number of members who deluged the office of Dr. Wiebusch on the last two days before the lecture.
2. The fact that 44 people made reservations and failed to attend.

Perhaps any dentist or office personnel who have had broken appointments by patients will be able to empathize with us in our dilemma.

Best Wishes,
L. T. Flippen, D.D.S.
President, Component IV

Dr. George Burke
Editor, *Virginia Dental Journal*
2015 Staples Mill Road
Richmond, Virginia 23230

Dear Dr. Burke:

The statewide program of dental continuing education in Virginia sponsored by the Virginia Dental Association deserves a round of applause. My introduction to this new addition to component meetings was Component 6's December meeting, where Dr. William Morris, an excellent speaker, provided us with an interesting program. The meeting ran smoothly, and the regular business session did not seem to be curtailed because of the addition.

The recently mailed schedule of coming meeting topics is widely varied and should provide the proverbial "something for everyone." Even the dentists who do not usually attend component meetings should be attracted by subjects ranging from hypnosis to pedodontics.

With mandatory professional continuing education sure to come for our profession as it has for medicine in the Commonwealth, these component-sponsored courses should be very popular. And the price is right. I have often spent much more for much less—and had to travel much farther.

The attraction of a well-known speaker along with continuing education credit should positively influence attendance at component meetings. The possibility of crossing over component lines to attend courses offers the extra advantage of more contact with our colleagues as well.

The concept of a program of continuing education at component meetings is timely and seems to be working well. Kudos!

Sincerely,
A. Carole Pratt, DDS

THE WHITE HOUSE

WASHINGTON

Dear Association Member:

President Carter has described to the American people his program for combating inflation, our most pressing economic problem. He is absolutely determined to make it succeed.

The program has three major planks--monetary and fiscal restraint by the Federal Government; reduction in the government regulations and interventions that inflate costs and interfere with competition; and the cooperation of all Americans in accepting voluntary standards.

In addition, the President announced on November 1 a complete set of actions to defend the dollar.

But governmental action alone is not enough. Success requires everyone's support. The President has therefore issued explicit standards. He has asked that pay raises in the coming year be held to 7% or less, and that the rate of increase in prices be cut at least 0.5% below the average rate of 1976 and 1977.

Some people have called for mandatory wage and price controls. The President has rejected this alternative because of the bureaucracy, distortions, and unfairness that mandatory controls inevitably involve.

The President's program strikes a balance that offers our best hope of bringing inflationary forces under control without plunging us into depression or putting the whole economy into a bureaucratic straightjacket.

Will it work? Consider the consequences of it not working. The plan has to work; asking whether it will is somewhat like asking "will America work?"

The administration of the wage and price standards is going to take much development; there will be thousands of individual questions and situations that will need to be brought to the attention of the Council on Wage and Price Stability. I urge you to do so.

You can reach us by writing me at 726 Jackson Place, N. W., Washington, D. C. 20506, or by calling 800-368-9191, or, in Washington, 456-6766.

Sincerely,

Alfred E. Kahn
Advisor to the President
on Inflation

CLINICAL CONTROVERSIES

Dr. Francis J. Filipowicz
School of Dentistry
VCU—Dept. of Oral Pathology
Box 637—MCV Station
Richmond, Va. 23298

Recent caries research has produced evidence suggesting that resistance of teeth to dental caries is provided not only by its structural component but also by physiological processes within the tooth. The key process is believed to be fluid movement from inside the tooth to the enamel surface.

Since the 1920's fluid movement within teeth has been demonstrated numerous times in humans and laboratory animals. The fluid movement is initiated in the odontoblastic processes and terminates on the enamel surface in the form of microscopic beads.

Recent animal experimentation has shown that the rate of fluid movement is under direct control of the parotid gland. A hormone is secreted by the parotid which stimulates fluid movement in the odontoblastic processes. The parotids are in turn directly controlled by the hypothalamus. This control mechanism of fluid movement in teeth has been named the hypothalamic—parotid gland endocrine axis.

Studies of fluid movement in the teeth of rats has disclosed a significant suppressive affect of dietary sucrose on the hypothalamic—parotid gland endocrine axis and fluid movement. There exists a direct correlation between this suppressed fluid movement and increased caries incidence. Rats on a cariogenic diet rich in sucrose generally have a tenfold increase in caries compared to rats on non-cariogenic diets.

The most significant feature of the hypothalamic—parotid gland endocrine axis as it relates to caries is that dietary sucrose suppresses this endocrine axis leading to suppression of fluid flow in teeth allowing the ingress of destructive micro-organisms and acids when conditions are favorable for caries. Demonstration of this ingress of destructive materials has been obtained using dyes placed in the oral cavities of rats on non-cariogenic and cariogenic diets. The dye fails to penetrate the enamel in the rats on non-cariogenic diets while deep penetration of the dye through the enamel is seen in rats on the cariogenic diet. The most recent studies in the area of fluid movement and caries have disclosed several compounds which as dietary additives stimulate the hypothalamic—parotid gland endocrine axis and fluid movement even in rats on high sucrose cariogenic diets. One compound in particular, carbamyl phosphate with egg shell for minerals and selected trace elements has produced promising results, reducing the caries incidence of rats on a cariogenic diet by 95-100%.

This new theory and related studies offers a possible new approach to human

caries prevention and control through systemic enhancement of the resistance capabilities of teeth.

Dennis G. Page, D.D.S.
Assistant Professor
MCV—Oral Pathology

If the above contribution from Dr. Page does not seem very significant, I suggest reading it again. The acidogenic and proteolytic theories of tooth decay satisfy many parameters of the initiation and progression of dental decay. Neither concept has universal acceptance. The acidogenic theory is a valid explanation of enamel caries while the proteolytic theory explains the carious process in cementum and dentin.

The theory of caries presented above does not deny either theory as valid. Acidogenic and proteolytic micro-organisms are still instrumental in the destructive process, but the reasons for their penetration and effectiveness can be accounted for in this new concept. An analogy would be the protective role attributed to crevicular fluid in the prevention of periodontal disease.

This new concept could explain the rampant caries seen in post-radiation patients with diminished salivary flow. It could also explain senile caries where salivary function is diminished.

This new knowledge further emphasizes the holistic approach to dentistry and the fact that caries management involves more than the technical skills of placing restorations or designing replacements. This concept bears serious consideration and comment on the clinical level.

F. J. Filipowicz

STATEWIDE PROGRAM OF DENTAL CONTINUING EDUCATION IN VIRGINIA CORRECTION

In the Virginia Dental Association's continuing education brochure mailed to you for the winter and spring of 1979 an error appears. The date for the Northern Virginia Dental Society's meeting will be May 9, 1979 at Airlie Foundation rather than May 12, 1979 which appears in the brochure. Please note this correction on your calendar.

TAKING THE INITIATIVE*

by Ronald J. Bognore

In Vancouver, British Columbia, where denturism has been legal for twenty years, a disco was opened in 1976 which enjoyed immediate success among the "in" people. Large, flashy, with three bars and an extensive dance area, the club demanded fashionable dress of its patrons and charged fashionable prices for its liquor. The owner was a wiry, balding man in his late sixties, Monsieur F. Under his approval, certain patrons in whom he took an interest were shown to a back room where a gaudy opulence prevailed. Fur couches, gigantic clam-shell love seats set in alcoves, silk draperies of overly loud colors, gilt cocktail tables with stupified cupids sporting unisex derrieres for the mildly voyeuristic, and complimentary drinks for the lucky invited few.

Monsieur F. had been a trucker all his life, moving up the economic scale from driver to owner to owner-manager of a small fleet of semis. At sixty-five he retired with enough money to realize a dream for his only son: he bought the thirty year old, careerless indolent offspring a nightclub. But he wisely retained ownership, and pretended to let his son manage the establishment. Only through the father's wisdom was the son's foolishness averted. Monsieur F. found that he was enjoying the club as much as his son, although the latter was most often found out in the dance area while the old man spent his time away from the insistence of the music in the quiet of the back room where he nightly met and entertained a wide variety of patrons. It was in that back room and under relaxed social conditions that I first heard what a real live member of the public thought of denturism.

"I don't know much about teeth," he said in the accent of a French-Canadian transplanted from Quebec, "because in Quebec where I come from, way up there in the northern sections, we used to have them all taken out as a wedding present from the groom's family to the bride. Her family did the same for the groom, if they could afford it. But it was very important that the groom's family do this special gift for the bride." He was clearly wearing dentures; they clicked continuously and the bite was visibly off.

"I didn't get married until I was over thirty, and by then I had moved here to Vancouver where they don't follow such customs. So I never gave my wife the present of being free from problems with her teeth. She doesn't wear dentures. She has a gum disease, and she needs to see a man to fix them every two weeks. I spend a lot of money on her mouth. But, you

* *Presented by Mr. Ronald J. Bognore, assistant secretary, Council on Prosthetic Services and Dental Laboratory Relations, American Dental Association, at the Virginia Dental Association Leadership Conference in Richmond, Virginia on November 11, 1978.*

can say," he added with a wink, "it's such a pretty mouth, it deserves the best."

Was the man who treated his wife a dentist?

"Yes, of course, a dentist. I told you, I only get the best for her. My son too, he goes to the same man."

And he, was he wearing dentures, and where did he get them?

"I went to the denture specialist man. No, not a dentist. The dentists cost too much. Besides, false teeth are false teeth. They always feel a little sore, but you don't have to worry about a toothache, no? Besides, the man who made them is a specialist in false teeth. Can I get you another drink?"

He obviously didn't know that the dental society in the province of British Columbia, right in downtown Vancouver, had established a clinic where people of all ages and of any income could obtain denture care at a cost which was within five dollars of the prices charged by the average denturist in the city. The clinic had been open nearly as long as the denturists were legal, close to two decades. During the first five years, the clinic had operated in the red, but the sixth year saw black, and the profits have continued to the present day. No one is refused care unless healthy teeth still exist in the mouth. The staff consists mainly of dentists who have come out of retirement to work part-time; many think it is the healthiest move they could make in their later years because the clinic affords them a continuous sense of being needed and rendering a service that is a logical extension of the careers they spent so long to build. Moreover, the majority of the patients are senior citizens, and there exists a camaraderie between patient and doctor that age alone establishes at once. Like Monsieur F., the founders of that clinic took the initiative to achieve a dream. Now that dream is a reality. You can visit the clinic and dance at the disco right now; they are both real places of business in Vancouver, British Columbia.

I returned from that Canadian visit in December of 1976 with an amazing number of quickly learnt experiences. I had met legal denturists and visited their offices. I had visited with the dental associations' representatives in Ontario and British Columbia. I had met a denturist's patient who showed me that he was satisfied completely with what my untrained eye told me were ill-fitting dentures, an opinion confirmed by two dentist colleagues who were with me. And I had been told by Canadian dentists that the dental profession in the United States will not believe what hit them when denturism comes to town in the lower forty-eight. The Canadian dentists told us back in the year of the Bicentennial that their U. S. counterparts had better take the initiative fast to squelch this social monster because, once it began, it would spread like an epidemic across our country just as it did in theirs. "Too little too late," was the excuse the dentists agreed was the reason that Canadian dentists could not stop the Canadian denturists. They also warned us of the "it can't happen here" syndrome which they promised

we American dentists would fall prey to, just as they themselves had from province to province.

Well it has happened here, and happened on a big scale.

