



NEWSLETTER

THE AMERICAN COLLEGE OF PROSTHODONTISTS

AN ORGANIZATION OF SPECIALISTS
DEDICATED TO SERVING THE PUBLIC

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PRESIDENT'S MESSAGE



It is my hope that all of you enjoyed the meeting in Nashville as much as Peg and I did. Jack Preston knew what he was doing when he picked his Annual Session co-chairmen. Charlie DuFort and Jerry DiPietro assembled an Annual Session that had something for everyone. I'm not sure, but I think I even heard Jack Preston humming a country western tune before the week was up! When confronted, he mumbled something about "just indigestion", but as good as the food was, we doubt it. And who can forget Major Brian Shul's inspiring presentation?—Ever?? We had speakers who would be the envy of any dental group in the world, we had seminars addressing interests of specific groups, we had programs for our ever loving wives. In short it was a great week and my regret is that space does not permit acknowledging the contributions that so many of you made toward the success of the meeting. It

was a huge team effort.

To find myself the president of what I feel is the best prosthodontic organization in the world is a humbling experience as the enormity of the task sinks in. Jack Preston was most helpful this past year in keeping me current with the multitudes of details that must be monitored in an organization the size of the American College of Prosthodontists. It is one thing to be briefed and quite another to assume the burden. My feeling of respect for all the past presidents will undoubtedly continue to increase as the year unfolds.

Most of you know of my love for history. Whether it's old bottles, frontier forts, telephone pole insulators, (check with Jerry DiPietro), pre-Columbian art or the profession of dentistry, I'm intrigued. Many of you know the early history of the College, (you lived it!), but many more are probably unaware of those early days. I'd like to share some

memories that came as I browsed through a notebook of correspondence relating to it's founding.

The first hint I had of what eventually became the American College of Prosthodontists came in a letter from Ray Loiselle dated April 23rd, 1969. (Ray eventually became our first president). Ray had surveyed the prosthodontists in the Veterans Administration concerning what their attitude would be toward a new prosthodontic organization based on **training only** as a criteria for membership. The ones surveyed were enthusiastic. The letter I received asked the same question—and my response and the response of my residents, Ken Turner and Don Smith, was equally enthusiastic. (At that time prosthodontic training alone was an admission ticket to **no** organization).

Considerable correspondence followed. A constitution was slowly developed. A meeting was held in Chicago on February 15th, 1970, of some of those involved in the correspondence. I missed that meeting (had to stay home and mind the store while the residents went to the Chicago Midwinter Meeting) but I believe Steve Bartlett, Louis Boucher, Ray Loiselle, Ken Rudd and Pinky Smith were there.

An ad hoc Executive Committee was formed to continue the development of the new organization, as yet unnamed. To include "Society" or "Academy" in the name invited confusion with existing organizations. A letter from Keith Marcroft to Ray Loiselle on May 15th, 1970 suggested the organization should be called a "College". A letter from Pinky Smith to the ad hoc committee members on June 3rd, 1970 endorsed the name College after he found the dictionary defined a college as "an association of individuals having certain rights and duties and

engaged in some common pursuit". The rest of us agreed—and "College" it was.

On August 27th, 1970, the ad hoc committee of Steve Bartlett, Louis Boucher, Ken Brown, Tony DeBello, Jim House, Ray Loiselle, Keith Marcroft, Ken Rudd, Pinky Smith, Bruce Stansbury and myself met at Wright Patterson Air Force Base in Ohio where Ken Rudd was stationed. Twenty items were on the agenda including the drafting of a letter inviting eligible prosthodontists to join the College, further refining the Constitution and Bylaws, selecting a slate of officers, planning the program and business meeting for the first Annual Meeting in Chicago in February, 1971, and considering membership in the F.P.O.

There were many divergent opinions, but it is amazing how closely the College developed along the lines where there was a unanimity of opinion. These areas centered on making the College a vehicle to help the students in prosthodontics, offering all possible aid to those preparing for board examination, presenting programs of interest to the specialist and improving prosthodontic treatment for the patient.

The seal of the College came from a design suggested by Steve Bartlett in a letter dated September 30, 1970. The center of the seal has been modified, but the rest is much as Steve submitted it. Did you know that the saw toothed border in the seal has significance? As Steve wrote, "each point may be called an 'indent' and the entire circle 'dentated' or 'toothed'. Being dentists, it is appropriate to have 32 indents or teeth". Frankly, I had forgotten that until I re-read Steve's letter.

I have a copy of the Official Program of that First Annual Meeting on February 11th, 1971 at the Sheraton-Blackstone Hotel in Chicago. The agenda for the Business Meeting in the morning consisted of the adoption of the Constitution and Bylaws and the election of officers. After lunch, the professional program was presented by John McCasland, Art Bahn and Bill Terry. Two committees were listed, the Program Committee and the Nominating Committee.

By the time the meeting was held, the College had 334 members; 163 of those members attended the first meeting. This was most gratifying. During the formative period the ad hoc committee felt that if just 100 members could be signed up the organization would fly.

The Constitution has been modified

many times since that initial meeting as the circumstances of the College changed. Much thought went into the Constitution first presented to the membership in Chicago. In the notebook of correspondence on the founding of the College there are at least six versions as it gradually evolved. One item that at first had a lot of support was to make only those younger than 60 or 65 years eligible for election to office and to mandate life membership for anyone over 65! Being now a middle aged 64, my reaction is now one of indignation—but I can't say it was back then! The thinking was to prevent anyone from perpetuating themselves in the officer structure. The solution was to limit the officers (except for the Secretary and Treasurer) to a single term.

The College has grown and that has been exciting. We have over 30 committees and over 180 slots on those committees, quite a change from the listing on the program for the First Annual Session of two committees with 11 slots. The number of volunteers who approached me for committee assignments during the meeting in Nashville frankly stunned me—and made me immensely proud of the group. I think that all who volunteered have been assigned. If you volunteered and haven't been placed, please let me know.

In closing, I'd be remiss if I didn't recognize Jack Preston for the magnificent manner in which he handled the presidency this past year. He gave it his best and brought honor to the College. Jack, all of us thank you.

I'd also be remiss if I didn't thank all of you for the honor of being entrusted with the presidency for the coming year. I will do my best to justify your trust.

—Bob Sproull

FROM THE SECRETARY

The 1984 Annual Session in Nashville, Tennessee, is history. Annual Session Chairmen Charlie Dufort and Jerry D. DiPietro organized and implemented a truly outstanding meeting. A near record 505 members registered for the meeting.

A new feature at the Annual Session was the addition of commercial exhibits. Mo Mazaheri and his committee accomplished a tremendous amount of work in a short period of time. Guidelines and contracts were developed, selected exhibitors were solicited, and

the exhibit area was selected and organized. Attendees appeared to enjoy the exhibits and of equal importance, \$18,000 income was generated for the College. The expense of presenting the Annual Session increases considerably each year, and the added income helps to defray those expenses.

Our membership continues to grow -1577 compared to 1430 at this time last year. Present membership includes 75 Life Fellows, 526 Fellows, 805 Associates, and 171 Affiliates. There are presently 618 Diplomates of the American Board of Prosthodontics. Of these, 540 are annual registrants and 78 are Life members. Our 75 Life Fellows comprise 96% of the Life members of the Board and our 526 Fellows make up 97.5% of the Diplomates who are annual registrants. We definitely are the organization of prosthodontic specialists.

Three new state sections have been approved - New York, North Carolina, and Virginia - bringing the total number of sections to 16.

The Executive council met for 16 hours in Nashville prior to and during the Annual Session. Forty pages of minutes and 94 specific chores for officers and committees resulted from the Executive Council and Business Meeting.

Plans for a national yellow pages program were completed at the Council meeting. Members should have received specific information on this program by now. If you haven't, let the Central Office know.

NEWSLETTER The American College of Prosthodontists

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Several other important items were considered during the Annual Session, including: approval of an ACP Peer Review Manual at the next Annual Session, approval of a motion to make the Ad Hoc Committee on National Peer Review a standing Committee, approval of a new 3 year lease for the Central Office, approval for hiring of an additional office employee for 20 hours per week, approval of funds for a new copying machine for the Central Office, approval for advancing the dates of the 1985 Annual Session in Seattle to October 16-19, 1985, approval for printing and mailing a questionnaire concerning an ACP Journal, approval of \$1000 for new computer software, approval of up to \$3000 to capitalize on the PR generated at the Annual Session and \$1500 for preliminary work in preparation for the PR program at the 1985 Annual Session, and, membership approval of a dues increase to \$195.

I would like to encourage all College members to pay their FPO dues for two important reasons. First, if 1000 or more of the 1331 College members who will receive dues statements pay their FPO dues, the College will gain another delegate to the FPO House of Delegates meeting and thereby increase our impact on the decisions made at that level. We would be the only organization with four official delegates. Second and most important, the specialty of prosthodontics is up for review in 1985. The FPO has been assigned the task of compiling all the information required by the review. This is a mammoth project, one which requires a tremendous expenditure of time, effort, and funds. The FPO is going to need our dues to meet this obligation and to successfully defend prosthodontics as a specialty.

The next meeting of the Executive Council will be in San Antonio, January 18-19, 1985. Anyone having suggestions, recommendations, or complaints, please let one of your officers or Executive Councilors know so that your area of concern can be discussed at the meeting. Remember - Executive Council meetings are open to any member who would like to attend.

—William A. Kuebker
Secretary

ACP INITIATES YELLOW PAGES LISTING

ACP members can now list their names under the ACP Logo in the Yellow

Pages. The American College of Prosthodontists has appointed a specialist advertising agency, National Yellow Pages Network, to assist the College in developing a nationwide Trademark program in the Yellow Pages.

The ACP Logo, with the participating members listed, will appear under the class heading of "PROSTHODONTISTS SPECIALTY GUIDE" in the Yellow Page books that allow Trademarks under this class heading.

In Yellow Page books that do not allow Trademarks under the class heading of "PROSTHODONTISTS SPECIALTY GUIDE", the ACP Logo with the participating members listed, will appear under the class heading of

"DENTISTS". In rare cases, a Yellow Page book publisher may allow dental Trademarks only under the heading "DENTIST GROUP ASSOCIATIONS".

Each College member will continue to correspond directly with the local Yellow Page books to maintain his/her name in the alphabetical listing under the class heading "DENTISTS".

Each College member will continue to correspond directly with the local Yellow Page books to maintain his/her name in the alphabetical listing under the class heading "PROSTHODONTISTS SPECIALTY GUIDE" whenever the ACP Logo is not allowed under this class heading.

If only one member participates in a given Yellow Page book, he/she will

IN MEMORIAM DR. DANIEL FRANCIS GORDON

May 14, 1920 - October 17, 1984

Daniel F. Gordon, a Past President of the American College of Prosthodontists, died of cancer at the age of 64 with his loving wife, Mary, at his side.

Dan was a superb practitioner. He personified the ideals of dentistry with his professional skills and his unusual ability to understand the needs and feelings of his patients. He was also a great teacher who could communicate in a very constructive manner with the dentists of the Odontic Seminar, a USC Study Group dedicated to the continuing education of dental practitioners and the students he taught in Advanced Prosthodontic Education at USC.

An alumnus of the USC School of Dentistry Class of 1942, Dan Gordon served in the U.S. Army during World War II where he was involved in many campaigns in North Africa and Europe. In 1946 he returned to Southern California and practiced in Santa Ana until 1977 when he moved his office to Newport Beach. Dan Gordon's involvement in dentistry was extraordinary. He was President of the Orange County Dental Society in 1955, President of the California Dental Association in 1972, President of the American College of Prosthodontists in 1979 and President of the Pacific Coast Society of Prosthodontists in 1981. In 1962, after a number of years of study and preparation, Dan Gordon took his examinations and was certified as a Diplomate of the American Board of Prosthodontics. He was a Fellow of the American College of Dentists and the International College of Dentists and a



Fellow of the Academy of Denture Prosthetics. In addition to the above, Dan Gordon chaired many important California and American Dental Association councils and commissions.

Dan Gordon was a quiet, warm, compassionate individual. He would listen carefully to the problems of his patients, his friends, or his peers. Then he would offer his evaluations, suggestions and opinions, carefully worded and with such discernment, that matters were settled and important decisions made without further discussion. Perhaps Dan Gordon's greatest asset was his ability to listen with an open mind and respond in an objective manner.

In addition to his wife Mary, Dan Gordon is survived by sons Terry and Shelley; a daughter Arlene; a grandchild, two brothers, Norman and Sidney; a sister, Lillian Susman; two stepchildren and three stepgrandchildren.

