



# NEWSLETTER

THE AMERICAN COLLEGE OF PROSTHODONTISTS

AN ORGANIZATION OF SPECIALISTS  
DEDICATED TO SERVING THE PUBLIC

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JUNE 1987

## "TIMES THEY ARE A-CHANGING"

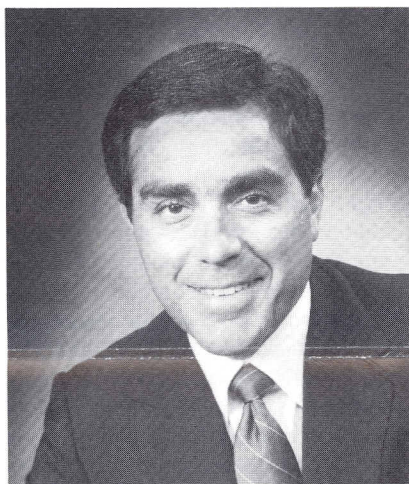
It was great being back in Chicago for our winter Executive Council meeting this past February. I never felt it to be essential for the College to participate in the Chicago Mid-Winter Meeting. However, other organizations expect us to be there, looking to us for guidance and direction. It is the obligation of the College to represent the specialty of prosthodontics at this very important meeting. As you know, we were holding our winter Executive Council meeting in San Antonio. We have already made arrangements for next year's winter Executive Council meeting to coincide with the Chicago Mid-Winter Meeting. Of course, we will continue our very successful cocktail reception. Mark your calendars!

"Times they are a-changing" was a song made popular twenty-five years ago by Bob Dylan. Listening to that song not only brings back memories of the past but also gets me thinking about the future. When you think about it, times are always changing. That's progress! The key to successfully dealing with progress is to be initiating it and to be initiated by it.

One of the primary goals of the College should be to be on the leading edge of progress. Dentistry and dental education are going through rapid and profound changes. Policy changes in dental education during the late sixties and early seventies provoked by an influx of government monies were responsible for what seemed to be an almost irreversible deterioration of our profession.

The subsequent oversupply of dentists over the next decade created an unhealthy competition not only between generalists but also between generalists and specialists. There has even been the competition for patients between specialists.

## PRESIDENT'S MESSAGE



More important and even more difficult to rectify is our profession's loss in stature. The numbers and quality of students seeking our profession have dropped precipitously. In actuality, this situation could help revive our profession if we can once again make dentistry attractive. We must have the ability to lure top quality students away from other professions and back into dentistry. Reducing the oversupply of dentists by more accurately projecting the needs of our profession is a good place to start.

You must be wondering what this has to do with the College. Well, a great deal. If we don't take a real hard look at our specialty and the role the College will play in the future, we will succumb to the most dramatic change in the dental profession since dentists were no longer allowed to cut hair.

What I am proposing is not new, but I think the time has come to debate these concepts openly and intellectually.

1. The Journal of the A.C.P.: I won't go into detail at this time, but I can't imagine pursuing this leading edge without a Journal.

2. Executive Director: This committee under the Chairmanship of Dr. Robert Saporito is making great progress. I'm sure he will have definite proposals by the Annual Meeting in October.

3. New Category of Membership: Those individuals who are not educationally qualified would be eligible to be a member of the College without vote. This certainly is not a new idea. It was suggested by Dr. Kenneth Rudd, President of the F.P.O. at our annual business meeting this past October. I feel this new category is important since the College has a responsibility to the specialty as well as the discipline. True we practice the specialty but we are responsible for the education of both the specialty and discipline. We will recognize those individuals who have significantly contributed to the education, research, or clinical aspects of prosthodontics. The College will be able to address the problems of prosthodontics from a broader base and be in line with the philosophy of the American Dental Association. That is, to bridge the gap between the generalist and specialist. The details will be addressed by the Executive Council and the appropriate constitution and by-laws changes made.

4. Fellowship Redefined: Again, not a new idea but the time has come to

The Central Office of the College moved its offices on May 15, 1987. The new address is:

**1777 N.E. Loop 410  
Suite 904**

**San Antonio, Texas 78217**

Please use **ONLY** the above address for mailings to the College.



reconsider our two tier system. All educationally qualified members will be Fellows. Diplomate status will no longer be used to distinguish College members. Heresy to some, an address to the future to others. I personally do not feel that Fellowship in the College was ever the driving force for an individual to seek Diplomate status. There are more fruitful means of encouraging eligible members to become Board Certified.

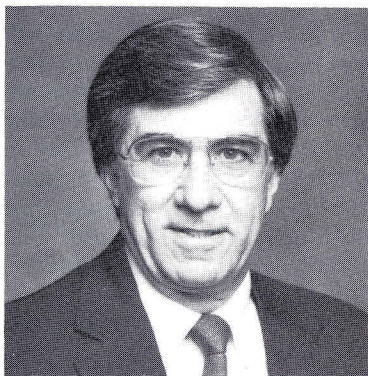
The future is ours to have if we approach it with the authority required to deal with it. We will need fewer dentists to fulfill the needs of our patients because of new technology, and procedures, improved dental materials, and most importantly reduced dental disease. As prosthodontists we must develop this projection to benefit and strengthen our specialty and not look upon it as a doomsday scenario.

The most difficult concept to come to grips with is that the above discussion leads to one obvious conclusion. We will require far fewer prosthodontists if we are interpreting the future correctly. Any manager will tell you proposing man power cuts is always the most difficult task.

The past was just the present; the future is the present waiting to happen. Let us not live in the past but instead create the future we will be proud to record as history.