Monsieur F. may be a real Canadian, but his is the soul of the American public in the late seventies: middle America has its priorities screwed up. People work hard in this country to achieve the American ideal, but after they make it, they remember what it was like on the way up, regardless of how many rungs of the success ladder they manage to climb, and they are reluctant to spend that hard-earned money on other than leisure. If a necessity—such as food—can be gotten at a discount, then the consumer will head for the sale. If dentures can be bought at wholesale, then to hell with the retail store. If you don't believe me, then listen to these doleful numbers.

On November 7, 1978 the voting public of the state of Oregon cast the following aspersion on the dental profession by the way of ballot box: the unofficial results of the initiative to allow denturists to work directly on the public in the state of Oregon, with 99.8% of the precincts reporting, were 77.7% for legalizing denturists and 22.3% against. With that overwhelming majority vote, the citizens of Oregon have instituted a law that abrogates all the protection of the public so many have worked so hard to ensure. Nearly seventy-eight percent, ladies and gentleman, voted against all the health arguments, voted against the dental profession, voted for the inception of an epidemic, voted for one of the worst types of denturism legislation.

This is the official reaction from the Headquarters building in Chicago:

"The American Dental Association believes Oregon voters have made an unwise decision in accepting Ballot Measure #5—the initiative to allow non-dentists to provide denture care directly to the public, without supervision by a licensed dentist.

"The consequences of this action could be serious. Oregon law no longer protects the public from the potential for inferior denture care rendered by individuals who are not trained to provide total denture care or total dental health care to patients. This lack of protection of the public health is likely to impact most heavily on the elderly citizens of Oregon.

"Quality denture care, which may expose serious conditions existing elsewhere in the body, is rendered only when thorough competence and ability in the complex biomedical processes of the mouth are assured through proper training and education. To consider complete denture care as simply the mechanical fabrication of dentures is to ignore the essential anatomic, physiologic and psychologic considerations.

"The Association therefore urges the citizens of Oregon to choose wisely those individuals who have the necessary educational training and qualifications to provide their denture care."

The unofficial reaction was: well,

now you know why I used the sixth letter of the alphabet for the name of the Canadian senior who owns the disco, the prototype of the American public's soul as represented by the citizens of Oregon.

We have lived through two other passages of denturism legislation: in Maine in 1977 and in Arizona earlier this year. So why such alarm at Oregon's action? The Maine and Arizona Acts placed the denturist under the supervision of a licensed dentist; Oregon's initiative does not.

Specifically, the legislation which becomes effective on July 1, 1980 permits denturists to provide complete dentures directly to public.

Also, it establishes a seven member State Advisory Council on Denture Technology under the Health Division of the Oregon Department of Human Resources to administer the law, such Council to be composed of

3 laymen
2 dentists, and
2 denturists.

The prescribed educational requirements to be licensed as a denturist in Oregan give the applicant two options:

—2 years of formal training and 2 years experience, or,

—a sixth month training course if, prior to July 1, 1982, the applicant has had six years of practical experience in denture technology (references to requirement of dentist supervision during six years of experience make the law unclear about whether or not experience as an "illegal operator" would comply with intent).

To ensure that the Health Division does not attempt to increase the educational requirements, a prohibition against the Health Division prescribing additional education or training requirements in excess to those specified in law is clearly defined in the language of the law.

An oral health certificate is required from a dentist or a physician dated within 30 days prior to treatment by a denturist. The certificate must state the "... oral cavity is substantially free from disease and mechanically sufficient to receive a denture."

Dental insurance policies after July 1, 1980 must include provisions for payments to denturists.

As a bit of irony, most likely unintended, the law requires the Health Division to establish policies and criteria for the assessment of the quality of the practice of denture technology. In other words, quality assurance mechanisms will be instituted for the denturists in Oregon.

That is what the fine print says. But if you think that the voters in Oregon were not given the opportunity to appreciate fully what they were voting on, let me read to you the ballot title as it appeared on every ballot right beside the box where those seventy-eight percent checked "yes".

"Measure authorizes taking oral impressions by licensed denturists, and constructing, repairing, fitting, etc. of dentures by licensed denturists or their assistants. Treatment requires dentist or physician's certificate that oral cavity is free from disease and suitable for denture. Establishes licensing requirements, creates Advisory Council

on Denture Technology within Health Division. Any dental insurance policy covering any service which may be performed by denturists must cover denturists' services. Major provisions of Act effective July 1, 1980".

What the voters did not read, although the media campaign by the dental profession stressed that the unqualified person would be allowed under this law to work in the oral cavity, is this:

"The prohibitions of this Act do not apply to . . . a person acting under the supervision of a denturist." Loosely translated into common English, that legalese means that a denturist in Oregon could, under the present provisions of the law, hire someone who has not even a grammar school education to work in the mouths of the people of Oregon. If that fact doesn't feel like a slap across the face of every dentist in this country, then there are a lot of malfunctioning maxillofacial nerve endings among the profession. There exists some question about the constitutionality of that section and a few others in the law which will be closely examined by legal counsel to determine whether or not the law can be challenged. But, remember, a bad law is still law until it is removed from the books through due process.

Without casting blame, but in the spirit of analysis to learn what went wrong in the Pacific Northwest last Tuesday, let us examine some of the events and attitudes which led to the passage of Ballot Measure Number Five. Let us, appropriately, begin with ourselves, our own actions and attitudes as a profession.

The dentist whose appointment book is filled and whose patients appear satisfied with his work sees little threat to his everyday routine. Even if denturism passed in his state, the probabilities are that he would continue to practice the same way with the same patients. After all, the denturists are going after those people who cannot now afford (or so the people think) to go to a licensed dentist. The denturist is not trying to steal this doctor's patients, so why should a dentist worry? That is the basis for the non-involvement of the average dentist with a good practice.

And yet, I can tell you with truth that when dental teams in Oregon took their dentists' patient lists and called to ask for support for the family dentist's stand on denturism, incredible numbers of voters, already in the dental delivery system, replied that they wanted a choice of dental providers, that they wanted a forced reduction of fees through this legislation, and that they were in support of the destruction of a monopoly. So much for the dentists' patients.

Our own professional press has contributed to this smug self assertiveness that "we are the good guys, we are noble professionals." For example, the *ADA News* on October 16, two short weeks before the election, did not ask the profession across the country to rally behind Oregon's cause. Instead, the top headlines read, "Dental profession is now 2nd in public confidence, according to Harris poll" and fed a false security that would soon

come crashing down on all those haloed heads. If one took the time to read more than the headlines, one would have seen that in response to the question, "How much confidence do you have in the following institutions or professions?" only 47% indicated that they had a "great deal" of confidence in the dental profession. One could hardly believe with conviction that the remaining percentage of the public, namely the majority, would be supportive of the dental profession's stand on issues with inherent controversy, such as denturism. Yes, we should emphasize the positive, but let us make sure that we are dealing with a real positive before we congratulate each other on our mutual wonderfulness.

For every two dentists who belly up to the bar at dental meetings to tell each other about the glories of dentistry, two other dentists are at the other end of the bar going for each other's philisophical throat. This in-house bickering, these differings of beliefs, lead as much as apathy to ineffectual public relations. If you don't agree with the strategy of access as a viable and real solution to the public's challenge, then step aside and allow your colleague who does believe in access to carry out his plan. Because, folks, access works; and all the arguments against access, including the fallacy that provision of low cost denture care will lead to a coerced reduction of all fees, fall flat in the face of successes such as Florida and Idaho. Those two states defeated denturism legislation this year on the strength of their access programs.

Watch: "Mr. Senator, Mr. Representative, we have no need for denturism in this state or for any other low cost care from unqualified individuals because, by God, the dentists of this state are already providing care at reduced fees for those who need financial assistance for health care needs. We take care, Senator, of the elderly and the indigent; we make available, Congressman, care at prices that can be afforded by those segments of your constituency which are on fixed incomes." That kind of statement cut ice in Florida this past spring; that kind of responsible response convinced the legislators in Idaho that quality care from dentists is the best alternative; that kind of statement should be emblazoned on the smocks of every dentist in these United States, because that kind of statement comes from the heart and the pocketbook—and if there are two areas of the human frame that our Hollywood-bred culture understands, they are the heart and the pocketbook.

I know you are working hard here in Virginia on increasing access to dental care for those who are in need of it. I applaud and commend you for it. But I urge those of your members who disagree with the need to advertise the availability of that access—not once, but continuously—to tuck their difference of opinion away in the closet with pneumatic drills, and let those of you who appreciate the drastic need to communicate the existence of such programs to the public get on with the job of good publicity.

At its most basic premise, advertising

purports simply to inform that a service or a product is available. Only the unethical turn advertising's nefarious cheek to the camera. Advertising is merely communication. Some people communicate better, more clearly, and more honestly than others; such is also the case with advertising. Hire yourself a public relations firm to get your message of available care out to the public in a form that is informative and correct. The American Dental Association has established policy through its House of Delegates to encourage advertising of access by your local and state societies. You will not be faulted; you will be lauded. Those states which have advertised the availability of reduced fee care—and Florida and Idaho are far from the only ones: you should ask Oklahoma for a copy of their radio spots in which a modern musical background accompanies a tasteful statement of what Oklahoma dentists are trying to do for their fellow Oklahomans—those advertising state societies are the leaders in thwarting the denturism movement. You owe it to yourselves, to the profession, and most importantly to the public whom you are trying to serve, to take a leadership role in this new approach to public education and the resolution of unmet dental needs in this country. If you want help from the American Dental Association, we stand ready and eager to assist you. Toll free.

Enough internal criticism. We are in no way solely responsible for the present situation. Other factors beyond our control have made significant contributions to the Oregon results. If you feel that the dental profession has been singled out for attack these days, you are missing the global point. Dentistry is currently caught in a backlash of consumer revolt. Because, as citizens, we want government programs that will protect us from fraud, abuse, and poor quality in everything from the foods we eat to the airplanes we ride to the drugs we take, we have allowed a governmental bureaucracy to exceed the boundaries of its powers. Under the white banner of consumerism, the Federal Trade Commission has infiltrated its cadre of lawyers into areas where it ought not to be. Health care may have business aspects to it, but its primary characteristic is a million DNA strands removed from business. And don't misunderstand, the FTC's comprehension of that sentence is levels below yours. Allow me to illustrate.

The San Francisco Regional Office of the Federal Trade Commission "intends to recommend that the Commission propose a trade regulation rule which may have a significant effect on existing state laws." We are talking about the potential for an FTC rule which will eliminate all the legislative battles over denturism by mandating that denturism become a national health policy of these United States. In the Commission's own words:

> "Non-dentists currently fabricate and evaluate the technical quality of complete dentures. The staff of this office believes that many non-dentists could also competently take impressions and fit dentures, and so could provide dentures of a quality equal to that required of dental

licensees. We further believe that such persons are likely to provide denture care at prices substantially below the prices at which most such care is currently offered in this country. By substantially reducing prices to consumers, denture care would become accessible to a great number of consumers who cannot now afford it. As denture care becomes more accessible, the incidence of ill-fitting and incomplete dentures is likely to decline. We have identified no risks in the denture care process or in the failure to obtain related dentists' care that would tend to outweigh this health benefit.

"Accordingly, the rule contemplated by the staff of this office would prevent the enforcement of current dental laws against non-dentists who provide, directly to consumers, complete dentures of quality acceptable under prevailing standards of dental practice, provided that such persons advise consumers of the desirability of obtaining an examination for oral disease from a dentist and other pertinent information. It would further permit such persons to sell dentures to dentists and to purchase dentures for resale from dental laboratories."