For those fortunate to have known Dan Gordon, he has not died, he lives on in their hearts.

—Alex Koper

be billed once annually for the cost of the name listing plus the cost of the 1" Trademark.

If two or more members participate, a 2" Trademark will automatically be placed and each member will be individually billed once annually for the individual member's name listing plus an equal portion of the cost of the 2" Trademark. For example, if four members participate in a given Yellow Page book, they will each be billed for their own listing (name, address, phone) plus one-fourth of the total annual cost of the 2" Trademark. With greater participation, the cost is reduced considerably.

If you would like to participate, return the order form as soon as possible. You will receive a bill from National Yellow Pages Network based on the membership participation in the Yellow Page book(s) you have selected.

National Yellow Pages Network will place the ACP Logo with your name listing in the Yellow Page book(s) you have selected.

If a participating member in your Yellow Page book(s) cancels out at the last moment, you will receive an additional bill reflecting a higher proportion of the Trademark cost.

The services of National Yellow Pages Network are paid by a commission from the individual Yellow Page books used. There is no additional cost to the ACP members.

Yellow Page book rates are generally based upon population and directory circulation within a given area.

The average annual rates are approximately:

- 1" Trademark - \$450
- 2" Trademark - \$900
- Name listing - \$90

There is a wide range of rates; Miami (circulation 1,089,000):

- 1" Trademark - \$1,458
- 2" Trademark - \$2,390
- Name listing - \$170

Grass Valley, California (circulation 28,000):

- 1" Trademark - \$114
- 2" Trademark - \$237
- Name listing - \$40

If your Yellow Page book is in a major metropolitan area, your rates will be considerably higher than if you are located in a relatively small city. However, the 2" Trademark cost will always be split at least in half, and in many cases, the cost to a member will be much less than half.

This project is a combined effort of the Public and Professional Relations Committee, the Prosthetic Dental Care

Programs Committee, and the ACP Executive Council. If you have questions, please call:

National Yellow Pages Network, (714) 759-1666 (9:00 am to 5:00 pm Pacific Time) or,

David W. Eggleston, D.D.S., (714) 640-5625 (6:00 pm to 7:00 pm Pacific Time)

The line in the name listing "Prosthodontist or Diplomate Amer Board of Prosthodontists" has been eliminated.

Special Note to Illinois Residents

Dear Sirs:

Literature for the American College of Prosthodontists nationwide campaign of trademark advertising has recently been directed to my attention. I am writing to you at this time to advise you of a potential problem which might develop in the State of Illinois which would cause your membership, if they participated in the program, to be in violation of Illinois statutes.

The State of Illinois is one of approximately fifteen states in the nation which licenses dental specialists. As such, we are protective of these specialties and have strict statutes and rules governing professional advertising of specialties and who can call themselves a specialist. Unless a dentist is licensed by the State of Illinois as a specialist in a particular discipline of dentistry, they can not hold themselves out to the public as a specialist. Regardless of membership or fellowship in American Boards or formal training received in recognized institutions, the statute in Illinois requires that the individual be recognized as a specialist in the State of Illinois by successful completion of the Illinois Specialty Examination.

A potential problem would arise in the situation where an individual holds membership in your organization and is not licensed by the State of Illinois as a Specialist. That individual would be holding him/herself out to the public as a specialist in that they advertised under your logo preclaiming "specialists in..." or "a national organization composed of specialists in one or more of the following..." The deception is carried even further if the advertisement is placed under the heading of "Prosthodontist Specialty Guide." Individuals who advertise in these areas as specialists and do not hold Illinois Specialty Licenses are in violation of Illinois statute and are disciplined as such.

I would suggest that you contact your membership in the State of Illinois, as well as other jurisdictions, and

advise them of the above, you may find yourself in the unenviable position of advising and encouraging your membership to violate the law.

If you have further questions, do not hesitate to contact me.

Sincerely,
Michael Vold, D.D.S., J.D.
Dental Coordinator

PRIVATE PRACTICE SEMINAR-NASHVILLE

By Paul Binon

The private practice seminar was held on October 20, 1984 in Nashville. There were 90 members in attendance. Dr. Larry Churgin, Chairman of the Committee on the Private Practice of Prosthodontics offered a brief introduction and Mr. Joel Severson, facilitator, instructed the group in the workshop format of the meeting.

Eight topic areas were selected and group leaders were assigned to lead the discussion and develop a consensus report for each of the groups.

PUBLIC EDUCATION WORKSHOP leader Dr. Balshi

The primary question to be answered was how to gain broader public recognition of the prosthodontist as a specialist. Three levels of recognition were identified, namely, national, local and personal.

The following groups, in order of importance, were identified as primary targets for an educational marketing program on the three levels: public at large; the medical profession in general, and in particular - ENT, plastic surgeons, speech therapists or pathologists, ophthalmologists, orthopaedics, internists and nurses, paramedical personnel in hospitals and nursing homes; legal profession; cosmetic industry; and other dental specialists and general practitioners.

REFERRAL PATTERNS WORKSHOP leader Dr. Shields

A consensus of the participants identified the following sources of new patients in a "typical" prosthodontic practice: patients - 34%; other dental specialists - 20%; general practitioners - 15%; physicians - 5-10%; telephone directory - 6%; attorneys, lectures, dental schools and local dental societies - each about 5%.

In general, the satisfied patient is the best source of new patients for the practice.

SPECIALTY RECOGNITION WORKSHOP

leader Dr. McFee

The following areas were identified as requiring attention by the individual prosthodontist and by the specialty in general. The areas were defined as two groups, extradental and intradental.

The extradental area was further identified as the public at large, state legislatures, state boards, the insurance industry, and undergraduate dental school programs.

For the intradental areas, the emphasis was placed on making sure the dental office staff understands our duties and knows that it is unique and different from the general practitioner. The staff should serve as missionaries for the specialty.

The following recommendations were made by this workshop: 1) support a dues increase or assessment or pledge funds for a program to promote the specialty, 2) ACP should develop a marketing program with a format that can be adapted to a local need; 3) present lectures at the national meeting by professional management and marketing consultants; 4) develop local promotion programs in conjunction with such programs as National Dental Health Week; 5) each member should mail prosthodontic brochures to local physicians.

THIRD PARTY PAYMENT WORKSHOP

leader Dr. Mazaheri

The main questions addressed were how to develop awareness of prosthodontists in order to provide adequate compensation levels within the insurance industry. The following recommendations were made: 1) Encourage political involvement in dental societies by individuals, particularly on state dental insurance committees; 2) The ACP should develop criteria to distinguish what constitutes specialty treatment as contrasted to generalist treatment; 3) The Public Relations Committee should contact employees, personnel and benefit managers to educate them to the value of treatment provided by a prosthodontist; 4) Fee profiles should be established by each Section of the College; 5) Develop a "model" insurance plan for distribution to insurance carriers and purchasers; 6) The undergraduate dental curriculum should include guidelines for referral of patients; 7) The ACP should develop a major dental insurance policy similar to major medical. The ACP could market such a policy or help a carrier underwrite it.

COMPUTER UTILIZATION WORKSHOP

leader Dr. Binon

A number of commercial computer packages are available that will meet the needs of a dental practice in general. Specific recommendations were not made because computer use is an individual decision.

Factors that are unique to a prosthodontic practice should be considered in the selection of a computer system after the basic criteria, such as vendor experience, software reliability, longevity of the company, etc., are met. Some of these special factors are: retrieval of referral sources, follow-up on patients referred outside our practice, retrieval of scientific data and patient variables, materials used, treatment planning and ability to bill for medical insurance. If your computer system generates five insurance forms a day, it will be cost effective on this basis alone.

ETHICS AND PROFESSIONAL DEMEANOR WORKSHOP

leader Dr. Barrack

The following areas were explored: 1) When, how and to whom should less than ideal clinical results be reported. The ADA Code of Ethics states the local dental society and not necessarily the patient should be informed. 2) On the subject of personal remarks to avoid failing dentistry, no consensus was reached as this is a highly individual decision based on multiple variables. 3) The ethical problems involved in marketing (advertising) were discussed. Institutional marketing was deemed professional as was personal marketing if properly done and in good taste.

FINANCING EXTENSIVE TREATMENT WORKSHOP

leader Dr. Martin

Recommendations developed by the workshop were: 1) Do not present fees of an extensive nature at the first or sometimes the second appointment; 2) Complete a thorough examination and diagnosis before presenting the fees; 3) Attempt to recognize a patient's ability to afford a proposed treatment.

Sources of financing were also discussed. These included: 1) Banks, a poor choice requiring collateral and high interest rates; 2) Credit Unions, a good choice due to more liberal lending requirements; 3) In-office financing, must conform to "Truth in Lending Act". This method increases treatment acceptance but also reduces cash flow initially and increases overhead cost. The policy of asking full payment initially for complete dentures was

questioned. A better alternative suggested was to establish a predefined nonrefundable fee for an exceptionally difficult patient, agreed to in advance in writing by the patient. Successful completion would then require the patient to pay the total treatment fee. Block fees allow greater latitude during treatment for the doctor as compared to itemized procedures normally required by insurance carriers.

OFFICE MANAGEMENT WORKSHOP leader Dr. Churgin

The group discussed the following points: 1) The office staff must understand the special nature of a prosthodontic practice; 2) Employee turnover must be kept to a minimum; 3) Identification as a prosthodontist should be included on all insurance forms and office stationary. The following factors were selected as being important for appointment book control: 1) New patients should enter the practice within a week of initial contact; 2) Emergency patients, old or new, should be seen the day of the complaint; 3) Patients of record should continue to receive our every courtesy; 4) Open time must be kept in the schedule to accomplish the above; 5) Block appointments for an entire treatment series is very effective; 6) Minimum appointment time unit should be 1/2 hour.

AFTERNOON INFORMAL MEETING

Dr. Dan Sullivan volunteered to collect and report information available on billing techniques to third part carriers in areas of TMJ, implants, and maxillofacial procedures. All College members are encouraged to contact him with details of successful billing methods for the above procedures.

Dr. Fran Clark was appointed to the Private Practice Committee and to chair a subcommittee on the procedures and techniques used in billing medical insurance carriers.

A proposal was made to split the Private Practice Seminar into two separate half-day sessions, the first being at the beginning of the Annual Meeting and the second at the end. This would allow more time for workshop groups to develop their charges. Dr. Sproull pledged his support.

Finally, a voluntary pledge letter was circulated to raise funds for the Public Relations Committee. Some 35 pledges were received totaling a commitment of \$12,450. Additional pledge forms may be obtained from Dr. Binon or Dr. Balshi.

COMMITTEE ACTIVITY OF THE COLLEGE

President Robert Sproull has recently announced committee appointments for the coming year. The increase in College participation in a wide range of activities has necessitated the creation of several new ad hoc committees. A brief summary of committee activity can be made as follows:

Current committees - 33

Committee members - 191

It is obvious that many College members are actively playing a role in directing the work of the organization. This is as it should be and is in sharp but pleasant contrast to other specialty groups that prefer to rely on a limited number of members to control the action of the group.

Any member interested in serving the College in some capacity is urged to contact Dr. Sproull or Dr. Noel Wilkie as soon as possible.

The current list of committees and proposed chairmen is as follows:

Constitution and By-Laws

Robert J. Sarka

Education and Advancement Committees:

Information and Publications

J. Crystal Baxter

Implementation of Aims and Goals

Charles R. DuFort

Advancement of the Specialty of Prosthodontics

Robert M. Morrow

Membership and Credentials

Philip V. Reitz

Research Committee

Gerald M. Barrack

Public and Professional Relations

Thomas J. Balshi

Necrology and Eulogy

Edward Cavazos

Ceremonies and Awards

John S. Ostrowski

Color and Color Matching

Richard McPhee

Prosthetic Dental Care Programs

David W. Eggleston

Nominating Committee

Jack D. Preston

Private Practice of Prosthodontics

Lawrence S. Churgin

Site Selection

Ronald D. Woody

Budget Committee

Noel D. Wilkie

Sections Committee

Dana E. M. Kennan

Central Office Advisory

Robert J. Everhart

Prosthodontic Nomenclature

Dean L. Johnson

Commercial Exhibits

Mohammad Mazaheri

International College of Prosthodontics

Jack D. Preston

Review and Revision of Goals and Objectives

Cosmo V. DeSteno

Committee on Ethics

Robert W. Elliott

Dental Laboratory Service

Mark E. Connelly

Geriatrics

James S. Brudvik

Care of the Maxillofacial Patient

Richard J. Grisius

Computer Utilization

Stephen F. Bergen

Journal of the American College of Prosthodontists

Donald O. Lundquist

Evaluation of the Annual Session

William A. Welker

Administrative Management

Noel D. Wilkie

Peer Review

David W. Eggleston

Investigations of Real Estate

Procurement

To be announced

Historian

James A. Fowler

Associate Editor of the Journal of Prosthetic Dentistry

Dale H. Andrews

Annual Session-Seattle 1985

Kenneth A. Turner

Local Arrangements-Seattle 1985

James S. Brudvik

The fall meeting of the Section was held November 30, 1984 at Fort Sam Houston Officers Club in San Antonio. It was hosted by the Army members of the Section.

Following a social hour and dinner three residents of the Brook Army Medical Center Prosthodontic program presented their personal research findings. The program included: Dr. Norman Avaki - "Vertical dimensions with head angulation changes"; Dr. Allan Estey - "Centric jaw relation records"; and Dr. Arthur W. Bryant - "Use the lingual rest preparation on mandibular cuspids".

Following the scientific session President Jim Fowler conducted the business meeting. Secretary/Treasurer Earl Feldmann reported the Section to be in good financial standing. Vice-President Marty Comella, who has served the Section so well as Secretary/Treasurer and Vice-President has been alerted for transfer this coming summer so will be unable to continue his good work with us. We wish him well.

The nominating committee, consisting of Ken Stewart, Chairman, Charles DuFort, Marty Masterson, and Wayne Simmons submitted the slate of nominees for 1985. Jim Fowler conducted the election and officers elected are as follows: President - Earl Feldmann, Vice-President - Charles DuFort, Secretary/Treasurer - John Ivanhoe.

Several College members in the Ft. Worth-Dallas area expressed a desire to form a sub-section to the Texas Section to initiate continuing education programs and enjoy social activities. A delegate would be appointed to attend and provide input to the Section meetings. The Section members were unanimous in their support of this concept.

The next meeting of the Texas Section will be sponsored by the University of Texas Dental School members.

Georgia: The Georgia Section met August 10-11, 1984, at Jekyll Island in conjunction with the Georgia Dental Association's annual meeting.

The Georgia Section sponsored a lecture-participation course on Basic Principle and Concepts of Partial Denture Design that was well attended and received by the dentists attending the GDA annual meeting. Dr. Wayne Franz from the Georgia Section was the course lecturer and gave an outstanding lecture presentation. Following the lecture, participants who brought patient diagnostic casts had an opportunity to sit down, one on one, with

NEWS FROM THE SECTIONS

Texas: The third annual meeting of the Texas Section was held at the City Club of San Antonio on September 22, 1984. The dinner meeting was attended by seventy-eight members and wives. The Section was particularly pleased to have Dr. Carolyn Parker from Dallas and Drs. Frederick Silverman and Gordon King and wives from Houston, indicating that we are truly a Texas Section. The guest speaker was Mr. Jim LaPrade, a member of Toastmasters International who spoke on the subject of "The Visit".

The evening was highlighted by a talk from a special guest, Dr. Frederick Elliot and his wife from Kerrville, Texas (see accompanying story). President Jim Fowler emceed the program and conducted the short business meeting that followed.

members of the Section and supplied surveyor to design and plan for mouth preparation for a removable partial denture.

A concurrent breakfast-business meeting of the Section was held. At this meeting, Dr. Michael A. Carpenter installed the following 1984-1985 officers of the Georgia Section: Dr. James S. Wheeler, President; Dr. George Priest, Vice-President; Dr. Janine Bethea, Secretary; and Dr. Charles Abney, Treasurer.



From the left: Dr. Michael A. Carpenter, Immediate Past President of Georgia Section; Dr. James S. Wheeler, President; Dr. Charles Abney, Treasurer; Dr. Janine Bethea, Secretary; and Dr. George Priest, Vice-President.

TEXAS SECTION HONORS DR. FREDERICK C. ELLIOTT



Dr. Frederick C. Elliott and Dr. J. D. Larkin

At the annual dinner meeting of the Texas Section of the American College of Prosthodontists on September 22, 1984, Dr. Frederick C. Elliott was honored as one of the Founders of the American Board of Prosthodontics. Dr. Elliott had a distinguished career serving as a teacher in removable partial prosthodontics and as Dean of the Dental College in Houston, which was incorporated into the University of Texas System during his tenure. In 1952 he left his position as Dean to become the Director of the Texas Medical Center in Houston, continuing in the latter until his retirement in 1963. Dr. Elliott was influential in the planning and integration of all institutions into the University of Texas Health Science

Center in Houston. The Texas Section applauded Dr. Elliott's accomplishments in the health sciences and especially his part in the organization of the American Board of Prosthodontics, dating from February 21, 1947.

Dr. James A. Fowler, Jr., president of the Texas Section chaired the meeting. Other officers include Dr. L. W. Carlyle, immediate past president; Dr. Martin Comella, vice-president; and Dr. Earl Feldmann, secretary-treasurer. Numerous scientific programs are held throughout the year by the group.

ACP NATIONAL PEER REVIEW

The Executive Council has approved the ACP Peer Review Manual to be used as a guideline for prosthodontic peer review. This comprehensive manual (over 200 pages) standardizes the peer review process. Important features of the manual include:

1. A four point graded system. As an example, a porcelain/metal crown would be graded in the following manner:
 - a. R = Range of Excellence. The restoration is of satisfactory quality and is expected to protect the tooth and the surrounding tissues.
 - b. S = Range of Acceptability. The restoration is of acceptable quality but exhibits one or more features which deviate from the ideal.
 - c. T = Replace or Correct for Prevention. The restoration is not of acceptable quality. Future damage to the tooth and/or its surrounding tissues is likely to occur.
 - d. V = Replace Statim. The restoration is not of acceptable quality. Damage to the tooth and/or its surrounding tissues is now occurring.
 - e. This grading system is equivalent to the school grades of "A" "B" "D" and "F". The letters "R" "S" "T" and "V" are used during the peer review patient examination to prevent the patient from keeping "score" during the examination.
 - f. This grading system would be used to grade the indication for the crown, the surface and color, the anatomic form (including occlusion), and the margin integrity.
2. Form letters and guidelines for construction of correspondence

with the prosthodontist, patient, and dental association.

3. Step by step check lists and flow sheets to organize the peer review process in a systematic manner.

The ACP Peer Review manual will be available for ACP Peer Review Committee use very shortly. The manual can be purchased by ACP members, for non-ACP use, for the cost of printing. The manual can be purchased by non-ACP members for the cost of production.

The objective of Peer Review is litigation prevention, for the benefit of the patient and the prosthodontist.

Peer Review of all ADA members is the responsibility of the state dental associations. By written consent of the dentist and the state association, a non-ADA member can undergo peer review. The peer review process is initiated by a patient complaint to the ADA at the component or state level.

The ACP Peer Review Committee will receive the complaint from the state or component association and gather all the necessary information, perform the patient examination, and write the resolution letter. The resolution letter is reviewed by the state association before it is sent to the patient and the dentist. A resolution in favor of the patient cannot exceed a full refund of the fee paid by the patient to the dentist.

The ACP Peer Review Committee will sponsor a workshop on the use of the manual at the 1985 Annual Meeting.

The ACP Peer Review Committee will be contacting each state dental association to offer the services of the ACP in providing prosthodontic peer review. The Committee has no desire to impart practice philosophies from one part of the country to another part of the country. Each peer review case will be examined by the most local members of the Committee. If you wish to serve on the ACP Peer Review Committee as an examiner, please send your name to Dr. Robert Sproull, and plan to attend the 1985 workshop on peer review.

The Committee plans to be fully operational providing prosthodontic peer review for state associations that accept our services by January, 1986. Respectfully submitted,

The ACP Ad Hoc Committee on National Peer Review

Dr. David Eggleston, Chairman
 Dr. Harold Litvak
 Dr. Robert Kaplan
 Dr. William Laney
 Dr. Dale Smith

SUCCESS OF ORAL SURGEONS AWARENESS PROGRAM SPARKS ENTHUSIASM FOR ADA MARKETING PLAN

Editor's note: The following exclusive interview with Dr. Edwin D. Joy of the Medical College of Georgia in Augusta was conducted by GDA Associate Editor, Dr. Richard A. Smith and Periodontal Awareness Chairman, Dr. Jefferson H. Hardin.

Dr. Joy, Professor and Chairman of Oral & Maxillofacial Surgery at MCG is the current and only chairman of the Public Information Committee of the American Association of Oral & Maxillofacial Surgeons (AAOMS). He has held this position for six years. The AAOMS recently released its report on its successful Public Education Program.

SMITH: Ed, can a marketing plan or a public awareness plan with a limited budget such as the one AAOMS undertook be successful?

JOY: The effectiveness of a campaign, at least the campaign that we did, is unimpeachable. In fact, we were told by the people who conducted the program's research that this was probably the most successful campaign for the money that they had ever seen in the history of their company. We started our campaign three years ago with a one million dollar a year budget which meant that each of our members was assessed \$275.00 a year for three years.

We had three main goals for our campaign. Since our earlier research had indicated only 10% of the population knew what an oral surgeon did, our first goal was to increase public awareness of our services. The second goal was to instruct the public to choose the services of an Oral & Maxillofacial Surgeon over and above a competing person in other medical specialties. The third objective, we want the public to see us as an altruistic profession who is in business for the public's well-being over and above our own; so that none of our messages would ever come across as self-serving. Because of the complexity of our goals and our messages, we decided that we needed to go with the printed media rather than television.

HARDIN: How successful was the AAOMS campaign and how were you able to measure that success?

JOY: Jeff, each of our messages carried an invitation to write the American

Association of Oral & Maxillofacial Surgeons for additional information and during the last year we actually added an 800 number for them to call. This gave us a handle on at least a certain number of people who had written or called. We had 24,000 people respond in writing or by telephone. An independent research company - no relationship with the AAOMS or with our ad company - found, what we thought was an absolutely astounding figure, that 50% of those people who had written in for more information, had either gone to an oral surgeon or intended to do so in the immediate future. Of the 50% who had intended to go to an oral surgeon, 20% had already had the surgery done and that 20% spent in excess of \$7 million. Now that was double the price of the campaign for the entire three years. And we only polled a small sample of the people who may have seen the Public Awareness Campaign material. We know that, for everyone who wrote to the Association, there were others who took direct action from the campaign and went directly to an oral surgeon.

"...Individual advertising that sets one professional up over another is bad."

HARDIN: How about your goal of increasing awareness as to the duties of an oral surgeon?

JOY: Eighteen months into the campaign we did a midstream study on how effective the campaign had been up to then. We found that there had been a 15% swing in the general public awareness - in other words only 18 months into the program, 25% of the American population now knew what an oral and maxillofacial surgeon was and what he did.

SMITH: We can see that you increased utilization and certainly increased awareness but how were you able to maintain an image of altruism?

JOY: Our messages were educational; they told a person a disease process that they might have and what could be done for that disease process. Then we told them that this message comes to you from your oral surgeon. We wanted the public to know that we wanted them to be healthier, and that we cared. These messages really have nothing to do with making us busier; but had a long range goal of heightening the image of oral and maxillofacial surgeons in the public's eye, as we educated them about our services.

SMITH: Ed, do you rate the success of your campaign as ongoing?

JOY: Yes, but it takes some time for a campaign to come to its full fruition. In our first year we had 3,000 people respond. In our second year we had 7,000 people call. In the third year 14,000. So, it was going up in almost a geometric progression. The interesting thing was, the year that we had 14,000 people call, we only had half the number of ads. So the look of the ads, the look of the message, the general ambiance of the message, was starting to click in the people's minds.

HARDIN: In the AAOMS program you had two major problems. One, of securing the two-thirds vote for the \$275.00 dues increase; and the other was to secure that vote in each of three consecutive years. How did you reach your naysayers who said it was unethical, that it was too costly, — you've heard all the arguments—how did you reach those people and get that vote?

JOY: Well, we tried to reach them on a one to one basis. We wanted to explain that marketing and advertising can be done ethically and professionally and it is done everyday. Some of the people we never convinced. We still have members who don't think this campaign was ethical and done properly. We will never reach all of those people. I guess the nature of the dental profession is that we are free thinking entrepreneurs, individually oriented and we don't necessarily all think the same.

I personally feel that individual advertising that sets one professional up over another is bad. But one that caters to an entire profession and is in the best interest of the public is good.