If you find that set of statements naive from a scientific standpoint, brace yourself for the testimony excerpts from statements made by representatives of the San Francisco Regional Office of the FTC before the Council on State Governments' Task Force in Anaheim on October 24, 1978, representatives who had the affrontery to disclaim that they were *not* speaking for the Commission, even though it was their association with the FTC which permitted them to appear on the program in the first place:

"First, denturism would produce an immediate increase in the number of firms providing denture care to consumers by removing the barrier to entry created by the requirement of a full dental education. Moreover, in the absence of a personal reputation for superiority or other characteristics making these firms peculiarly desirable as a source of denture care, these firms would be required to compete with dentists on the basis of price. And assuming that restrictions on the form and operations of these firms are as limited as the restrictions on dentists' practices would be under the Suggested Act, these firms would also have to compete with each other on the basis of price. Thus, in contrast to the use of dental prosthetic auxiliaries, denturism would not only create additional firms to compete in supplying denture care, but firms whose ability to compete would depend, in large part, on providing such care at lower prices.

"Second, denturism would reduce to the greatest extent possible the investment necessary to enter the market for denture care. No personnel need recoup the costs of the training and education necessary to provide a full range of dental services, or for that matter, even prosthetic services other than complete dentures. Nor need an investment be made in equipment and supplies to perform those other services. This

will clearly reduce the costs to the firm of providing denture services. Presumably, competition among such firms will require that these cost savings be passed on to consumers.

"Finally, denturist firms can reach a minimum efficient scale of operations at a much smaller size than practices employing both dentists and dental prosthetic auxiliaries. In other words, even while serving much fewer patients than practices which include a dentist, denturist practices can be both profitable and low priced. This is no small consideration in light of the fact that approximately 45% of our edentulous population resides outside of standard metropolitan statistical areas, in rural areas where population density is low. Moreover, whether located in central cities or rural areas, denturists can offer to low income consumers some of the variety in practice setting which is now available only to those who can afford to pay higher prices. This non-price factor may be especially important with respect to denture care, in which psychological factors may determine the success or failure of treatment."

May I assure you that in Canada the denturists uniformly set up their practices in large metropolitan areas. The simple fact is that rural areas contain insufficient numbers of edentulous persons who are in need of first-time or replacement dentures to support a denturist. The situation in Ontario has deteriorated even in the metropolitan areas where denturists have dried up the pool of edentulous mouths; some have returned to commercial laboratories; others have sought employment in totally different fields. Those who are hanging on to their denturism vocation are now seeking legislation to allow them to provide partial dentures directly to the public.

Denturism's main characteristic is that of inherent obsolescence. The proof can be shown through computer simulation of population growths, preventive dentistry orientation, retention of teeth by larger and larger numbers of people, and the trend toward the elimination of the edentulous mouth as a human condition.

The public is in revolt. We are at the threshold of an economic revolution which may or may not be realized. The proposition 13 type of tax relief legislation is spreading; people want to escape from rising costs. Dentistry is caught in the crossfire of the FTC, the denturists, and an insurrecting public. Social change is progressing at an accelerating rate, and dentistry must keep abreast of that change. Your handpieces may one day contain laser beams to eradicate decay; and you will adapt. You have in the past, and you know you will in the future. Well, some of the future is here today, and you must adapt.

Have you noticed the pattern of denturism legislation which has thus far been passed? First Maine, a New England state, the uppermost right corner of this country; secondly Arizona, the lowermost left corner of this country; and now, Oregon, just one state below the uppermost left corner of this country. I am not worried much

about Florida because of their access programs. That leaves me floundering somewhere around in the South in order to complete the symmetry. That should leave you with more concern than other parts of the country have for this coming year. We are being surrounded by the enemy, ladies and gentlemen. If the ADA is the heart of the profession, then look to the midwest to be choked by an ever tightening circle until the end finally arrives with a fatal stroke of a legislative pen.

We do not have to lose this battle. The FTC, like all bureaucracies which grow at rates unequal to their capabilities, will eventually fall, broken-winged and bleeding, a splintered arm of the federal government; and the feds into whose bailiwick they have sidled will weep no more tears than we will. The denturists will, to use the vernacular, pig out on their own greed until they consume themselves in a grotesque gummy death. And Oregonians will one day become educated to the folly they have foistered upon themselves and their grandparents, and in so doing will renounce their new law. I believe those things will come to pass because I believe the lessons of history, and I believe in American dentistry. I know that the gloves are going to come off and the bare knuckles will whiten for the fight because American dentists will not take any more of this lying down. You will fight for the public you serve, you will fight for the need for quality education for dental providers; you will fight for the future generation of dentists; and you will win—by belief in yourselves, by hard work, by God. *You will win.* Otherwise, this country and its principles will fall like Rome's Empire, and I don't believe America is sufficiently corrupted to so crumble —because I believe, I *have* to believe, in Americans, in you and the work you do. Now show the rest of the country and get them to believe as I do by meeting the consumer challenge through well publicized access. So help me, so help you, in this way *you will win.*

Conducting Community Health Education with Dental Student Teams

*Steven B. Zucker, D.M.D., M.Ed.**

Over the past five years dental students at the Medical College of Virginia School of Dentistry have been conducting a variety of dental health education programs in various community settings. These programs are a component of their community dentistry coursework during their freshman year. The objectives of these programs are: (1) to have each dental student acquire experience in conducting dental health education programs in community settings; (2) to have each dental student learn to identify dental needs of indigent populations; (3) to aid each student to recognize his responsibilities to the public as a practicing dentist; (4) to give students the opportunity to work in group settings; (5) to tap the creative abilities of students in community problem solving; and (6) to provide dental health education to as many groups, agencies, and individuals as possible.

The sites are selected to give as much diversity to projects as possible. Among the sites that have been utilized are rural and urban school systems, day care centers, senior citizens homes, boys' clubs, neighborhood health centers, and several institutions for the handicapped.

The students' teams begin their programs by visiting chosen community sites, and participating in field seminars where they meet with a representative from the site to discuss how the facility is operated and funded, and how it is related to particular community needs. They then meet with faculty advisors to develop their preventive dentistry programs according to needs of each individual site.

While all programs include an instructional and motivational component in preventive oral disease control, the methodology by which each group presents its preventive dentistry program varies considerably. Most of the student groups use several forms of audiovisual media to supplement their instructional activities. Several groups have developed their own skits and plays (including scripts and costumes) to perform in auditoriums, gyms, or other meeting rooms. Contests and games have been devised and brush-ins implemented to help stimulate interest in preventive dentistry. Puppet shows and coloring books are other motivational tactics that have been utilized. All groups attempt to develop in their program a lasting effect that will continue after visits to the sites end. To this end, they work with teachers, school nurses, and often parent groups at the sites.

All groups associated with these programs have been extremely positive about the results of their efforts. It is estimated that over 10,000 children

* *Assist. Prof., Department of Community Dentistry, MCV/VCU.*

and adults have benefited from these programs over the past five years, and at least 2000-3000 more will benefit in each succeeding year. Administrators and staff at field sites have responded extremely favorably to these programs with numerous letters of appreciation being received each year, and 95 percent of the sites have expressed an interest in continuing in the program. Dental student reaction to these programs is similarly favorable.

The effect of the student based community programs goes far beyond a limited number of visits for instruction in preventive dentistry. Students gain experience in understanding needs of special population groups they would not otherwise come into contact with in their dental training. This exposure to all different types of individuals will hopefully broaden their horizons in their future dental practice. One such program involving preventive dentistry for the visually handicapped recently was awarded first place in the National Preventive Dentistry Contest (A.S.D.A.). The program at the Boys' Club in Richmond was so well received that reports of it were published in a national Boys' Club publication in attempts to foster preventive dentistry programs in boys' clubs on a national basis.

The effectiveness of these programs produced by the dental students in a relatively short period of time in addition to a full dental school schedule is commendable. Citizens of Virginia can look forward for years to come to a large pool of dentists sensitive to the needs of their special population groups and experienced in working with these individuals and with special community sites.

RESEARCH NEWS

Availability of a report on animal tests of technical-grade iodoform for cancer-causing activity (carcinogenicity) was announced by HEW's National Cancer Institute in today's *Federal Register*.

Iodoform, an antiseptic, was given orally by stomach tube to rats and mice for 78 weeks. According to a summary of the report included in the announcement, the compound was not carcinogenic under the test conditions.

The tests are part of the Institute's Bioassay Program. Copies of the report, Bioassay of Iodoform for Possible Carcinogenicity, are available from the Office of Cancer Communications, National Cancer Institute, Bethesda, Maryland 20014.

EXPANDED DUTIES FOR DENTAL ANCILLARIES: THREAT OR TREAT†

*John H. Mosteller, D.D.S.**

In January, I participated on a panel at the Dallas Mid-Winter Dental Clinic which considered the question, EXPANDED DUTIES FOR DENTAL AUXILIARIES: PRO AND CON. The panel was composed of two protagonists, (Dr. Omer K. Reed of Phoenix, Arizona and Dr. Smith R. Armstrong of Lexington, Kentucky) who advocated expanded duties for dental ancillaries which included most of the procedures normally performed by dentists; and two antagonists, who opposed what would seem to be a laudatory and progressive notion. Due to our reputations as conservatives, Dr. Charles M. Stebner of Laramie, Wyoming and I were cast in the roles of antagonists. I hated to disappoint the program chairman, for I was deeply honored to be on the program of the Dallas Mid-Winter Dental Clinic for the fifth time over a span of 24 years and I hope to be invited back because they are always so kind and gracious to both Janet and me when we visit Texas; but I am a very poor antagonist. I am known as an innovator of new ideas and technics, not as the foil of other champions of noble causes.

Some claim a notable exception occurred during the near hysteria of the preventive dentistry renescence a few years ago, but I was never against preventive dentistry; I was against hucksterism. When I criticized the hucksters who were trying to commercialize the movement, they accused me of being anti-prevention. They said restorative dentists like me felt threatened by the effect of preventive dentistry on our discipline. Threatened, indeed. The value of good restorative dentistry is still just as great and just as highly respected, while most of them have disappeared back into the woodwork. A few of them are still visible at dental podia, but now they usually talk about expanded duties for dental ancillaries; and if you will keep paying to hear them, they will keep finding other subjects to talk about.

Conservatism

I am a conservative, if that label means I am dedicated to conserving all that is good and fine about dentistry and to working for its continued improvement; and therefore I am bitterly opposed to any efforts by government bureaucrats, social do-gooders and opportunists, as well as those who have been influenced by these three groups, to destroy America's traditional dental health care delivery system.

†*Presented before the House of Delegates at the 109th Annual Meeting of the Virginia Dental Association in Roanoke, Virginia on September 17, 1978.*

* *Clinical Professor of Dentistry, University of Alabama in Birmingham, School of Dentistry; Editor of the JOURNAL of the Alabama Dental Association; and First Vice-President of the American Dental Association.*

Increased Utilization of Dental Ancillaries

I utilized the concept of "four-handed dentistry" long before it was suggested in the literature by people with little or no experience in private practice. I was considered a progressive advocate of the increased utilization of ancillary personnel many years ago. One of my adversaries on the panel in Dallas, Dr. Reed, devoted much of his formal presentation to quoting from my writings on the subject 10 and even 20 years ago. He asked why I had changed from a liberal proponent of the increased utilization of dental ancillaries to a conservative opponent of expanded duties for the same people? I haven't changed; the two propositions are completely different.