In today's market place many of the previously conservative, very professional, national organizations such as The American College of Surgeons and American Hospital Association are now out there marketing. The marketing people told us three years ago that the people who are out there first establishing their position in the market place will be very difficult to unseat later on by somebody getting in late.

SMITH: Then how long can we stay out of the advertising arena?

JOY: Well, I think we'd probably be in great error for staying out of institutional advertising. That is to be distinguished from personal advertising. In institutional advertising everyone gets the benefit of the message which is very carefully scrutinized as far as its professionalism and its altruistic nature by a group of people who have one objective. Personal advertising has, for the most part, the objective of increasing the busyness of one dentist over his

dental colleagues. Also, personal advertising is subject only to the ethical standards of that one person for better or for worse. *It is my feeling that good solid institutional advertising will probably retard personal advertising.*

SMITH: What was your experience with membership retention during the AAOMS campaign?

JOY: Richard, we had a rough idea from some data we received from the American Association of Orthodontists who started their campaign approximately a year before we did. We had planned on about a 15% drop in membership. We speculated the 15% who would leave were those near retirement, in the military service, or someone who just saw this as the "last straw". We did not feel we would lose members only because of this. We only lost 7% of our membership, or let me put it another way, 7% of our membership resigned in the first year of the campaign for *all* reasons.

"...good solid institutional advertising will probably retard personal advertising."

SMITH: What is your normal attrition rate in a year?

JOY: Probably 5%.

SMITH: So you might have had a 2% increase in the number of drop-outs during the years that you had the campaign?

JOY: Yes, but on the other side of the coin, which I think is very important, we had no discernible decrease in young oral surgeons joining the program at the beginning of their career, even knowing that they were going to have to pay an additional \$275.00.

HARDIN: Did you have a larger number threaten to leave than actually did leave?

JOY: Absolutely!

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WASHINGTON NEWS BULLETIN

The following are quotations from the Washington News Bulletin, Volume 17, Number 5, November 1984, a publication of the American Dental Association.

The 98th Congress adjourned without taking final action on several issues of interest to the dental profession. On a positive note was the failure to adopt the Administration's proposal to tax

employer health benefit contributions.

Congress did not adopt the FTC authorization bill, which included a restriction on Commission activities with regard to state regulated professions, and legislation to restrict the authority of the ERISA laws.

Agreement could not be reached on substantive changes to several Public Health Service Act programs including health manpower, the National Health Service Corps, health planning and health maintenance organization assistance.

Except for a possible key change in the Senate Finance Committee chairmanship, the 1984 elections produced little significant movement on the major committees which address issues of paramount importance to dentistry. The issues in the 99th Congress are not likely to differ greatly from those faced in the prior Congress. It is certain that the Administration's proposed tax on employer health benefit contributions, or some variation of this proposal, again will be the main issue confronting dentistry.

Federal Trade Commission: As reported earlier, the FTC authorization legislation, S. 1714 and H.R. 2970, died in the waning days of the 98th Congress due to an unresolved controversy over the legislative veto—congressional review of agency rules and regulations.

The FTC authorization bills also contained statutory limits on FTC authority to preempt state laws relating to the practice of dentistry and other professions. Such proposed limitations would pertain to state laws regulating the quality aspect of professional practice as opposed to the commercial factor.

It is expected that there will be FTC authorizing measures reintroduced in the 99th Congress following hearings before the respective House and Senate Commerce Committees. The Association will be actively involved in these hearings in an effort to include language restricting FTC authority concerning the professions in any authorizing bills that are introduced in both legislative bodies next year.

Military Dependent Dental Care: Association opposed legislation permitting space available dental care for military dependents has been approved by Congress as part of a \$297 billion Defense Authorization Act, H.R. 5167. The effective date of the new authority is delayed until July 1985 with stipulations, the (1) active duty dental needs

are to be met first, (2) the services not attempt to increase staff or facilities for purposes of dependent care and (3) the Defense Department submit to Congress by February 1985 a detailed report on the Pentagon's plans and resources for providing space available dependent dental care.

In a related development, the Pentagon is reviewing a draft of a proposed group dental insurance plan for military dependents. The program, which would be administered by private insurance carriers, is to be initially financed through a combination of federal sponsorship and monthly dependent premiums. Military families who elect to join the insurance plan would pay an estimated \$5.00 monthly premium, plus additional copayments for dental services rendered.

The Defense Department would provide approximately \$100 million annually towards the cost of the program. Although few details are available, it is understood that the dental benefit package would be limited to preventive, emergency and restorative dental services. Pentagon officials indicate that the proposed insurance plan is intended to supplement, not replace, the recently enacted space available dental authority. The ADA will seek Congressional support in 1985 for a comprehensive program of dental care benefits for dependents of active duty military personnel.

Malpractice Reform Legislation: Last summer the Association submitted statements to both the House Ways and Means Committee and the Senate Labor and Human Resources Committee outlining its concerns with H.R. 5400 and S. 2690, which would establish a no-fault malpractice liability system as an alternative to the existing tort litigation process.

Under the proposal, all health providers—including dentists—who render services under federally funded programs such as Medicare, Medicaid, VA, CHAMPUS, etc., would be covered if such legislation were enacted. If the state passed a model state alternative liability law, then the system would be applicable to all malpractice cases.

There is no doubt that Representatives W. Henson Moore (R-LA) and Richard A. Gephardt (D-MO) along with Senator David Durenberger (R-NM) will reintroduce this legislation in the 99th Congress despite its mixed reviews from health providers, insurance companies and the legal community. The Association staff in Washington will continue to monitor

this alternative liability legislation to determine whether or not it can be workable in ameliorating the escalating costs of professional liability insurance.

Cost Containment: There is no question that efforts to control rising health care costs will be a major issue in the 99th Congress. Enactment last year of the prospective reimbursement system for Medicare hospital services marked a major departure in the mechanism for reimbursing hospital services. There will be efforts next year to extend the prospective payment system to physician services for hospital inpatients. It can be expected that Senator Kennedy (D-MA) and Representative Gephardt (D-MO) will reintroduce their legislation to require that all services, whether paid for through public or private programs, be subject to a prospective reimbursement system. Other regulatory proposals also can be expected.

It is likely that there will be a variety of competition oriented proposals introduced in the 99th Congress as well. Included will be legislation to override state barriers to the development of Preferred Provider Organizations. There is a significant element of Congress which is interested in assisting the private development of alternative, cost-saving health care delivery systems.

It is not clear whether the regulatory and competition approaches are mutually exclusive or whether one will have more appeal to the Congress. Certainly there will be extensive efforts to expand Congressional intervention in rising health care costs.

State Legislation

Montana Voters Pass Denturism Initiative: By a 53% to 47% margin, Montana voters approved a denturism initiative at the November general election. With an effective date of December 1, 1984, the measure establishes a new state board of dentistry consisting of three denturists and two public members. Of the two public members, one will be a senior citizen representative and the other a low income representative. Additionally, the board will appoint a fair practice committee from the association of Montana denturists. With regard to its duties, the new board will determine the qualifications of applicants for licensure; administer licensure examinations; collect fees and charges; and issue, suspend and revoke all licenses under conditions prescribed in the act.

The measure defines a denturist as

an individual licensed to engage in the practice of dentistry. A denture is defined as any removable full or partial upper or lower prosthetic dental appliance to be worn in the mouth. The practice of dentistry is defined as:

(a) the making, fitting, constructing, altering, reproducing or repairing of a denture and furnishing or supplying of a denture directly to a person or advising the use of a denture; or

(b) the taking or making or the giving advice, assistance, or facilities respecting the taking or making of any impression, bite, cast or design preparatory to or for the purpose of making, constructing, fitting, furnishing, supplying, altering, repairing, or reproducing a denture.

After April 1, 1985, a person must have a license to engage in the practice of dentistry. Exceptions are made for licensed dentists and physicians, and for students and interns in dentistry. The act also provides standards of conduct, sanitation and practice for denturists, and sets forth restrictions on their scope of practice. With regard to the latter, a denturist may not:

1. extract or attempt to extract teeth;
2. initially insert immediate dentures in the mouth of the intended wearer;
3. diagnose or treat any abnormalities;
4. recommend any prescription drug for any oral or medical disease; or
5. construct or fit orthodontic appliances.

Applicants who file before April 1, 1985 must successfully pass an examination, as well as show that they have been employed in denture technology for at least five years prior to application, are able to demonstrate competency in intraoral procedures, and document the successful completion of coursework in ten areas of study, including radiology. Applicants who file on or after April 1, 1985 must complete two years of formal training at an educational institution accredited by an accrediting agency recognized by the Montana state board of regents. In addition, they must complete a two-year internship in Montana or three years out of state.

The measure also includes a non-discrimination provision regarding dental insurance coverage of denturist services. The act provides that whenever an insurance policy covering dental care provides reimbursement for any service that is within a denturist's scope of practice, the insured is entitled to reimbursement for that ser-

vice whether the service is performed by a dentist or a denturist.

Finally, the measure will permit licensed denturists to take x-rays. This provision includes denturists as licensed practitioner under the state radiologic technology law. It also provides that denturists do not have to have a separate authorization from the radiologic technology board to administer x-ray examinations related to their practice. This type of authorization to use x-ray was not included in similar initiatives adopted in Oregon in 1978 and Idaho in 1982.

The initiative can be amended by the Montana Legislature when it meets in January. While details of any legislation are not available at this writing, the Montana Dental Association has decided to "pursue aggressively all avenues to clean up the initiative to make it better for the people of Montana."

ECONOMIC SURVEY OF PRIVATE PRACTICE PROSTHODONTISTS

By Paul P. Binon, D.D.S., M.S.D.

Over three hundred private practice prosthodontists responded to the American College of Prosthodontists' National Economic Survey for fiscal 1982. The survey represents a national cross-section of the fee for service prosthodontist in today's economic environment.

The sample averaged 15 years in private practice and ranged from less than one year to 54 years of practice. Those in practice less than 10 years made up the bulk (44%) of the survey group. The 10 to 19 years in practice constituted 28%, the 20 to 29 years group 13% and those in practice more than 30 years represent the remaining 15%.

Solo practitioners comprised 60% of the respondents. Group practice and shared office settings accounted for 22% and 18% respectively. Financially independent practices (solo and shared office) therefore accounted for 78% of all respondents (291). The highest frequency of association in a group or shared office setting was with another prosthodontist (38%). Some 32% of the prosthodontists practiced with a single general dentist. The remaining 30% of the group or shared prosthodontists practiced with other specialists (8.6%) and various combinations of one or more prosthodontists, other specialists and/or general den-

tists (21.4%).

The work week for prosthodontists ranged from less than 25 hours per week to more than 51 hours per week with 72.5% working between 26 and 40 hours per week. The greatest number (31.4%) worked 26 to 30 hours per week. According to the survey data, the majority of practitioners (42.4%) worked 200 to 249 days per year and 36.1% worked 150 to 199 days per year.

The survey respondents were asked to characterize the scope of their practice as "limited" or "general". Nearly 80% of the prosthodontists described the scope of their practice as "limited" to the specialty. The remaining 20% characterized their practice as "general" in nature. The amount of general dentistry performed in practice, relative to the character of the practice, indicates that the "limited" practice averages 8.2% general dentistry whereas the "general" characterized practice averages 35.6% general dentistry.

The status of the prosthodontic specialist relative to recognition as a specialist by state or local dental societies was investigated. Some 80% of the respondents are recognized as specialists by organized dentistry on a state and local level. Only 11% of the "limited" practice prosthodontists were not recognized on a dental society level whereas 52% of those characterized as "general" are not recognized as specialists. Recognition as a specialist is therefore, dependent not only on formal certified training, but also on the conduct of the practice and most important, how that conduct is perceived and categorized within the local dental community.

An average of 15 new patients were seen each month by the survey group. New patients entering the prosthodontic practice ranged from 1 to 65 per month. The "limited" practice averaged 14 new patients whereas the "general" practice designate averaged 17 new patients per month. Among the prosthodontists surveyed, 38.5% reported 6 to 10 new patients per month, 20.5% reported 11 to 15 new patients per month, 16.1% received 16 to 20 new patients per month, and 6.8% recorded 21 to 25 new patients per month. Some 5.3% reported 26 to 30 new patients per month and the remaining 5% recorded 31 to 65 new patients per month. A total of 243 prosthodontists composed the sample.

Patient visits for the entire sample, ranged from 30 to 600 patients visits per month, with an average of 188

patient visits per month. The "limited" practice averaged 175 patient visits per month compared to 238 patient visits per month for the "general" practice characterization. Among the sample, some 44.6% had a frequency of 101-200 patient visits per month and 20.4% reported 51 to 100 patient visits per month. In general, the prosthodontist sees fewer patients per month and spends more time with each patient than the generalist.

In-house laboratory technicians and laboratory facilities characterize the prosthodontic practice. Some 44.3% of the respondents had laboratory facilities with dental technicians employed and 27.2% had laboratory facilities unstaffed with technicians. The remaining 28.5% of the sample had no laboratory facilities within the confines of their prosthodontic office. A significant number of private practice prosthodontists (71.5%) therefore, directly supervise their own laboratory work or do some or all of their own laboratory work within the dental office. The 44.3% of the sample employing dental technicians ranged from 10 or more full-time technicians to 1 or more part-time technicians with the majority (46.4%) employing 1 full-time technician.

The total number of employees ranged from 0 to 11 for solo practitioners and 1 to 36 for group/share practices. Some 49% of the solo practitioners employed two or three staff members compared to 52% of the group/share practices who employed two to five staff members (limited to front office and dental assistant personnel). The greatest number of employees for a solo practice was 11 of which 7 were dental technicians. This practice generated a personal gross of \$492,000 per year with a patient flow of three hundred twenty patient visits per month. The greatest number of employees for a group practice (7 prosthodontists) was reported at 36 shared staff members with a personal gross of \$427,000 per year for the one respondent. Prosthodontists practicing in a group/share office setting with a large staff consistently had a higher gross.

Staff salaries presented a wide range of values. Hourly wage for front office staff ranged from a low of \$3.00 per hour to a high of \$20.00 per hour with an average of \$7.31 per hour and a median of \$7.50 per hour. Dental assistant salaries were less and ranged from \$3.00 per hour to \$25.00 per hour with an average of \$6.48 per hour and a median of \$7.00. Only 7.8% of the dental assistants made more than \$8.00

per hour compared to 39.9% of the front office staff reported in this sample (378 respondents). Dental hygienists are utilized in 62% of the practices. Some 75.2% of the group/share practices employed hygienists as compared to 53.6% of the solo practices. Full-time hygienists were utilized in 39.6% of the solo practices compared to 56% of the group/share practices.

The average gross income for the survey group in 1982 was \$223,000. The gross income ranged from \$33,000 to over \$600,000 for the 228 respondents. Representing the largest group, 37.1% had a gross between \$100,000 and \$200,000. The next largest group 28.1% reported a gross between \$200,001 and \$300,000. The \$300,001 to \$400,000 gross practice comprised 14.5% of the sample. Some 5.4% had a gross of \$400,001 to \$500,000 and 3.2% said their gross production exceeded \$500,001. Those practicing in a group/-shared office setting accounted for higher frequencies in the \$300,001 gross or more categories, indicating a definite benefit to this type of practice arrangement.

The average overhead for the sample was 57.6% with a range of 96% to 10% of the gross income. Some 23.8% of the respondents reported an overhead of less than 50%. Overhead of 50% to 59% was reported by 28.6% and an overhead of 60% to 69% by 31.4% of the sample. In contrast, 11.9% experienced higher overhead figures between 70% and 79% and 4.1% of the sample responded with overheads above 80%. Laboratory overhead averaged at 15.5% of gross income with a range from 42.5% to 1.1%. The low average and broad range may be attributed to a considerable number of prosthodontists who do some or all of their own laboratory work. The average overhead attributed to dental supplies was reported at 7.3%.

Production per hour varied greatly among respondents, ranging from an average of \$145.00 per hour with a high of \$416.00 per hour and a low of \$20.00 per hour. One third (33.2%) of the practices reported a production of \$51.00 to \$100.00 per hour. Some 22% reported production of \$101.00 to \$150.00 per hour and 18% were between \$151.00 and \$200.00 per hour. Only 21.1% of the respondents produced at a level greater than \$201.00 per hour, a figure given by most practice management consultants as a goal for the efficient and well-managed practice.

Collection percentage reported, indicates that a majority of practices

have good financial controls. Some 40.4% of the respondents collected 99% to 100% of what they produced. In addition, 31.6% collected between 94% to 98% and 15.5% of the practices had a collection rate of 90% to 93%. Those collecting 89% or less made up 12.4% of the sample and this may indicate front office ineffectiveness and poor management.

Fees for selected prosthodontic procedures were also surveyed. Denture fees ranged from \$208.00 to \$3000.00 per arch. An average fee of \$764.00 for a maxillary denture and \$777.00 for a mandibular denture was recorded. Of the 267 respondents only 37 varied their fees for a mandibular denture. Interestingly enough, two respondents charged less for a mandibular denture than the maxillary counterpart. The average fee for a laboratory processed denture reline was recorded at \$190.00 per arch.

Fees for porcelain fused to metal restorations also varied significantly. The average fee for a PFM restoration with precious (noble) metal was \$452.00, presenting a range from \$225.00 to \$1000.00 per unit. The fee for non-precious PFM's was slightly lower, averaging \$420.00 with a range from \$180.00 to \$1000.00 per unit. Some 40.6% of the respondents did not provide non-precious PFM crowns for their patients. Those practitioners who provided both types of restorations, charged equal fees 53% of the time and 2% charged more for the non-precious versus the precious metal PFM restoration.

Full gold crown fees averaged \$422.00 per unit. Fees ranged from \$200.00 to \$850.00 per unit. The average fee for the 3/4 gold crown restoration was \$409.00 with a range of \$200.00 to \$850.00 per unit. Some 12% of the respondents indicated they did not provide this service for their patients. An average of \$71.00 was charged for a complete dental exam and a full radiographic survey by the survey participants.

In addition to economic and fee questions, some general information was also requested. An overwhelming 92.3% of the respondents are happy as prosthodontists. Half the sample, however, feels that they are not adequately compensated for the additional education and extra efforts expended in treating patients. When asked, "are there enough prosthodontists in private practice?", 69% replied that there were enough with 7% being uncertain. Of the two hundred seventy-one respondents

to the next question, 52.4% stated that their practices were not as busy as they would like. Perhaps this explains why a majority believe that there are enough prosthodontists in private practice at the present time. Of those responding, 67% indicate that insurance carriers in general do not recognize the prosthodontic specialist. An additional 6.3% were uncertain as to their status within the insurance industry.

When the private practice prosthodontist was asked if he or she was willing to pay for a media campaign to inform the public as to what a prosthodontist has to offer the public, 81.9% answered affirmative, 17% said no and 1.1% were non-committal. In addition, some 77.1% would agree with an assessment for this purpose and of those, 95% would contribute \$250.00 or more.

Very little information has been available on the economic status of the prosthodontic practice in the past. In 1979 the ADA¹ published the results of a survey of 1634 dentists nationwide for fiscal 1978 that did include 261 specialists of which 8 were prosthodontists. Due to the small sample size, a net average income for the specialty of prosthodontics was not reported. For fiscal 1982, the same source² reported a net income of \$55,570 for general practitioners and \$84,250 as a composite for all specialists. Additional unpublished data for the same year based on a total of 500 specialists did provide average net incomes for 4 of the 6 dental specialties. Again an insufficient sample size was available to report any income figures for prosthodontists.

Based on the figures obtained from this survey, the "average" prosthodontist, having an overhead of 57.6% and a gross production of \$223,000 would realize a net average income of \$94,500. Considering that 73% of the respondents grossed between \$100,001 and \$350,000, the average figures for this group may be more representative of the "typical" prosthodontist. The average gross of this "middle income" practitioner is \$203,313 with a net income of \$86,205. These figures conflict substantially with those reported in DENTAL MANAGEMENT³ for prosthodontic specialists in fiscal 1982. Based on their survey of 150 dental specialists, 49 of which were orthodontists, they report an average gross for prosthodontists of \$124,749 and a net of \$54,443. Of the six specialties listed in this article, the prosthodontist had the lowest gross, averaging \$52,000 less than the aver-

age gross for the general practitioner. They reported a net income for the prosthodontist of \$25,000 less than the average net of the other specialists and \$9100 less than the general practitioners surveyed. Obviously, the information presented in DENTAL MANAGEMENT relative to the prosthodontist is grossly inaccurate. It reflects conclusions based on too small a data base to be accurate and meaningful.

For the first time an economic survey of sufficient sample size for prosthodontists in private practice has been completed. For those in post graduate training and active practice, it provides a reference point. The results of this survey are incidental to how the individual perceives success. Patient and professional satisfaction as well as economic remuneration are all very personal considerations.

Profile of the Average Prosthodontist

Years in Practice	15.1
Hours worked per week	34.5
Number of non-hygienist full-time auxiliaries	3.4 (Solo practice)
Lab technician in office lab	44%
Practice with hygienist	62%

1982 Gross Income	\$223,000.00
1982 Net Income	94,500.00
1982 Overhead	57.6%

1982 Net Income By Specialty

	ADA ²	Dental Mgmt ³
General Practitioner	\$55,570	\$63,540
Prosthodontists (ACP* \$94,500)	-0-	54,443
Orthodontists	92,930	87,352
Oral Surgeons	89,120	74,499
Periodontists	85,260	88,529
Pedodontists	67,130	78,571
Endodontists	-0-	75,666

(-0-; insufficient sample size)

1. Bureau of Economic Affairs, ADA, March 1984.
2. Bureau of Economic Affairs, ADA, Verbal Communication. Nov. 1, 1984.
3. Wilson, B.: Dentists' Incomes: National and Regional Survey. Dental Management, 23, No. 6: 16, 1983.

* ACP - American College of Prosthodontists, Survey 1982.

SYNOPSIS OF PAPERS PRESENTED AT THE EDUCATORS/MENTORS SEMINAR

TITLE: Observations on Today's
Advanced Prosthodontic
Education

Presenter: Dr. William R. Laney
Synopsis By: Dr. Lee M. Jameson

Dr. Laney offered his observations and preceptions of advanced prosthodontic programs based on his expertise as a prosthodontic consultant for the American Dental Association.

He set the background for reviewing the ADA accreditation process for advanced programs by discussing the expansion of program curricula due to new research, clinical methods, and technologic developments. His conclusion was that programs in the near future may have to extend their curricula to 30-36 months to accommodate this new knowledge. He also noted advanced prosthodontic programs today lack consistency. Even though the accreditation process is constantly scrutinized and reformed, it can be subject to political manipulation; thus, the potential for weak programs to survive.

Based on observation of clinical performance of candidates, the American Board of Prosthodontics has emphatically recommended to the Council on Dental Education, that to be a prosthodontist capable of practicing the specialty as defined, candidates must be trained and educated in all subdisciplines of prosthodontics. Therefore, all programs as of 1986 will no longer be listed by the subdisciplines or as combined but will be designated as prosthodontic programs except maxillofacial third year programs.

Too much time has had to be spent by program directors on clinical laboratory basics due in part to the reduction in the undergraduate curriculum. On the other hand, didactic programs must not be guilty of training clinicians solely to pass a certification examination nor should emphasis on services be done at the expense of the didactic curriculum as in some non-school based programs with stipends. As stated by Dr. Alvin Morris, "the quality of education is the balance that is struck between training (dealing with equipment and techniques) and education (dealing with people and ideas) and the quality

and effectiveness of our educational efforts."

Dr. Laney pointed out that there are more foreign trained dentists in advanced prosthodontic programs than any of the other specialties and was quick to note they do not automatically weaken programs but their performance on licensure examinations has not been remarkable. In addition, those that have completed programs do not end up where the actual need for clinical services is high-in the private practice sector.

A very key observation was that the excellence of a program lies with the quality and character of the curriculum, the program director and the faculty rather than the institutional setting. Thus, providing quality education by a stimulating and qualified teaching staff (which is allotted adequate time for self-development and clinical practice) with proper administrative support is the key formula for excellence in a program.

Next, the Future of Dentistry Report was discussed which recommends a reduction in first year specialty positions based on a highly arbitrary specialist to generalist ratio of 7.5 to 100. The specialty programs have shown virtually no growth through the 1970's and 1980's, while first year undergraduate enrollments in dental schools have been declining since 1975. The need for the specialty of prosthodontic services is more than sufficient to warrant specialty recognition from the standpoint of patient need, demand and protection.

Dr. Laney concluded with the following challenge, "it would seem the major question today, is all of this essential and can it be done in two years?"