Ten years ago, if a patient came to my office, while I was absent, because she had lost a temporary filling, it was against the law for my assistant to replace it. That was ludicrous, when the physician in the next suite could hire girls off the street and train them to inject parenteral medications. So, I suggested reforms in our State Dental Practice Act, which were obtained. I still support those reforms, but they do not permit dental ancillaries to practice dentistry by any stretch of the imagination.

As an analogy, 20 years ago, I also advocated comprehensive sex education for adolescents. Some people called me progressive and others said I was the devil's partner. I still support that concept but I deeply believe in conjugal love and bitterly condemn promiscuity.

I have great respect and affection for dental assistants, dental hygienists and dental laboratory technicians. I could not perform the way I do without them, but those who wish to practice dentistry should first obtain a college education and then go to dental school and earn a dental degree. Dental ancillaries who are not fulfilled by their present occupation, should seek another career.

Denturists

The denturists, who are illegal in all but one of our 50 states, would like to assume the responsibility of full denture prosthesis. After that, it would be partial denture prosthesis and we have no one to blame but ourselves. In our enthusiasm to maintain patients' natural dentitions, we have neglected the edentulous. Many dentists refuse to make dentures and others quote prohibitive fees, which has the same effect. The prosthetic department has become a stepchild at many dental schools and some state boards have eliminated most of their requirements in full and partial denture prosthesis. No wonder the denturists, or whatever these illegal dental laboratory technicians call themselves, believe they can convince state legislatures that they can provide full and partial dentures, which are as good or better than those available from dentists and at less expense to the patient, or to the third party purchaser of dental care.

Denturists have been legalized in the State of Maine, but they may treat patients only under the direct supervision of a licensed dentist. The first group of denturists to be edu-

cated under the provisions of this law have not completed their training, but many of the original denturists, who were licensed by credentials, are unable to find employment. Very few dental offices can justify economically the hiring of such an expensive dental ancillary. Denturists are designed to work independently or else in a "denture mill." They do not fit into a comprehensive dental health care practice.

After the dental profession has trained and licensed a hundred or more denturists in Maine, who cannot obtain employment, you can be sure legislation will be passed allowing them to treat patients independently.

The Attitude of HEW

A "Discussion Paper on Benefits under National Health Insurance," prepared by the Department of Health, Education and Welfare and sent to President Carter on October 28, 1977, stated the following:

> "Dentures for all edentulous persons would add an essential health service but be excessively expensive. This could be ameliorated by direct purchase from the lowest cost providers."

If we don't know what that means, we are, indeed, naive.

Dental Hygienists

The same document asserts, "Most United States dental hygienists fail to use their full range of skills for which they have been trained, much less for which they could be trained." Then, it goes on to say that many countries, less affluent than the United States, provide their citizens with a wide range of services by training dental nurses and dental hygienists to extract and fill teeth. It reports that the U.S. does train "dental professionals" other than dentists (I take exception with the term, dental professionals) but in most states their duties are restricted by law to assisting the dentists and providing minor care of patients. HEW's attitude has encouraged the American Dental Hygienists' Association to lobby in several state legislatures for primary health care provider status.

Many dental hygienists hope to practice in their own offices without the supervision of a dentist. Once they obtain this independence, they plan to provide all phases of periodontal therapy. They are confident they can demonstrate, under the helpful guise of clinical research at some cooperative university dental school, that they can be trained to do all these procedures as well or better than dentists and at less expense to the patient or to the dental care purchaser, whether it be the government or some other third party.

The coup de grâce, however, is HEW's contention that the current delivery system for dental prophylaxis and periodontal therapy is not only too expensive but also it is "difficult to control the quality of service rendered." Supposedly, both of these deficiencies can be corrected by having other "dental professionals," as they are called, provide the services.

One Eastern state is considering the addition of full denture prosthesis to

its dental hygiene curriculum. Some of its dental leaders believe it would be better to allow dental hygientists to provide patients with dentures, under the direct supervision of a dentist, than to license independent denturists. However, if dental hygienists are designated primary health care providers, and according to their national organization that is what they seek, dentistry will still lose full denture prosthesis even though denturists, per se, are not legalized.

Dental Therapists

Some advocates of expanded duty ancillaries, or EDA's, want to teach and license these people to administer local anesthesia, prepare cavaties and restore, as well as extract, teeth. The HEW report concedes that dental care under National Health Insurance will be possible only through the establishment of "an innovative low cost delivery system." It conjectures that training and licensing dental nurses, or whatever you wish to call them, coupled with nation-wide flouridation of all local water supplies would allow the federal government to provide dental benefits under NHI. This estimate is based on an annual income of $10,000 to $12,000 for these new "dental professionals."

New Zealand's Program

New Zealand trains and license school dental nurses, who treat young children under a socialized dental health program. In a recent pamphlet, the nurses claimed their skills and talents are being wasted. They want to treat young adults and be called school dentists, rather than school dental nurses.

The New Zealand dental nurses say they "teach a much fuller programme of dental care than private dentists... (and) are trained to do about 90% of the work done by dentists." Perhaps, they do 90% of the procedures performed by New Zealand dentists, but they do less than 10% of the procedures I perform in my practice. They are not dentists any more than I am an Ethiopian astronaut.

I have no objections to a dental assistant, dental hygientist or dental laboratory technician becoming a dentist. I admire those who have. The chairman of fixed partial denture prosthesis at the University of Alabama School of Dentistry, Dr. William D. Powell, is a former dental laboratory technician; and there is no other dentist in the world whom I respect more. But, let the ancillaries come up to the educational level of our profession; don't lower our level to their's. I am considered an outstanding dentist by my colleagues and I still have difficulties treating many patients in spite of my education, experience and skill. How can you expect a nonprofessional to practice comprehensive quality dentistry.

The Advocates

Who, besides federal government bureaucrats, who specialize in solving problems that don't exist and in creating jobs that are unnecessary, advocates our relinquishing most of the professional duties we have traditionally performed? One small group is the previously identified social do-

gooders. Some of these people are trained sociologists, but most are amateur ideologists. They can be found in dental education, public health and even private practice; but more often they are not dentists. They are laymen with a poor appreciation of dental health care and a strong conviction that American dentists are over-educated and over-compensated for what we do.

The third squad of this small but devastating four-squad platoon is made up of opportunists who envision a profit from employing dental ancillaries to treat their patients. The enthusiastic members of the fourth squad, which could grow into a battalion or even an army, are dentists who have been misinformed by the first three groups.

What Should We Do?

What should we do? The first thing we dentists should do is get our heads on straight and stop allowing those who advocate the forfeit of our profession to snow job us. We must recognize the dangers of training non-professionals to provide patients with professional dental health services.

Sociologists are amazed by dentistry's progress, in less than a century, from an often lampooned quasi-profession to the third most respected vocation in America. The clergy, government, law, engineering, pharmacy, architecture and accounting are all hundreds of years old and yet sociological studies reveal that only physicians and prominent higher educators are held in greater esteem than dentists by the American public.

Dilution

Beware of those who would destroy our profession by dilution. If we give periodontics to the dental hygienists; relinquish prosthodontics to the denturists and surrender restorative dentistry to EDA's, dental nurses and dental therapists; we will have orthodontics, endodontics and oral surgery left, at least for a while.

Why should an orthodontist spend four years in college, four years in dental school and two years in a graduate orthodontic program to learn how to straighten a kid's teeth? I am sure someone can design an 18-month curriculum to train people to do orthodontics, without a college education and dental degree as pre-requisites.

Endodontics

With all due respect to my friends who are edondontists, I would not like to spend the rest of my life treating and filling root canals; but I am confident a group of intelligent and ambitious people, with reasonable dexterity, could be taught to do root canal therapy without the scientific education received by dentists.

Oral Surgery

Dental therapists are anxious to learn how to extract teeth and the HEW game plan is for them to do "routine extractions," whatever that means. Physicians control most hospital staffs, so it is reasonable to assume they will allow only those with doctorate degrees to perform sophisticated oral surgery. We might end up with a dental health care delivery

system similar to some European countries, where there are a few stomatologists with a doctor's degree and many other dental practitioners, without doctorates, who provide most of the dental health care.

Our federal government already tells physicians how long their patients may stay in a hospital with a particular disease and how long they may convalesce after a certain surgical operation, if either the patient or the hospital is receiving federal aid. The idea of HEW certifying others than physicians and dentists to perform oral surgery in a hospital setting is not preposterous.

So, don't feel too secure or believe you are immune to this threat, regardless of your dental discipline.

We Must Do The Following

Rather than lobby for new state dental practice acts, which would rob us of our exclusive right and privilege to practice our profession, we must fight to retain our present state laws regulating the practice of dentistry. Rather than become accessories to the demise of America's dental health care delivery system, we must demonstrate to the public and convince state legislators it is in the public's best interest to preserve the traditional professionalism in dentistry. We must maintain complete control over our ancillary employees; we must accept the full responsibility of their training; and, lastly, we must insist upon a moratorium on the training of ancillary personnel, even under the guise of research, to perform procedures that are against the law.

Conclusions

The bureaucrats, social do-gooders and opportunists will never destroy our dental health care delivery system, unless American dentists capitulate and become their allies; because the vast majority of this nation's population do not want non-professional dental health care and they will not accept it, unless the dental profession, itself, bestows respectability upon interlopers.

REVIEW OF SECOND SESSION OF THE 95th CONGRESS

For a variety of reasons the 95th was not a health oriented Congress. One factor was the Administration's apparent lack of interest in the broad range of health issues, including various program extensions, which could have been acted upon by the Congress during the past two years.

The Congressional focus on issues such as energy and taxes reduced the opportunities for consideration of legislation in other areas, including health. The major portion of the time Congress set aside for health matters was used in extending and amending existing programs. Even this relatively noncontroversial activity was not completed until the final 34-hour marathon weekend of this Congress when a spate of health extensions was approved. Because of the last minute rush to adjournment Congress did not adopt one major health extension, the health planning law amendments. The existing planning law was simply extended under a continuing resolution. Amendments to the planning law will be an early item of business for the 96th Congress.

Following is a summary of the health activities of the second session of the 95th Congress:

Bill Number	Description
H.R. 13611—Rogers (D-FL) S. 1392—Ribicoff (D-CN)	*Child Health Assurance Act (CHAP)*—Approved by House Commerce Committee and Senate Finance Committee, but no final action in either House.
H.R. 10553—Rogers (D-FL) S. 2474—Kennedy (D-MA)	*Health Services and Centers Amendments*—Passed by Congress and signed into law by President. (Conferees approved, but final bill omitted fluoridation funds.) P.L. 95-626.
S. 2466—Kennedy (D-MA)	*Health Services Research, Health Statistics, and Health Care Technology Act*—Passed by Congress, including H.R. 12584, an amendment to the health manpower law to waive dental school capitation requirements—P.L. 95-623.
H.R. 3053—Corman (D-CA) S. 1197—Dole (R-KN)	*Medicare Amendment* to clarify reimbursement of covered services provided by dentists and to expand coverage of hospital expenses for dental patients. Passed Senate and House as part of H.R. 13097 and S. 1470. No final action.