TITLE: The American Board of
Prosthodontics-Past, Present,
and Future

Presenter: Dr. John E. Rhoads
Synopsis By: Dr. Peter F. Johnson

Dr. Rhoads recounted the history and growth of the American Board of Prosthodontics from its inception in 1947 when the American Dental Association requested the Academy of Denture Prosthodontics to take responsibility for certification in the specialty of prosthodontics, through the development of the current format and its present sponsorship by the Federation of Prosthodontic Organizations. Dr. Rhoads stated that the purpose of the Board

was to determine the competency of candidates to be Diplomates in the speciality of prosthodontics. However, the Board must evolve as knowledge and skills change.

Dr. Rhoads expressed extreme concern over people who are completing residency programs but are not seeking Board certification. He cited as reasons for this:

- 1) certification is not necessary to limit a practice to prosthodontics
- 2) the fear and disappointment of failure
- 3) the magnitude of the effort involved
- 4) the cost
- 5) a lack of understanding of the importance of Diplomate status

He emphasized the importance of Diplomate status in that it defines the specialty, it rebuffs general dentists who cite the low number of Diplomates as a reason for the nonentity of the specialty of prosthodontics, and it upholds our responsibilities to the profession and the public in maintaining specialty standards rather than relying solely on educational exposure. It is his feeling that certification by the Board should be required to practice prosthodontics as a state board is required to practice dentistry.

Dr. Rhoads stated that there are many pressures on the training programs which center the proper preparation of candidates for the Board. They are:

- 1) selection of candidates from a smaller pool
- 2) poorer preparation at the predoctoral level
- 3) candidates performance reflect the practices of the residents in the program
- 4) pressures to complete the programs within time constraints
- 5) budgetary constraints

In commenting on the Board Examination, Dr. Rhoads made comments about the following sections:

Phase I

Part I-written examination. That the knowledge examined is finite but the questions change to improve construction

Part II-patient presentation. This gives insight into diagnostic and planning abilities, and clinically it tests prosthodontic skills

-interview. Depth of knowledge and treatment skills are revealed; interfacing with the candidate occurs and testing of the candidate's ability to apply knowledge

Phase II

Part I-clinical examination shows the candidate's competence, mastery and ability to "put it all together"

Dr. Rhoads personal observations over fourteen years as a Board examiner include the following:

- 1) There is considerable variation in knowledge, inherent ability, and the capacity to assimilate and utilize pre-and postdoctoral training
- 2) Clinical examination areas that were done well were the pre-treatment planning for fixed examiners and the removable patient evaluations
- 3) Poor areas of the clinical exam included the removable cusp set-up, finishing the acrylic resin bases, the choice of inappropriate retainers and pontics, occlusal refinement in wax and metal, and overall metal finish.

His overall impression was that the candidates were not showing mastery of the specialty discipline.

In summary, Dr. Rhoads felt that the purpose of the Board is to determine the competency of candidates to practice the specialty of prosthodontics, that the Board bends over backwards to pass candidates, and that the programs must overcome external obstacles to adequately prepare residents for the Board. Mentors should encourage residents to take the Board to strengthen the specialty of prosthodontics.

TITLE: Some Pragmatic Problems Facing Prosthodontics

Presenter: Dr. Douglas A. Atwood

Synopsis By: Dr. George E. Monasky

There are many external forces exerting pressure on the profession that threaten significant change. The important point is these forces seem to be exerting their influence in a manner which is difficult to control.

Dr. Atwood attempted to identify, guide and suggest modification of these forces. He cited the reports since 1980 that have had impact on prosthodontics: e.g., the AADS report of September 1980, ADA Interim Future of Dentistry Committee report of 1982, September 1983 Final Report of Future of Dentistry.

Various aspects of the reports were discussed. Some of the predictions were - today's dentists are better prepared to do procedures normally

undertaken by specialists; general practitioners only refer the more complicated patients; specialty organizations will resist efforts to remove or reduce their specialty status.

The Final Report of September 1983 looked similar to the Interim Report even after the topical areas were thoroughly investigated, data collected and opinions solicited from widely scattered sources.

Dr. Atwood discussed Strategic Plan for dentistry with 5 principal recommendations. Seventy-one recommendations of the Strategic Plan were mentioned and 6 were considered relevant; (1) study of the competency required for the future practice of dentistry; (2) all graduates take a one year post-doctoral program; (3) influence quality and quantity of manpower supply by maintaining a quality educational system and reducing manpower production; (4) reassessment of current enrollment level and type of specialty training; (5) decrease the number of first year dental specialty positions in order to maintain the current level of specialist ratios; (6) phase out or redefine or merge selective specialty areas.

The ADA Council on Dental Education (1983) recommended to revise the criteria for specialty recognition and to conduct a periodic (10 year) review of all eight specialties. The House of Delegates of ADA directed the Council on Dental Education to implement review process recommendations. Public Health and Prosthodontics are the first to be reviewed.

The ADA Council on Dental Education Report (1984) in response to Future of Dentistry Report identified seven areas of priorities for action. Dr. Atwood stated that the FPO presented forceful and timely responses both in writing and orally to the Committee and Council findings that impact on prosthodontics.

Some of the Pragmatic Problems facing Dentistry and Prosthodontics:

1. Manpower supply-organized dentistry created need for more production, now calling for decreased supply of manpower production. Let supply and demand prevail.
2. Quality of pre-doctoral education-shortening of school from 4 to 3 years, most schools back to 4 years. Planners now considering a fifth year.
3. Post-doctoral programs for 1/2 of each class. Unfortunately, top half would get it but bottom 1/2 of class is the one that needs it.
4. Deans expressed concern for find-

ing and retaining qualified students to fill their government subsidized expanded class size.

The Future of Dentistry Report despite the decreased pool of quality applicants sees increased competency of dentists and less need for specialist. Dr. Atwood states this seems to be fallacious.

Curriculum committees must keep curriculum relevant and current. Prosthodontics must be represented on all curriculum committees.

The specialty of prosthodontics took giant steps forward when it revised Requirements for Advanced Education Programs in prosthodontics. Specialty of prosthodontics must continue to earn the specialty status the old fashioned way, they must earn it.

Graduates of programs must take the Board and practice specialty of prosthodontics.

He predicts 3rd party payments will eventually recognize prosthodontics and we must work for it.

Implantology was discussed.

1. No recognized program.
2. Overlaps surgery and prosthodontic disciplines.
3. Implantologists knocking on the door of prosthodontics.
4. Must develop consensus position and stick with it.

We are small in numbers, less than 1% are listed as prosthodontists. Carl O. Boucher saw need for and organized FPO with 20 member organizations.

The number of prosthodontic specialists needed to teach, do research and practice prosthodontics is a concern of ours. The number of seniors going into programs is decreasing. A large number of postdoctoral students are foreigners.

Dr. Atwood feels that the role of government should be less in supply and demand and more in support of those in financial need. Prosthodontics provide support for those in financial need. Prosthodontics needs subsidization of teacher training and research.

Conclusion:

1. Be informed of external forces that affect us.
2. Communicate among ourselves and develop consensus positions which we can unite and present strong voice that will be listened to.
3. Be aware that what happens to pre-doctoral education affects post-doctoral. Insist any curriculum review have prosthodontists included so as to protect the students and the public we serve.

4. Be aware that subsidization of advanced practice programs without equity of subsidization of advanced prosthodontic programs weakens advanced education in prosthodontics.
5. We must maintain high standards of education.
6. We must assist FPO as it fulfills ADA mandate in the review of prosthodontics program.

(To put it mildly we had better be aware of all the forces seeking to change prosthodontics and do what is needed to keep the ship afloat. Keep the port and starboard lookouts alert.—Editorial comment of synopsis writer.)

SUMMARY OF ACTION ITEMS

Dr. Laney:

1. Pursue all available sources of stipend support for all advanced prosthodontic programs in order to attract quality people to our specialty (a good topic for the Educators/Mentors seminar series).
2. Continue to challenge the Future of Dentistry Report (a formal policy statement) and more specifically the arbitrary specialist to generalist ratio of 7.5 to 100 and the recommendation of reducing first year specialty positions.
3. Establish a policy statement directed to the ADA Council on Dental Education to strengthen existing constraints (or develop new ones) to reduce the potential for political manipulation of the accreditation process for advanced programs in order to establish and maintain consistent quality in all prosthodontic programs.
4. Explore the possibility of establishing an annual forum which would review current research, clinical methods, and technologic advances and their potential influence on the curricula of advanced prosthodontic programs.

Dr. Rhoads:

1. Campaign to increase the number of trained prosthodontists presenting themselves to be examined by the American Board of Prosthodontics.
2. Strengthen postdoctoral programs in the integration of didactic and clinical courses to the end that a higher quality level of prosthodontic skills is demonstrated in candidates to the Board.
3. Diplomate status defines the specialty. More Diplomates will accu-

rately represent the specialty in true dimension.

Dr. Atwood:

Relative to the future of Prosthodontics:

1. Keep informed
2. Unite in a strong single voice
3. Strengthen prosthodontics in predoctoral and postdoctoral curricula
4. Seek stipend support, equality to other programs
5. Strengthen prosthodontic teaching quality (faculty, availability)
6. Support and assist FPO in the Specialty Review process

AFFILIATES/ASSOCIATES SEMINAR

Dr. J. Crystal Baxter moderated the Affiliates/Associates Seminar in Nashville on October 19, 1984. Dr. Baxter stated the purpose of the seminar was to assist non-board members who are preparing to take the Board examination.

Dr. Jack Preston was the Board's representative present at the meeting. He stated that candidates have eight years to complete the process of certification. This period starts when the candidate makes application to take the examination and not when training has been completed. Dr. Preston stated that there are now more specific guidelines. Elaborate presentations such as leather bindings, gold embossed booklets, etc. are not permitted. Each presentation is judged on its merit. Dr. Preston observed that partial dentures are the area that seem to cause the most trouble. Merely stating that "this is the way I was taught" is not sufficient. This does not exempt the candidate from knowing other philosophies or techniques in detail. The examiners score the presentation and recommend pass or fail. If the decision is borderline the presentation is reviewed before a final decision is reached.

Dr. Preston stated that the second oral examination is a much broader one. The Board members want to know you as a person as well as a prosthodontist.

Following Dr. Preston's presentation, four recently successful candidates presented their experiences of the Board. The candidates are Drs. Zaki, Shields, Drago and Malament. A brief synopsis of their comments follows.

Dr. Zaki:

1. Don't listen to anybody who says the Boards are difficult.
2. If you are not prepared, you will not pass.
3. Read textbooks, pick two texts on each subject, including maxillofacial.
4. Old questions are vital.
5. Keep case simple and ask a million questions.
6. Have friends criticize your case.

During the actual examination, the main points were:

1. Questions were primarily on maxillofacial subjects.
2. Examiners were very courteous.
3. Partial denture questions were the most difficult.
4. Photograph every step and keep all records.

Dr. Zaki summarized by saying his experiences were good and the people were very nice.

Dr. Drago offered the main thoughts of his presentation:

1. The study guide is invaluable.
2. Buy recent textbooks, Preston's on color, McCracken and Stewart's on removable partial dentures.
3. Keep presentation simple.
4. Have pre- and post-operative casts, dies and master cast and a survey and design cast.

Dr. Drago also noted that:

1. Most questions asked were maxillofacial.
2. If you don't know, say so.
3. Examiners are very fair in the clinical portion.
4. My assistant saved me about six hours of work.
5. Recommend visiting the place where the exam is to be held.

Dr. James Shields made the following points:

1. Take your time in answering questions.
2. The Board wants us to pass; we do ourselves in.
3. Taking the Board is a culmination of our academic effort.
4. Taking the Board in fixed is difficult as you have to bring your own patient.
5. In Phase II it is easy to develop a stress-management problem.
6. The glossary is very important.
7. Most articulators in Phase I were semi-adjustable.
8. Try to stay away from porcelain.
9. Shimstock is used to check occlusal and proximal contacts.

Dr. Kenneth Malament was the last presenter and the most important aspects of his presentation follows.

1. Failure is a painful idea but success is a tremendous feeling and opportunity.
2. Read all board examiners papers.
3. Answer all questions in the study guide.
4. Read Curtis' book on maxillofacial.
5. Keep your case simple and know materials.
6. Equilibrate the patient and the final cast.
7. Take an assistant.
8. A microscope is a must.

Dr. Malament emphasized the importance of occlusion in his summary.