Bill Number	Description
H.R. 13817—Rostenkowski (D-IL) S. 3506—Hathaway (D-ME)	*PSRO Amendments*—Passed the House, no final action in Senate.
S. 3085—McGovern (D-SD)	*Child Nutrition and School Lunch Amendments* — Passed Congress and signed into law—P.L. 95-627.
H.R. 3816—Eckhardt (D-TX) S. 1288—Ford (D-KY)	*FTC Amendments of 1978* (provision expanding FTC authority over nonprofit organizations deleted from both bills). Second Conference Report defeated on House floor because of House insistence on legislative veto provision.
H.R. 13304—Flowers (D-AL)	*Amendment to exempt health professions organizations from antitrust laws*—Referred to House Commerce and Judiciary Committees. No committee action.
H.R. 14320—Ford (D-TN)	*Medicare amendment to provide dental care under Part B.* Referred to Ways and Means Committee.
H.R. 12929—Flood (D-PA)	*Fiscal 1979 Labor-HEW Appropriations* —Passed by Congress and signed into law by President, P.L. 95-480.
S. 2450—Kennedy (D-MA)	*Community Mental Health Centers and Biomedical Research Extension Act*—Includes nutrition study, ionizing radiation research, and commission to study ethical problems in biomedical research, P.L. 95-622.
H.R. 11488—Rogers (D-FL) S. 2410—Schweiker (R-PA)	*National Health Planning and Resources Development Act Amendments*—Passed by Senate, House passed substitute one year extension of existing programs by continuing resolution, P.L. 95-482.
H.R. 13266—Rogers (D-FL) S. 2534—Schweiker (R-PA)	*Health Maintenance Organization Act Amendments of 1978*—Passed by Congress and signed into law by President, P.L. 95-559.

H.R. 6038—Price (D-IL)	*Army-Air Force Dental Corps bill*—Amended by Congress and signed into law as part of 1979 Defense authorization bill.
H.R. 6575—Rogers (D-FL) and Rostenkowski (D-IL) S. 1391—Kennedy (D-MA)	*Hospital Cost Containment Act*—Modified version passed by Senate, no final action.
H.R. 6221—Rogers (D-FL) S. 705—Javits (R-NY)	*Clinical Laboratory Improvement Act*—Passed Senate and approved by House Commerce Committee. No final action.
H.R. 13315—Thompson (D-NJ) S. 926—Clark (D-IA)	*Public Financing of Congressional Elections*—Defeated by House and Senate.
H.R. 8494—Rodino (D-NJ) S. 1785—Kennedy (D-MA)	*Lobbying Reform Act* — Passed by House, markup begun, but not completed by Senate Governmental Affairs Committee.
H.R. 12980—Rogers (D-FL) S. 2755—Kennedy (D-MA)	*Drug Regulation Reform Act of 1978*—To amend drug approval and labeling requirements. Extensive markup begun by House Commerce and Senate Human Resources Subcommittees. No final action.

Congressional Elections

The makeup of the 96th Congress on a party basis will not differ dramatically from the 95th. However, there is a feeling that many of the members of Congress from both parties who will be serving their first term next year are more conservative than those who have been replaced. It also may well be that those who have been reelected or those Senators who were not up for election will be somewhat more conservative than in the past, at least with regard to fiscal matters, because of the current national movement in this direction.

In the House there will be 12 more Republican members in the 96th Congress than there were in the 95th. This relatively modest pickup in seats will result in 276 Democrats and 159 Republicans. In the Senate there was an increase of 3 Republicans, giving a final Democratic majority of 59 to 41.

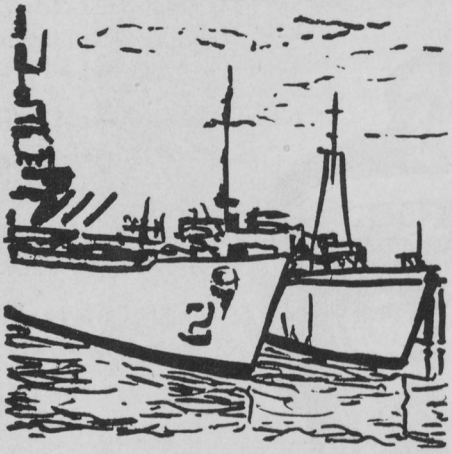
The VDA Legislative Committee and liaison dentists will have a luncheon meeting with our National Legislators on April 23, 1979.

Robert M. Lawrence, Jr., D.D.S.
Chairman, Legislative Committee

NEW DENTAL COMMANDER IN NORFOLK

The Virginia Dental Association takes great pride in welcoming Rear Admiral John B. Holmes, DC, USN, to the Virginia Dental Community. Admiral Holmes recently assumed command of the Naval Regional Dental Center, Norfolk, Virginia 23511. Our best wishes go with him as he undertakes responsibility of this important health mission.

COMPONENT NEWS



COMPONENT I

VIRGINIA TIDEWATER DENTAL ASSOCIATION

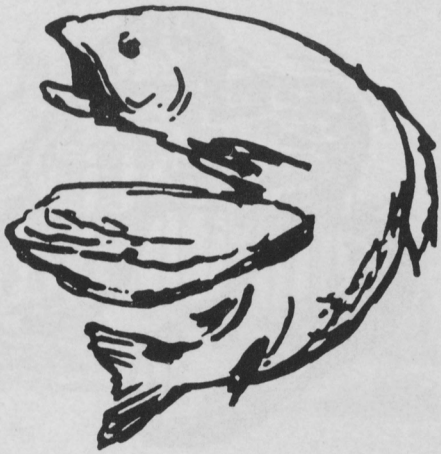
Cecil J. Carroll

Associate Editor

A well deserved Merry Christmas present for dentistry was published in December's "Money" magazine. In a poll entitled "Services That Work Best and Worst", dentists capped the lists (pardon the pun). Dentists were judged to perform their service more completely and thoroughly than anyone else. On a scale of 5.00, dentists recorded a winning 3.90; railroads pulled in last with 2.31 (pardon that pun, too).

Every dentist is invited to the Third Annual Southeastern Virginia Dental Symposium in Williamsburg on March 15-17. This event is co-sponsored by Components #1 and #2 and will present Paul Randle, Ph.D., on the first day speaking on "Financial Management for the Whole Dental Team". The next two days, Dr. Robert P. McGraw will persent "Effective Practical Administration—The Way to Stress Free Practice."

With the burgeoning number of Dentists in Tidewater, a new philosophy seems to be emerging regarding treating another's regular patients. I can remember years ago having a patient of mine treated in my absence by another dentist; on my return, I received a call from the doctor advising me of his emergency treatment and of the patient's further needs which were then appointed in my office. A similar case happened this year, but it seems that the emergency treatment required five appointments —three to complete a root canal therapy and two more for a crown. Our office was informed of this only by the patient when he called for his routine check-up appointment. Oh, well, there does seem to be a shortage of patients.



COMPONENT II

PENINSULA DENTAL SOCIETY

Mayer G. Levy
Associate Editor

"It is now my pleasure to call forward Doctor Marvin Kaplan, today's recipient of Dental Society Treasurer of the Century Award." Oh, Marv didn't design some new budgetary scheme. He did better than that. At the regular December Society meeting, Marv began the usual dreary opening reports by acknowledging that they are just that. Then . . . a la Gilbert & Sullivan, he sang his reports with lyrics that you wouldn't believe. It was so fantastic that we still hardly believe it. Thank you, Marvin Kaplan.

At the same meeting, Fred Davis, M.D. pathologist, presented a delightful after-dinner program on colorectal cancer. We are thankful to Doctor Davis for conducting a colorectal cancer screening program for the Society. Each member had available a home kit for detecting occult blood in self screening. If you are interested in a similar program for your society, contact Mayer Levy.

In November, the Peninsula Dental Society entertained at our annual Legislators' Seafood Feast. It must be all that good seafood that makes Pat Watkins so attractively effective with our lawmakers. Of course, she does the same thing over beef.

We continue to have regular radio, television, and newspaper contributions by Society dentists. If we can advertise the benefits of good dentistry, maybe that sort of advertising is a service to the consumer.

The Society has renewed its contract with the agency that operates our Executive Offices. The phone number remains 804-244-4498.

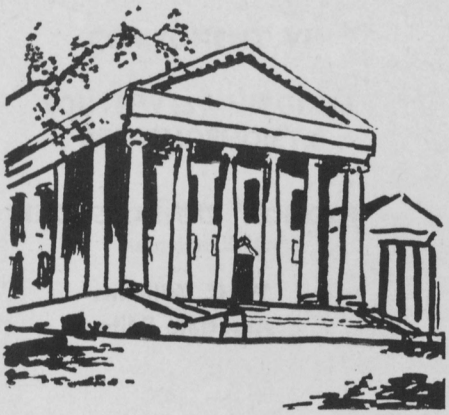
COMPONENT III
SOUTHSIDE DENTAL SOCIETY

A. Wright Pond
Associate Editor

Our February 7, 1979 meeting was held at the Ramada Inn in Petersburg. Dr. Ted Olenburg, Chairman of the Department of Pedodontics at the University of North Carolina, delivered a program on the subject of "Pedodontics."

A more thorough report on our business session at this meeting will be presented in our next issue of the *Journal.*

This is an important change. The speaker for our Saturday, May 5, 1979 meeting in Williamsburg has been changed. Dr. Preston has cancelled this appointment with us, and we are having Dr. R. E. Jordon, Professor and Chairman of the Department of Restorative Dentistry at the University of Western Ontario in London Ontario, Canada. We are looking forward to a very interesting meeting. This Williamsburg meeting will be at the Cascades Motor Lodge.



COMPONENT IV

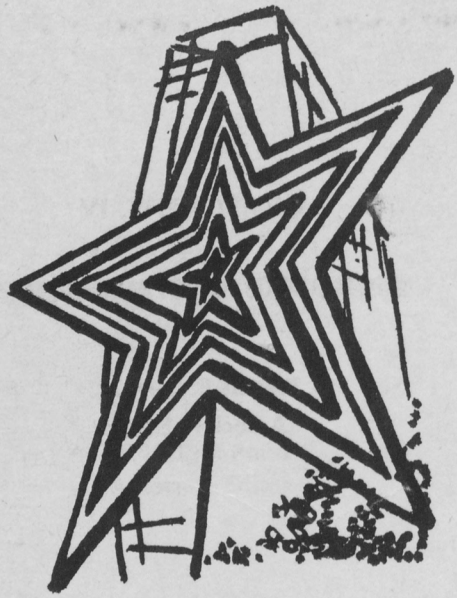
RICHMOND DENTAL SOCIETY

Francis F. Carr, Jr.
Associate Editor

There is no slowing down of our octogenarian member, Dr. Franklin Adair Tyler; and a delight it is to behold. Frank is a 33° Mason and one of 200 members of the Royal Order of Scotland. Looking for "Roots", he and twenty of the Brothers with their wives visited Scotland July 4, 1978. After arrival several days were filled with a busy schedule that included tours in deluxe buses to places of special interest, banquets, luncheons, and meetings. One of the numerous highlights during the trip was a social visit with Lord and Lady Elgin of "Kincardine" where the entire group was entertained graciously at their lovely home. Another highlight was a visit to the Castle formerly occupied by the tragic figure, Mary Queen of Scots and where she dwelt during the early years of her sad and unhappy life; but, her son, who became King James I of England and is associated with the King James version of the Holy Bible, lived to boast that he was the first English Freemason to wear a Crown.

To say the least, a great time was had by all as they stood on ground that was sometimes hallowed. They returned home tired and weary but full of beautiful memories.