SYNOPSIS OF PAPERS PRESENTED AT THE NASHVILLE ANNUAL OFFICIAL SESSION

By: Dr. Don Garver

TITLE: A Computer Study of the Human Mandibular Movement

Presenter: Dr. S. Hobo

Dr. Hobo gave a very thorough and in-depth presentation on his computer analysis of mandibular movement. Initially, Dr. Hobo stated that the six degrees of freedom of mandibular movement must be measured at the three apexes - the condyles and the incisal point. He stated that we must measure all six of the movements if we are to know the exact movement of the mandible. Initially he showed the audience an overview of his sensing device which measured all three apexes at one time using the writing styli on conductive plastic plates. A cemented intraoral clutch was used. All of the information from the sensor plates was sent to a computer and plotted for evaluation of the mandibular movement.

In the research project that Dr. Hobo used to prove his theories, he evaluated fifty patients. Using the 130 millimeter intercondylar distance as his recording position, he found that there was a ten to one ratio of the movement between the working side and the non-working side condyles. He further found out that the sagittal condylar inclination on the non-working side was an average of 41.3 degrees. The working side evaluation produced very similar results. Dr. Hobo did an evaluation of the Bennett Shift of the condylar elements, and found that there was a shift in almost all side movements. To determine this, Dr. Hobo used a compu-

terized plotting of the change between the center of the condyle in centric occlusion, terminal centric occlusion and the position of the condylar head in terminal lateral positions. Dr. Hobo referred to the two condylar axes intersection as the cross point. A kinematic drawing of the cross point showed that there was a direct lateral side shift of this kinematic center. This he referred to as the Bennett Shift. The conclusion of this particular project: during lateral movements of the mandible, the non-working side condyle moves straight outward initially and then backward, upward and outward.

In order to reduce the expense of the exotic method of using complete pantographic recordings, Dr. Hobo developed a specific system of measurement. This system is called the Cyberhopy F3 system. Using a special clutch that prevents any opening movement during lateral excursions, Dr. Hobo is able to measure displacement of the anterior mandible in three dimensional space on a pure lateral movement. He can measure the right and left lateral and protrusive movements at three different times, and then take a mean value of those particular movements. Involved in this system is a "facebow-like" device that measures the inclination of the placement of the clutch intraorally. It measures this inclination on all planes. Using a gyroscope-like measuring piece, he is able to correlate the position of the clutches to an anatomical horizontal or perpendicular plane. Once all of the measurements have been done and the mean values equated, mental analogs that correspond to the measurements as recorded are put into the Cyberhopy articulator and the articulator is then adjusted to the patient's measurements.

Using this new measuring device, Dr. Hobo made more experimental projects which enabled him to further measure the immediate and progressive side shift of the mandible and the Bennett Angle. He was able to develop formulae to figure the Bennett Angle, the correlation between the immediate side shift, and the progressive side shift. This formula is called the IPB correlation formula, and it is used to evaluate the intercorrelation between all three measurements of mandibular movement of the patient.

To further prove the evaluation of the immediate side shift, the Bennett Angle and the progressive side shift, Dr. Hobo used different articulators and methods of interocclusal recording to evaluate

the accuracy of four different systems. His initial system was a complete pantographic tracing which, when used, recorded the three factors as being true for the patient. Utilizing the IPB method, Dr. Hobo proved that his system of anterior measurement using the computer was right on the actual movement paths of the patient's mandibular directions. Using the Bennett Angle method developed in 1908 by Dr. Gysi, Dr. Hobo found that check bite records and commensurate articulator settings proved that all of the immediate side shift recordings were actually inside the actual path of the patient's complete pantographic tracing. Utilizing the 7.5 degree lateral side shift technique as established by Dr. Lundeen in 1973, Dr. Hobo found that this system made immediate side shift tracings that were normally outside of the actual tracing of the patient's pantographic recordings.

Dr. Hobo further perfected his system of evaluation of check bite records by placing an electric circuit within the articulator for the IPB system. A sensor plate in the incisal pin area of the articulator holds a light which is lighted only when the condylar elements are in contact with the metal analogs and guidance factors of the articulator. If the condylar heads become non-contacted, the light goes off and you know that the check bite records have not been accurate.

In this in-depth evaluation of mandibular movement, Dr. Hobo studied the anterior guidance position and challenged the audience with questions as to the efficacy of the anterior guidance and its importance. Through an intricate system of evaluation using his computer records, Dr. Hobo found that there was definitely a correlation between the sagittal protrusive path and the incisal path, that there was a correlation between the immediate side shift and anterior disclusion, and that there should be a correlation between the incisal guidance and the condylar disclusion in lateral excursive movements.

In conclusion, Dr. Hobo recommends that the patients are properly measured in the six degrees of freedom at the three apexes and that a computer be utilized to establish mean records for the establishment of a correct articulator simulation.

Inquiries pertaining to this essay should be addressed to: Sumiya Hobo, DDS, MSD, DDSc, Internation Dental Academy, 25-18 1-Chome Shohtoh, Shibuya, Tokyo 150 Japan

TITLE: Tissue Integrated Fixtures in Oral and Maxillofacial Prostheses

Presenter: Dr. Ingvar Branemark

Dr. Branemark began his very rapid and in-depth discussion of tissue integrated fixtures with a review of the bony problems of the edentulous mandible and the need for proper retention and stability. He likewise over-viewed augmentation procedures and the problems that doctors have in spite of ridge augmentations. Implantology was looked at, and the problems with the periodontum interface to the implants was discussed as having no predictability. Dr. Branemark was very positive in stating that we should never try to imitate nature - just go about restoring function and esthetics in the best way we possibly can. His comments were pointed at the fact that the facsimile reproduction of the pseudo-periodontum does not work. In his research he found out that the only system that does work is the anchorage system. He went on further to state that any system has to be biocompatible. It has to be able to penetrate through the integument, and it must have a resistance to forces. The cemented hip joints used by the orthopedic surgeons appeared to work; however, they very often did fail, and since the cementing media created a very great increase in the temperature of the bone during cementation, there was destruction of bone cells. A "direct connection" was the goal of his research projects.

In Dr. Branemark's evaluation of the osseointegration system, his goal was to have the bone and marrow tissues heal in union and not as low differentiated scar tissues. It was shown that following insertion of the titanium fixtures, demineralization of the adjacent bone followed by a remineralization of the bony outlines against the serrated fixtures, followed by a maturing of the bone tissue, and then total integration between the bone and the fixtures. In the mandible, this process took from four to five months, and in the maxilla, six to eight months.

Dr. Branemark reviewed a ten-year animal study showing excellent tissue integration in a very thorough histologic review of the animal studies. The surgical technique was very important, and his review of the bone and blood systems in the surgical area prove that careful techniques are essential if success is to be had. The heat from the bone cutting or the heat from any

cementing technique, did cause permanent bone damage, and it was recommended that a fifteen rpm cutting device be utilized to cut the holes for the placement of the fixtures. The placement of a maximum of six fixtures was recommended strictly in the anterior segment of either the mandible or the maxilla. Dr. Branemark gave an excellent review of different techniques used for the restoration of the severely ravaged dental ridge. He reviewed overdenture techniques, he showed partial edentulism and how the integrated fixtures could help in the treatment of such cases, and he showed traumatic defect management and extraoral uses of the fixtures' techniques involving the replacement of ears, eyes and the relief of the impaired hearing patients.

Dr. Branemark concluded his fine presentation by showing the results of clinical projects that prove a high percentage rate of success in maxillary and mandibular fixture placements from one year through thirteen year reviews of the patients. We are now able to take patients who were in an edentulous state and return them to a dentate state. In the facts and figures that Dr. Branemark showed in his presentation, the osseointegrated fixtures appear to have a fine future within the dental profession.

Inquiries pertaining to this essay should be addressed to: Per-Ingvar Branemark, Institute for Applied Biotechnology, Box 33053, S-400 33 Goteborg, Sweden

TITLE: A Talk for Quality:
A Prosthodontic Specialty
Practice

Presenter: Dr. Ronald P. LuBovich

Dr. LuBovich gave an interesting presentation utilizing much philosophy and explanation of how he has found success in his own way within the specialty of prosthodontics. Dr. LuBovich reviewed the problems that are facing dentistry today, possibly due to "too fast and no care" treatment of many patients by doctors and the support staff. He ended this review by stating that the goal of all professionals should be to always represent quality, to have value-oriented principles, and to make sure that we do look into the patient to find out what the patient may want. He challenged us to think, to believe, to dream and to dare. He commented that we should be very positive and, in his words, that we should be excessive -

excessive meaning in our dedication to our work, excessive in our commitment to our patients, and excessive in the compassion that we have for our patients and staff.

The presenter talked about a life cycle of learning that the doctor must take himself through and then guide his staff through the same cycle. That cycle being that we first are **unconscious and incompetent** as we commence learning our dental specialty. We then become **conscious and incompetent** once we have learned some of what we are trying to do. We should strive to become **conscious and competent**, and further strive to really not have to think or be **unconscious in our competency**. Once we have arrived at this particular position, however, we should re-challenge ourselves to commence the cycle over, learning something else or taking upon another obligation. It is imperative that we put our staff through the same types of things.

Dr. LuBovich transferred his thinking now into the way that any prosthodontic office should portray itself to patients. He called this the "wholistic" approach which is really a friendship approach - thinking about others - thinking about the people, thinking about the place and thinking about the product. It is a secret ingredient, and it is necessary that we reinforce this constantly to our staff and to our patients. Initially the patients should know that there is a policy and a philosophy statement should be prominently placed that shows to them that your office is totally devoted to their care. He listed a few things that are very important and successful in any well run office - those being: (1) Cross over training so that the staff can intermix in their job responsibilities. It is important to find out who your employees are, what they have as an innate capability, what they want to do and then bring out the best through self motivation and taking them through the learning cycle; (2) To have a clean neat office in the fact that the search for perfection can not be done in a messy workplace; (3) To enhance your walls with things that are important not only to you, but to your staff and to your patients; (4) To use proper methods of advertising such as the yellow pages, articles that you write for newspapers, a newsletter from your office, maps of how the patients can get to your office and brochures on many things that you do for your patients in the realm of treatment procedures; (5) Proper consultation

periods where you take time to find out about your patients; and (6) Leadership.

Dr. LuBovich concluded the philosophy aspect of his presentation by pointing out that all men have to do more than they really can do in order to find out what they can do.

Inquiries pertaining to this essay should be addressed to: Ronald P. LuBovich, DDS, MSD, 2828 Bransford Avenue, Nashville, TN 37204

NEW DENTAL JOURNAL STARTS PUBLICATION

The principal aim of the new journal, DENTAL MATERIALS, is to promote rapid communication of scientific information between academia, industry, and the dental practitioner.

The journal will publish original manuscripts on clinical and laboratory research on both basic and applied character in which the focus of the effort is on the properties or performance of the dental materials or reaction of host tissues to materials. Manuscripts concerning the technology of the application of dental materials in clinical dentistry or dental laboratory technology are also appropriate. Only manuscripts which adhere to the highest scientific standards will be accepted. In addition to original articles the submission of comprehensive reviews of specific aspects of the field of Dental Materials Science and the application or use of materials in clinical dentistry are encouraged. Research communications (technical notes) are solicited where important information has been generated and timely publication is desirable but the results incomplete.

Manuscripts should be submitted to the Editor, Frank Young, D. Sc., Department of Materials Science, Room 453, Medical University of South Carolina, Charleston, South Carolina 29425.

NATIONAL ASSOCIATION OF DENTAL LABORATORIES

As one of the results of the Public and Professional Relations Committee efforts, the National Association of Dental Laboratories has been in contact with the College regarding a closer working relationship with the American College of Prosthodontists and with its members.

Mr. John R. Reynolds, the Managing Editor of the Association's publication: *Trends and Techniques* is anxious for the participation of ACP members in their magazine both as contributors and as subscribers. Mr. Reynolds is offering *Trends and Techniques* through the auspices of the ACP to our ACP members at a one third discount on the regular subscription price of \$30.00. The subscription for the ACP members would be \$20.00.

Mr. Reynolds is also looking for laboratory related articles suitable for publication in *Trends and Techniques*. He would like to encourage our membership to submit articles for publication as well as work toward establishing a closer relationship with the National Association of Dental Laboratories.

TWO FIRST PLACE WINNERS IN SHARRY RESEARCH COMPETITION



President Jack Preston and Mrs. Rachel Sharry congratulate research competition co-winners Dr. James Coffey and Dr. John Murphy.

For the first time in its eight year history the members of the College in attendance at the John J. Sharry Research Competition in Nashville voted two first place winners.

Dr. James P. Coffey for his study "In Vitro Study of the Clinical Wear Characteristics of Natural and Prosthetic Teeth" and sponsored by Dr. Richard J. Goodkind was one winner.

Dr. John C. Murphy for his study "Effect of Soldering Investment on the Surface Finish of Porcelain During Simulated Post-Ceramic Soldering" and sponsored by Dr. Robert R. Faucher was the other first place winner.

Both of the winners received the \$1,000 prize.

The second place award went to Dr. Ayodeji T. Idowu for his research on "An Evaluation of Masticatory Function

in an Elderly Population". He was sponsored by Dr. Gerald N. Graser.

Mrs. Rachel Sharry, wife of the late Past President, together with President Jack Preston, presented the awards to the finalists.

The other semifinalists and their sponsors were:

Dr. William M. Dern, Dr. E. Taylor Meiser and Dr. Alfred W. Fehling, all sponsored by Dr. Richard A. Hesby.

NASHVILLE HAS SOMETHING FOR EVERYONE

On hand for the 15th Annual Session in Nashville were 499 College members and 24 guests, the best attendance of members to date.

From the very beginning, and throughout the meeting, the Executive Council met to pursue the ever-increasing initiatives and business of the College. The Early Arrival's Dinner initiated the social activities, leading to the Re-Acquaintance Cocktail Party, which provided good cheer and fun for everyone. A number of tours for the spouses and a social event for each evening brought members closer to the spirit and history of Nashville. It was gratifying to have a record of over 350 members attend the Business Luncheon and a standing room only crowd on hand to listen to the humor and delicate message delivered by our luncheon speaker, Major Brian Shul, USAF.

This year's 24 table clinicians received overwhelming attention and success. New to the session were 21 Commercial Exhibits and the audio taping of the entire program. Member response has assured the continuance of these events in the future. A multifaceted scientific program and research competition highlighted the meeting, appealing to the spectrum of interests of members. As an organization attempting to address the needs and interests of all its members, the Affiliates/Associates Seminar, Educators/Mentors Seminar, Private Practice Workshop, ACP Sections Meeting, Ladies Workshop and the College Business Meeting provided at least one forum for everyone.

The 16th Annual Session in Seattle promises to be another outstanding event. Plan to attend, to participate and to benefit from an organization uniquely attuned to the promotion of the prosthodontist.







INTER-SOCIETY COLOR COUNCIL MEETING

The 54th Annual Meeting of the Inter-Society Color Council will be held in Pittsburgh, April 14-16, 1985 at the Sheraton Station Hotel. It will be followed on April 17-18 by a Symposium on Color Appearance Instrumentation jointly sponsored by the Federation of Societies for Coating Technology and the Manufacturers Council on Color and Appearance. The theme of both events is "Color: The End User".

Workshops will include "A Survey of Color Systems" by Fred W. Billmeyer, Jr. and "Metamerism from Strict Definition to Real Samples, Observers and Illuminants" by Henry Hummendinger.

Other topics will include "The Many Facets of Pigment Tinting Strength" by Ruth M. Johnson-Feller, Dr. Robert Feller of Carnegie-Mellon on "Recollection of Pigments Past", Walter C. Granville on "Color Harmony: What Is It?", and Dr. Robert Boynton of California on "A Proposal for an Alternative System of Colorimetry and Photometry".

The meeting will have a comprehensive display of color measuring instruments assembled by Charles G. Leete of MCCA. Registrants may operate much of this equipment and are urged to bring samples for evaluation.

ANNUAL JOHN J. SHARRY PROSTHODONTIC RESEARCH COMPETITION ANNOUNCED

The American College of Prosthodontists is sponsoring the Ninth Annual John J. Sharry Prosthodontic Research Competition to be held during the October 1985 Annual Session in Seattle, Washington. The award for first place is \$1,000.

Eligible are those students enrolled in a graduate program qualifying them for examination by the American Board of Prosthodontics and those individuals having completed advanced education within three years of the date of competition.

Abstracts of research papers of not more than 500 words and not previously published or presented at a major meeting must be submitted by April 15, 1985 to: Gerald Barrack, D.D.S., PA, Chairman, Research Com-

mittee, 101 West Street, Hillsdale, New Jersey 07642.

CAN YOU ANSWER THESE?

1. With a distal extension RPD, you want to make an impression of the edentulous tissue at rest. Which material do you use?
 - a. Plaster of Paris
 - b. ZnOe
 - c. Polysulfide
 - d. Silicone
 - e. Modeling plastic
2. Which attachment is an intracoronal attachment?
 - a. Ceka
 - b. Neu Rohr
 - c. Sterns B/L
 - d. Dalbo
 - e. Rotherman
3. In an article by DiPietro, he suggested a patient having an FMA angle of 18° would have:
 - a. group function
 - b. anterior disclusion
 - c. posterior disclusion
 - d. none of the above

QUESTIONS?

IDEAS?

PROBLEMS?

Call The
Central Office

(512) 340-3664

REVISED PUBLICATIONS AVAILABLE FROM THE COLLEGE

The Study Guide for Certification has been revised with the latest Board Guidelines. The new edition should be available from Central Office by March 1, 1985. The Guidelines are also available to be purchased separately.

The J.P.D. Index has been updated with articles published from 1980 through June, 1984. The new edition should be available by March 1, 1985 from Central Office.

The new edition can be purchased in entirety, or the 1980-1984 section can be purchased separately.

CLASSIFIED

Opportunity Available - California: Well established prosthodontist seeks fully qualified board eligible or certified prosthodontist as associate leading to a space-sharing or partnership position. Requires California license, excellent skills, ambition, drive, a pleasant personality and a good sense of humor. Roseville is located 7 miles east of Sacramento; 1½ hours to San Francisco, 2 hours to the ski resorts at Lake Tahoe, with ample hunting, fishing and water sports available in the immediate area. A good place to raise kids or retire. Send C.V. to Paul Binon, D.D.S., M.S.D, 1158 Cirby Way, Roseville, California 95678.

FROM YOUR EDITOR

With this issue I begin my tenure as Editor of the American College of Prosthodontists **Newsletter**. To assume the duties after the outstanding performances of J. D. Larkin and Bob Elliott is no small undertaking. Rest assured that I will pursue the road to maintaining this excellence as vigorously as I am able.

In order to make the **Newsletter** meaningful to the readers input from our members is essential. Please send items you believe to be of interest, such as honors, promotions, etc. to me or to the Central Office. I will publish as many of these as space permits.

I would also like to begin a Letters to the Editor column. In this column I would like to publish your opinions on major issues dealing with the College, our specialty and the profession in general. Controversial items are welcome as long as they remain in acceptable taste. The Editor will retain the right to edit the letters in the interest of space.

I look forward to serving you and the College and I would appreciate constructive criticism on the **Newsletter**. Please write me or call me at any time.

—Kenneth L. Stewart

CHANGE OF DATE SEATTLE-ANNUAL SESSION

Due to circumstances beyond the control of Local Arrangements Chairman, Jim Brudvik, the dates for the Annual Session of the College in Seattle have been changed from October 23-26, 1985 to October 16-19, 1985. Please note the change and make plans to attend what promises to be an outstanding meeting.

COLLEGE HISTORY

College Historian Dr. James Fowler is compiling an in-depth history of the College from its inception to current activities. Recent years, 1980-84, are well documented but the earlier years, 1970-79, are sketchier and require further documentation to properly illustrate the growth and progress of the College. Members are asked to send any material; letters, documents, photographs from this period, etc. to the Central Office, in care of Dr. Fowler.

ACP ROSTER

In a recently conducted survey by the Central Office members were asked to verify the accuracy of the listing in the membership roster of names and addresses. A question was also asked if members wished to add telephone numbers to the listing. A number of returns contained the phone numbers but the "Yes" box granting permission to publish the number was not checked. To avoid violation of the Privacy Act phone numbers cannot be published unless written permission is given. Members desiring to have phone numbers included in the roster listing, notify the Central Office Director, and it will be included in the next printing.

The Executive Council, at its winter meeting, voted to combine the Membership Roster and the Constitution and Bylaws in a single booklet. The next printing of the roster will reflect this change.

WERE YOU RIGHT?

1. e
2. c
3. b

BOOKS AVAILABLE

The "Study Guide for Certification", "Classic Prosthodontic Articles" and the "Index to the Journal of Prosthetic Dentistry" are available. To get your copy (ies) of these valuable books, complete the form below and mail to the Central Office Director, 84 N.E. Loop 410, Suite 273 West, San Antonio, Texas 78216.

Name _____

Address _____

City _____ State _____ Zip _____

1. I would like ___ copy(ies) of the "Classic Prosthodontics Articles" Volume I (Price Members \$20.00; Non-members \$25.00)
2. I would like ___ copy(ies) of the "Classic Prosthodontics Articles" Volume II (Price Members \$20.00; Non-members \$25.00)
3. I would like ___ copy(ies) of the "Classic Prosthodontics Articles" Volume III (Price Members \$20.00; Non-members \$25.00)
4. I would like ___ copy(ies) of the 1985 EDITION of the "Study Guide for Certification" (Price Members \$25.00; Non-members \$30.00) (Includes new Board guidelines.)
5. I would like ___ copy(ies) of the REVISED 1981, 1982 and 1983 Phase I, Part I Questions and Answers for the American Board of Prosthodontics as a Supplement to the Study Guide (Price \$5.00)
6. I would like ___ copy(ies) of the "Index To The Journal of Prosthetic Dentistry". Bibliography spans 1960 to June 1984. (Price Members \$35.00; Non-members \$45.00, plus \$3.00 postage for out of the country mailings)
7. I would like ___ copy(ies) of the "Index To The Journal of Prosthetic Dentistry Update". Includes 1980 to June 1984. Available Spring 1985. (Price \$10.00)

Amount enclosed \$ _____

Make checks payable to:

The American College of Prosthodontists



Item

ACADEMIC ROBES

To obtain order forms and material samples complete the form below and mail to: Central Office Director, 84 N.E. Loop 410, Suite 273 West, San Antonio, Texas 78216.

Name _____

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City & State _____ Zip _____

	Regular Material #1119	Delux Material #87
DOCTOR'S GOWN (with lilac front panels and sleeve bars outlined with gold nylon braid)	\$201.81	\$251.18
SQUARE STIFF MORTARBOARD CAP (with gold nylon tassel)	\$ 17.00	\$ 21.50
REGULAR DOCTORAL HOOD (with dental school colors)	\$ 68.35	\$ 85.17

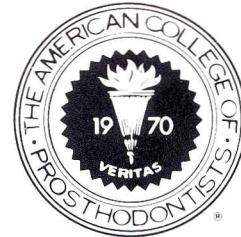
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 ADDRESS _____
 CITY & STATE _____ ZIP _____

CHECK ITEMS
YOU WISH
TO ORDER

Jewelry (ea)	14K	10K	1/10 DRGP	(Plate) Number	Jewelry (ea)	14K	10K	1/10 DRGP	(Plate) Number
Pinette	<input type="checkbox"/> \$ 67.50	<input type="checkbox"/> \$ 50.50	<input type="checkbox"/> \$ 20.50	_____	College Key	<input type="checkbox"/> 69.50	<input type="checkbox"/> 51.50	<input type="checkbox"/> \$ 21.85	_____
Tie Bar	<input type="checkbox"/> 72.50	<input type="checkbox"/> 55.50	<input type="checkbox"/> 26.50	_____	Lapel Pin	<input type="checkbox"/> 67.50	<input type="checkbox"/> 50.50	<input type="checkbox"/> 20.40	_____
Cuff Links	<input type="checkbox"/> 143.50	<input type="checkbox"/> 110.50	<input type="checkbox"/> 39.00	_____	Ladies Charm	<input type="checkbox"/> 67.50	<input type="checkbox"/> 50.50	<input type="checkbox"/> 20.30	_____
Tie Tacs	<input type="checkbox"/> 67.50	<input type="checkbox"/> 50.50	<input type="checkbox"/> 20.45	_____					_____

OTHER ITEMS (ea) — Blazer Pocket Patch—Old \$9.00 Number _____ Wall Plaque \$23.10 Number _____
 Blazer Pocket Patch—New \$16.00 Number _____

In ordering 1/10 DRGP (Plate) Jewelry, Blazer Patches and Wall Plaques, please enclose check to cover costs, which includes mailing, payable to the American College of Prosthodontists.

***Note:** 14K and 10K jewelry are special order items and prices fluctuate with the costs of gold. You will be billed for the items you order on receipt by the Central Office of the manufacturer's invoice. Do not send check with order for 14K or 10K items.