With the passing of Dr. Samuel Kent of Danville, Frank is the remaining member of his Class of 1915; with his zesty spirit and limitless storehouse of energy he plans more travels and further stories to be written for our pleasure.



COMPONENT V

PIEDMONT DENTAL SOCIETY

W. C. Williams
Associate Editor

Now hear this—Again let it be said that the semi-annual meeting will be March 9 and 10 at Hotel Roanoke. Clinician will be Dr. Joel Leeb, Assistant Professor and Chairman, Department of Endodontics, School of Dentistry, University of North Carolina. Dr. Leeb's curriculum vitae fills six pages, highlighted by many original articles and textbooks—so the speaker is well qualified. Tentative outline calls for Friday morning to be devoted to diagnosis, treatment planning and emergency care. In the afternoon, surgery will be discussed. Saturday morning will treat technical endodontics and post treatment care of the tooth. This sounds like a fine program and all for the price of the luncheon, if you are one of the Brothers of the VDA.

The Roanoke Valley Dental Society had an interesting full day meeting at VA Hospital on January 10. Dr. Ernest Mingledorff, Chairman of C&B Department at Temple, discussed commonly encountered problems in C&B, with special emphasis of porcelain fused to metal restorations.

COMPONENT VI

SOUTHWEST VIRGINIA DENTAL SOCIETY

A. Carole Pratt
Associate Editor

The Southwest Virginia Dental Component met for its regular meeting in Marion at the Holiday Inn, Saturday, December 2, 1978.

Dentists voted into new membership were Drs. Thomas Bays, Raven; Dee Danner, Christiansburg; Joseph Ray, Marion; Raymond Salyer, Castlewood; Ramsey White, Abingdon; and Richard Schambach, Pulaski.

Dr. F. B. Wiebusch was on hand for the first Component 6 participation in the statewide program of dental continuing education sponsored by the Virginia Dental Association. Dr. Wiebusch described the progress of the continuing education program and outlined plans for future meetings.

Dr. William Morris, West Virginia University law professor and noted world wide authority in the field of dental litigation, presented a varied program on the dental malpractice problem.

The next Component 6 meeting will be April 6, 1979, at the Midtowner Motel, Galax. A program entitled "Current Concepts of Clinical Pedodontics" will be presented by Dr. David Myers, chairman of the Department of Pedodontics, School of Dentistry, Medical College of Georgia. Topics of interest to the general dentist who treats children will be discussed. Registration, open to all Virginia Dental Association members, their auxiliaries and colleagues, is being handled through Dr. F. B. Wiebusch, Assistant Dean for Continuing Education, Virginia Commonwealth University, MCV Station, Box 637, Richmond, Virginia 23298.

COMPONENT VII

SHENANDOAH VALLEY DENTAL ASSOCIATION

William B. Hanna
Associate Editor

On December 6 a workshop for committee chairmen was presided over by Component President Dr. Michael Kivlighan at the Holiday Inn North in Staunton to review committee progress. Numerous topics were discussed. The Committee for the Care of the Elderly and Needy reviewed the progress of the statewide effort to provide aid to the elderly and needy in denture service. Dr. Craig Zunka reviewed the current continuing dental education program being presented by MCV. This is a two-year trial program and Component VII supports the effort wholeheartedly. The Dental Health and Public Information Committee is getting underway with projects to elevate the public's awareness of dental health matters. This program is to include a newspaper column in all local newspapers, slide programs to be presented in schools by dentists, and radio spots. More workshops and committee activities are being planned for Component VII.

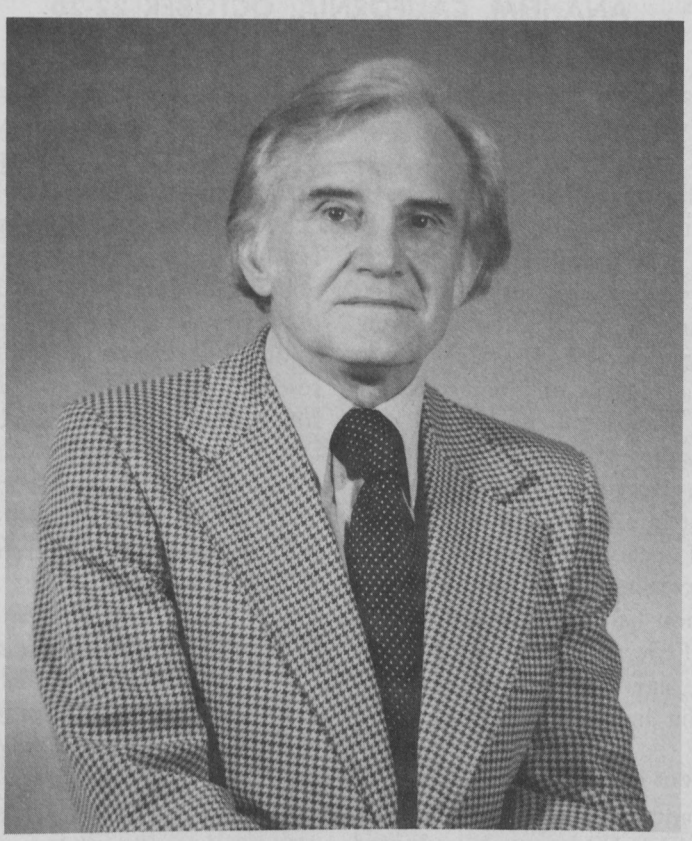
Shenandoah component members are saddened by the tragic loss of one of its members. Dr. David Mincey of Harrisonburg died in a plane crash that also took the lives of two other men, Dr. Mincey's father, Mr. Elry Mincey of Charlotte, N. C., and the pilot of the private plane. The plane went down in the mountainous area outside of Harrisonburg on November 22. Conditions prevented the wreckage from being located until November 28.

Dr. Mincey grew up in Charlotte, N. C., received his B.S. from U.N.C., and his D.D.S. from the Baltimore College of Dental Surgery. Following active duty in the Navy, Dr. Mincey took his residency in oral surgery at the University of Chicago. He had practiced in Harrisonburg for five years where he was member of the Lions Club, Elks Lodge, and President of the Spottswood P.T.A. He is survived by his wife, Diane Onsgard Mincey, and their three children, Lisa, Amy, and Todd. Memorial donations are being accepted by the Civil Air Patrol in care of Muhlenberg Lutheran Church, 281 E. Market Street, Harrisonburg, Va.

The next meeting for Component VII will be on March 23 at the General Wayne in Waynesboro.

MCV NEWS

G. L. Button, D.D.S., Associate Editor



A new Chairman has been appointed for the Department of Restorative Dentistry. He is Doctor Florian Knap, presently Chairman and Professor of Fixed Prosthodontics at Marquette University in Milwaukee, Wisconsin. Doctor Knap has been an instructor in operative dentistry, a research assistant in dental materials as well as his current position which also includes being Chairman of the Conjoint Committee on Occlusion.

As Diplomate of the American Board of Prosthodontics, Doctor Knap received his D.D.S. as well as his specialty training at Marquette. He has also studied at the Royal Dental College at Copenhagen, and with colleagues in Malmo, Sweden and the Eastman Dental Hospital in London. In addition, he has a nine year study of "Motions of the Mandible in Six Degrees of Freedom".

MCV can look forward to a bright future in the area of Restorative Dentistry under the direction of Doctor Knap.

A REPORT FROM THE VIRGINIA DELEGATION TO THE 1978 ADA HOUSE OF DELEGATES MEETING IN ANAHEIM, CALIFORNIA, OCTOBER 22-26

Participants in the 119th Annual Session of the American Dental Association October 22-26, 1978 in Anaheim, California, tallied more than 29,000. Dr. Joseph P. Cappuccio of Baltimore was installed as the 115th President of the Association and Dr. I. Lawrence Kerr of Endicott, New York, was elected President-Elect. The 417 delegates of the House of Delegates considered 50 reports, 150 resolutions and several special reports from the Board of Trustees. The House met in executive session during its second meeting to discuss critical issues concerning litigation and potential litigation between the Association and the Federal Trade Commission and other agencies. House of Delegates action included:

Revisions of Principles of Ethics

Significant amendments to the ADA Principles of Ethics were adopted and still others were referred for further study and report back to the 1979 House of Delegates. In an attempt to bring Section 12 into conformity with the Supreme Court's decisions on advertising by professionals, the House approved the following substitute language: "A dentist may advertise the availability of his services and the fee that he charges for routine procedures. No dentist shall advertise in any form of communication in a false, misleading, deceptive or fraudulent manner." The title of Section 2 of the Principles of Ethics was amended to add the words "and Quality of Care" to emphasize the practitioner's primary obligation to deliver quality care to the public. The House urged constituents and components to refer suspected violations of sections entailing alleged false, misleading, deceptive or fraudulent representations to the proper state agency for action. The House also directed that a special workshop to consider revisions in the Principles of Ethics be convened as soon as feasible with results of the workshop reported back to the 1979 House.

Opposition to FTC Rules Adversely Affecting Public

Following 11 hours of hearings by the Council of State Governments on suggested state dental practice acts, the House directed the Board of Trustees to use all needed resources to combat any of the Federal Trade Commission's proposed trade regulatory rules that adversely affect the public and dental practice. A recent trade regulation rule was considered by the FTC Regional Office in San Francisco that abrogates all state laws which currently prohibit nondentists from designing and furnishing complete dentures to edentulous persons. The House reaffirmed that the constitutional responsibility for the health, safety and welfare of citizens of each respective state are the responsibility

of each state and that state alone, and should not be abrogated. It called upon each dentist to do all in his power to preserve this constitutional responsibility and right. The 1978 House of Delegates has declared it will support only those suggested dental practice acts that are consistent with Association policies.

Legislation

The House directed the Association to continue to seek amendments to the PSRO law to provide dental representation at the national and local levels. If PRSO authority is expanded to include review of ambulatory services, the House directed the Association to seek amendments requiring each PSRO to have a dental component for review of dental services.

Noting that dental schools across the nation are being pressured to violate state dental practice acts to obtain federal grants for the TEAM program, the House directed the appropriate Association agencies to seek legislative or executive relief from certain TEAM requirements.

The House called for legislation to achieve full and comprehensive dental care for the economically disadvantaged and the developmentally disabled of all ages. Constituent societies were urged to seek legislative amendments in their state Medicaid and public health programs toward this end.

The Department of Defense was urged to re-establish the Special Assistant for Dental Affairs within the Office of Assistant Secretary of Defense and urged to update its criteria for establishing "remote" area designation and to give complete information to recruits concerning the scope of dental benefits available to them and their dependents.

Dental Care Programs

In further actions the House urged the Council on Dental Care Programs to continue to evaluate, monitor and vigorously oppose dental care programs proposed by organizations which are not in harmony with the Association's guidelines; recognized the direct reimbursement mechanism as a dental benefits approach available to purchasers of dental plans; urged that descriptive narratives on dental insurance claim forms be given "professionally appropriate" consideration and that under no circumstances should the procedure codes take precedence over the narrative.

In the event that a national health program which includes dentistry becomes a national legislative priority, the House directed Association agencies to develop a prototype National Dental Prepayment Program based on the Association's Guidelines for Dentistry's Position in a National Health Program. The House rescinded 1970 policy supporting the inclusion of dental care "in all public and private health programs".

Budget

A 1979 budget of $20,977,000 was approved for operating and non-operating expenditures, a 9.8 per cent increase over 1978, which provides for a surplus of $1,353,700 over projected income.

Other Actions

The House reaffirmed ADA policy regarding the relationship of sugar to dental health and called for the elimination of sugar-rich foods in federally supported school food programs, the sale of confections in schools and food product labeling revealing sugar content. Declaring its strong objection to misleading or deceptive television advertising of sugar-rich foods to children, the House of Delegates adopted two new policies relating to the influence of television on children's attitudes about dental health and adopted a Statement on Advertising of Sugar-rich Products to Children over Television.

A plan for seven-member councils and rotation of council seats was adopted by the House resulting in a net increase of 14 council seats. Each Trustee District will occupy eight council seats each year.

The House urged constituent societies to form statewide denture referral services and asked appropriate ADA agencies to provide expertise to this project.

In other action, the House adopted Guidelines for Comprehensive Health Planning, directed the Board of Trustees to assign high priority to developing solutions to problems brought to light by the Association's dental manpower study and adopted extensive policy on the National Health Service Corps which advocates immediate modifications in federal regulations for the program.

Virginia Delegation

The Virginia Delegation was composed of Delegates: Doctors L. O. Clark, Jr., Harry B. Fleming, Charles F. Fletcher, Elmer O. Fisher, Jr., William B. FitzHugh, Virgil H. Marshall, Earle W. Strickland and Douglas C. Wendt; Alternate Delegates: Doctors J. Wilson Ames, Jr., Harry L. Hodges, Walter H. Dickey, Lester Ferris, James E. Kennedy, Emanuel W. Michaels, Curtis R. Woodford and French H. Moore, Jr.; Secretary for the Delegation, Pat Watkins. Dr. Douglas C. Wendt was elected Chairman of the Fifth District Caucus. The Virginia Delegation hosted a social hour for the Fifth Trustee District Caucus meeting in Atlanta. All delegates were assigned to reference committees and attended all caucus meetings and House of Delegates sessions. The Virgina Delegation participated actively in all meetings relating to and including the House of Delegates meeting for 1978.

VIRGIL H. MARSHALL, D.D.S.
Chairman, Virginia Delegation

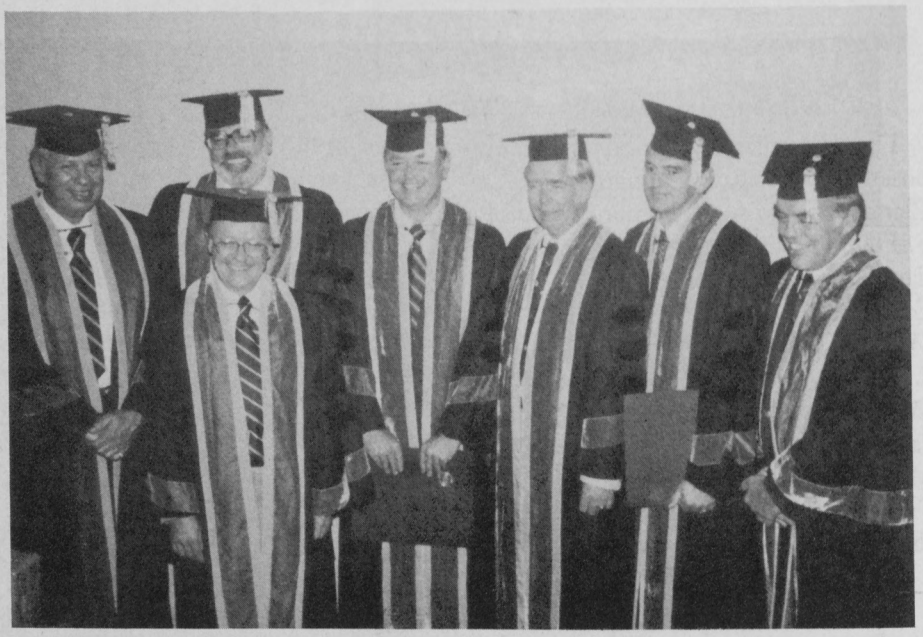
ADA NEWS

More than 1,000 appearances on radio and television programs in their local communities have been made by dentists placed through the ADA's Public Education Program (PEP).

The spokesman program, undertaken in 1976, has been well received throughout the country both by more than 800 dentists who have been trained in PEP seminars and the media, which have welcomed appearances.

ADA President Dr. Frank P. Bowyer commented on the program: "PEP training and placement programs have become a strong communications force based on the belief that the individuals best qualified to discuss issues vital to dentistry are the dentists themselves. Through the continued efforts of PEP spokesmen, we have successfully reached millions of Americans with the important messages of good dental health."

Among the Virginia dentists who have appeared on radio and TV programs for PEP during the first eight months this year include Dr. Robert Rubin, Dr. Bernard Einhorn and Dr. Ira Gould, all of Norfolk; Dr. Mayer G. Levy and Dr. Madison Price, Newport News, and Dr. Kent Palcanis and Dr. William B. Fitzhugh of Richmond.



Virginia dentists inducted into Fellowship of the International College of Dentists at the Annual Meeting in Anaheim, California, are: Doctors Thomas J. Fitzgerald, South Hill; Harry L. Hodges, Richmond; Richard D. Wilson, Richmond; James E. Kennedy, Richmond; Robert T. Edwards, Franklin; J. Gary Maynard, Richmond; and Clark B. Brown, Springfield.

Third Annual
Southeastern Virginia Dental Symposium
March 15, 16, 17, 1979
Colonial Williamsburg Convention Center
Williamsburg Lodge

Jointly sponsored by

PENINSULA DENTAL SOCIETY AND
VIRGINIA-TIDEWATER DENTAL ASSOCIATION

An Invitation is extended to

Dentists, Wives, Dental Hygienists, Dental Assistants,

Office Managers, and Technicians

Thursday, March 15, 1979

Paul A. Randall, Ph.D. – Logan, Utah, Teacher, Financial Consultant, Investment and Economics Advisor.

Topic – "Financial Management for the Whole Dental Team".

Friday and Saturday, March 16, and 17, 1979

Robert P. McGraw, D.D.S. – Independence, Missouri, Practitioner, Lecturer and Teacher. The most outstanding lecturer on Practice Management in this country.

Topic – "Effective Practice Management – The Key to a Stress-Free Practice".

Also – **Friday, March 16, 1979** (During Lunch) –
Lunch and Learn with our Military Colleagues and Auxiliaries

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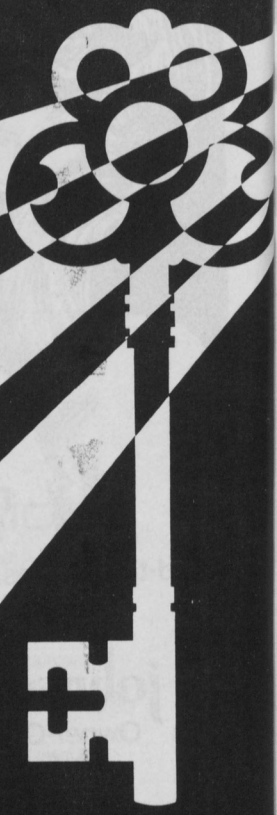

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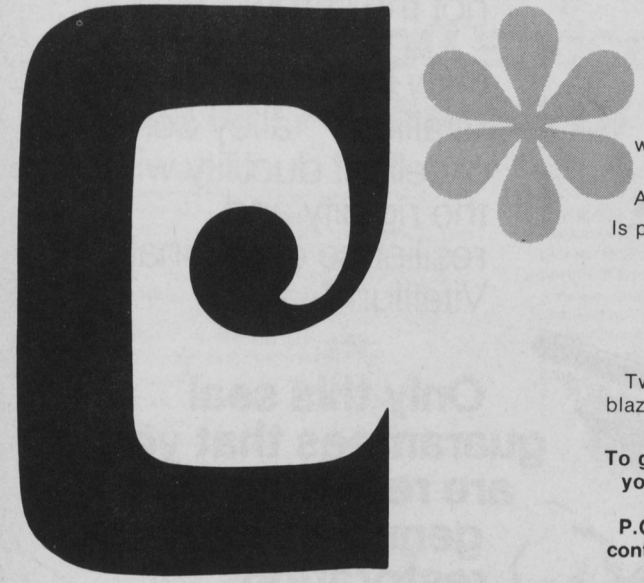

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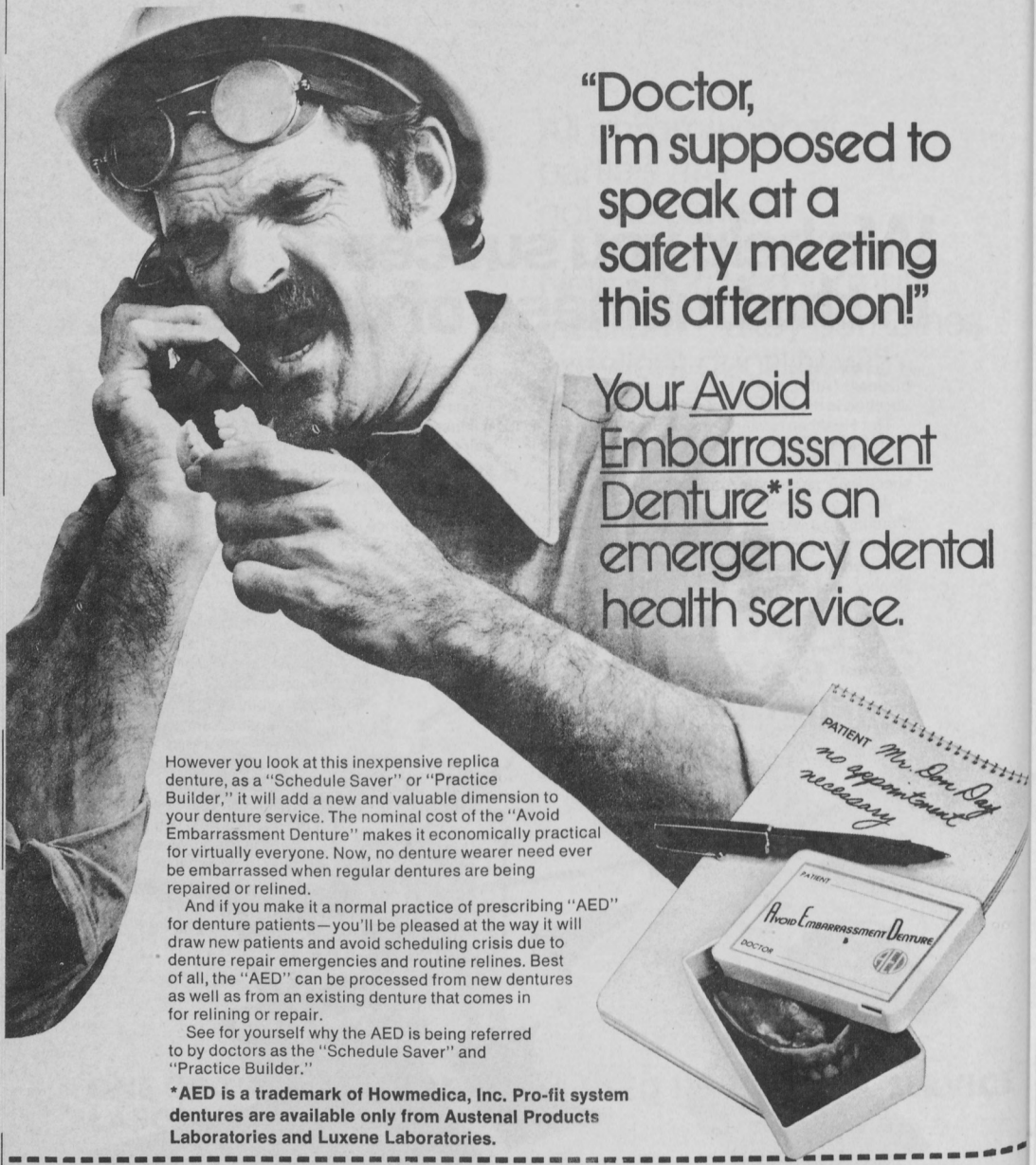

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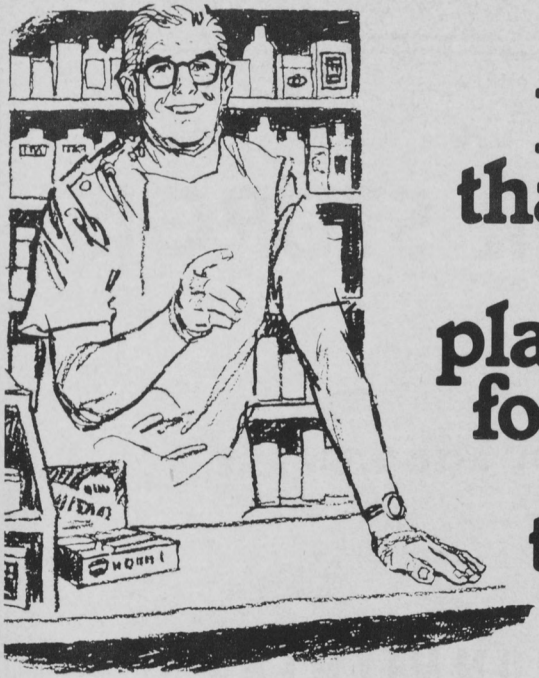

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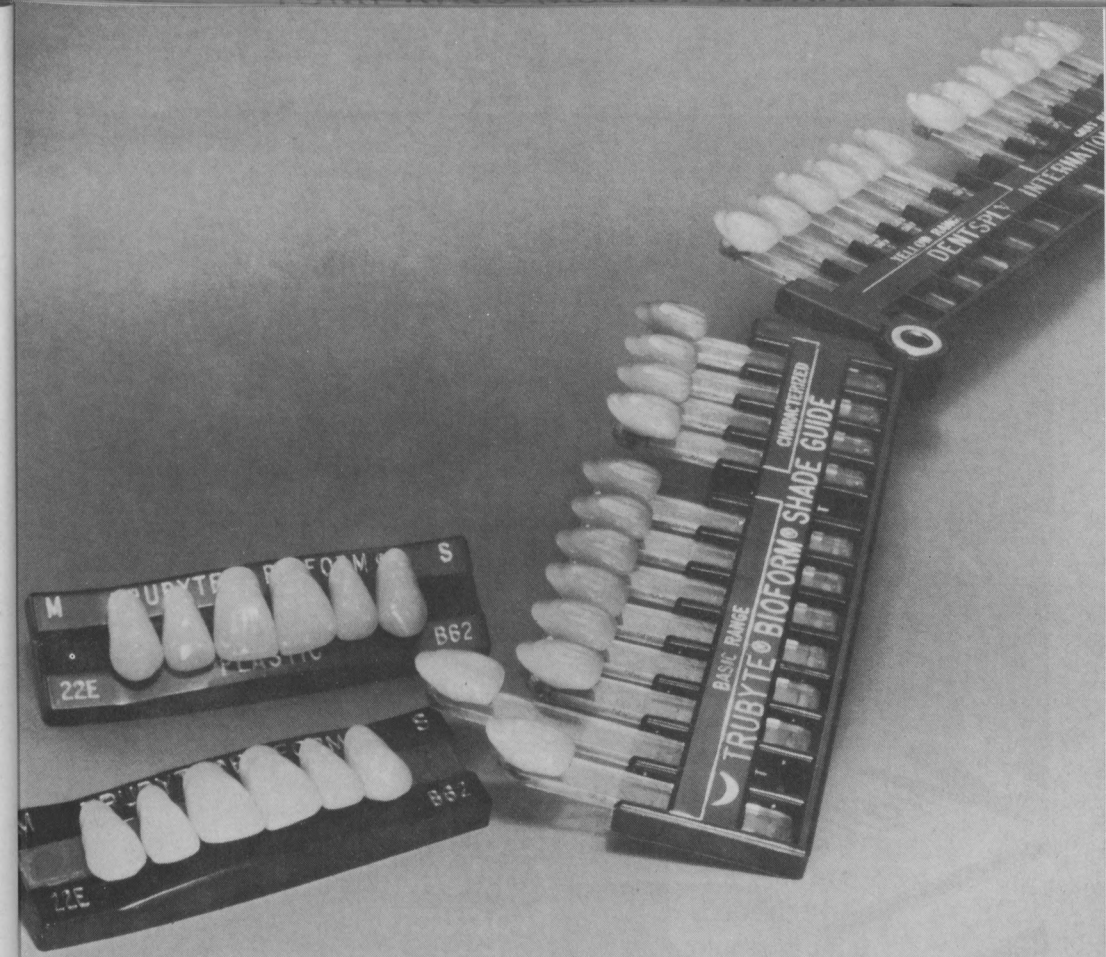

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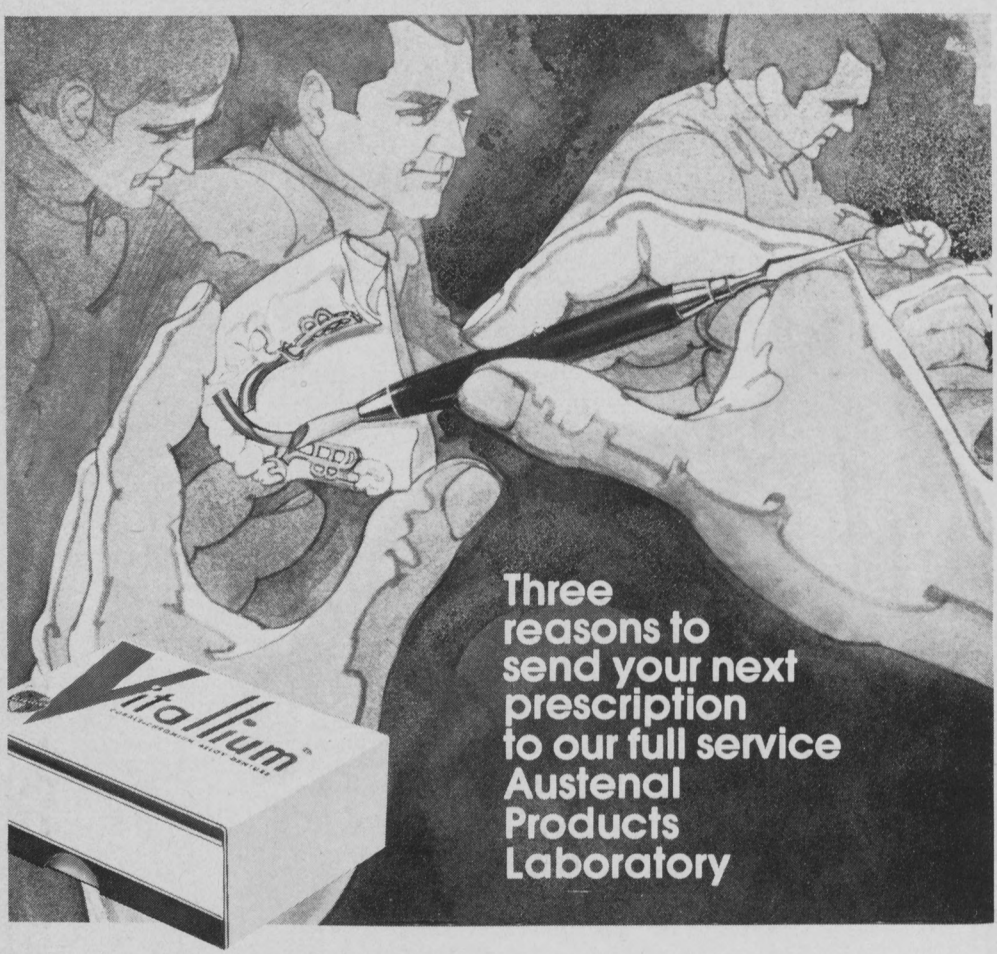

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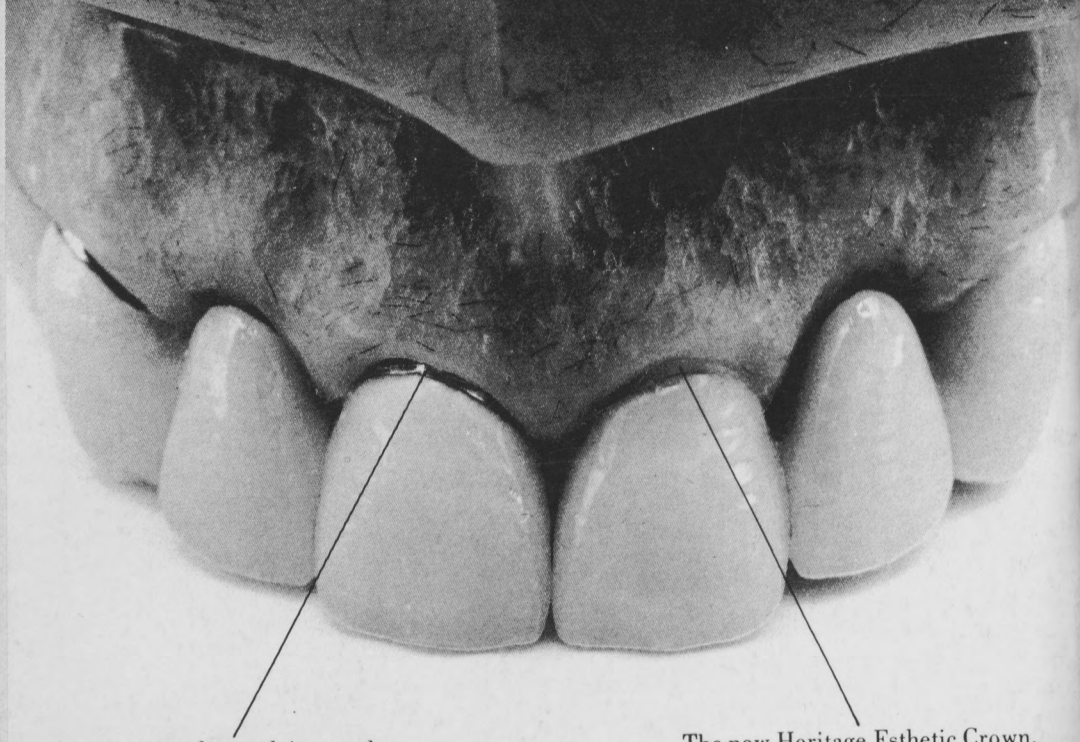

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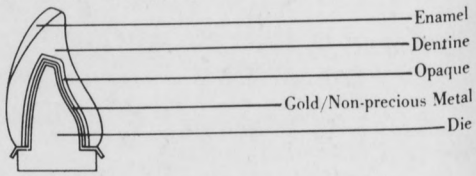

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