Your President  
Cosmo V. De Steno, D.M.D., Ph.D.

## FROM THE SECRETARY



In June all Diplomates of the American Board of Prosthodontics will be voting for a new Board examiner to replace Dr. William H. Pruden (deceased). The new Board member should be qualified in fixed prosthodontics and will assume active membership on the ABP in September 1988. For your information any member organization of the Federation of Prosthodontic Organizations may nominate

a qualified prosthodontist for membership on the American Board of Prosthodontics. The nominating and supporting documents must be forwarded to the Council for the Affairs of the ABP by April 1st. After distributing all background materials to the Council members, the Council meets on June 1st to select two or more of the most qualified nominees. Ballots will be sent to all Diplomates on June 12th with a July 13th deadline for receipt of ballots. After a count of the ballots, the nominee with a plurality vote is elected to the ABP.

The American College of Prosthodontists elects its nominees at the Annual Session Business Meeting. Our nominee for the Board this year is Dr. Ronald D. Woody, Professor and Director of Graduate Prosthodontics at Baylor College of Dentistry.

You may be interested to know that the Council for the Affairs of the ABP consists of Diplomates of the ABP who are in good standing with the Board and the Federation of Prosthodontic Organizations. The nine member Council is composed of three representatives elected by the ACP, one representative each from the American Academy of Maxillofacial Prosthetics, the American Academy of Crown and Bridge Prosthodontics and the Academy of Denture Prosthetics. Additionally, there are three at-large representatives elected by the FPO House of Delegates from member organizations other than those permanently represented on the Council. The term of membership on the Council is three years and no individual may serve more than six years.

The Council for the Affairs of the ABP is composed of the following:

Member	Organization	Term Expires
Dr. Dale E. Smith	PSCP	1989
Dr. Robert C. Sproull	ACP	1989
Dr. Ronald G. Granger	AACBP	1989
Dr. Dale H. Andrews	ACP	1988
Dr. Thomas A. Curtis	ADP	1988
Dr. Harold Litvak	NGS	1988
Dr. Louis Rissin	NPS	1987
Dr. William R. Laney	AAMP	1987
Dr. Robert J. Leupold	ACP	1987

The following is extracted from the "Criteria for Selection of Nominees for Election to the American Board of Prosthodontics" which was prepared and distributed by the Council for the Affairs of the ABP. The criteria is intended to aid the Member Organizations in their selection of a suitable nominee.

Election to the American Board of

Prosthodontics is an honor and a privilege which provides the opportunity for service to prosthodontics and the public served by the prosthodontist. A nominee for election to the Board should be well-qualified professionally and possess the personal attributes so necessary for the efficient and effective function of this certifying body. Qualifications should include but not be limited to the following:

### Professional Qualifications

1. Diplomate of the American Board of Prosthodontics.
2. Clinical expertise and experience by the virtue of an established broad background in private, intramural, or institutional practice.
3. Recognized by peers as an outstanding practitioner and continuing student.
4. Exceptionally well-qualified in at least one of the three prosthodontic subdisciplines; as demonstrated by publications, essays or clinical presentations, or courses given.
5. Academic experience which embodies subscription to and active support for the objectives and ideals of pre and post doctoral education in prosthodontics; awareness of education modalities and testing procedures.
6. An appreciation for dental research and understanding of research methodology.
7. Demonstrated service to the profession through organized dentistry; in good verifiable standing with

### NEWSLETTER

#### The American College of Prosthodontists

#### Editor

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San Antonio, Texas 78230



the national, regional, and local societies in which membership is held.

#### Personal Qualifications

1. Exemplary ethical standards.
2. Compatibility necessary to relate positively with other Board members.
3. Flexibility, tolerance, and respect for other points of view; a willingness to compromise.
4. Ability to interpret and evaluate with professional and personal objectivity.
5. Possess compassion and empathy necessary for establishing professional rapport with candidates.
6. Interest, dedication, and time commitment essential to accepting and fully discharging the responsibility of a Board member.

As Secretary, it was my responsibility to submit the nomination of Dr. Ronald D. Woody to the Council for the Affairs of the ABP on behalf of the College. The nomination package included a current curriculum vitae, a letter from the nominee stating his willingness to serve if elected, letters of recommendation supporting the nominee and a letter from the member organization stating why it believes the nominee is qualified. I have carefully reviewed Dr. Woody's C.V. and some nineteen letters of recommendation written by eminent prosthodontists from all areas of the United States. It is my sincere opinion that Dr. Woody successfully meets all the professional and personal qualifications for Board selection and that he merits the support of all College members.

Dr. Judson C. Hickey, a renowned prosthodontist, educator and editor of the Journal of Prosthetic Dentistry has stated: "Of all of the qualified board prosthodontists that I know, Dr. Woody represents the ideal person to serve on our Board. During his career he has excelled as a clinician, author, researcher, educator, administrator, and in his ability to relate to other persons. As a member of the Board he will be demanding of excellent performance, yet with total fairness and compassion." —James A. Fowler, Jr.

Secretary

October the question that has plagued the College through much of its history, our relationship with the Federation of Prosthodontic Organizations, rose again. A member of the College moved that the College withdraw from membership in the FPO citing instances where the FPO was not providing the necessary leadership in the specialty of prosthodontics.

The attendees discussed the advantages and disadvantages at length. Most of the discussion was based on sound facts and solid opinions and for the most part heated arguments were avoided. This speaks well for the maturity of the College that has developed over the past 17 years.

The result of the action on this motion at the business meeting was that a second motion to table the original motion to withdraw was made and was successful. This matter will now be on the agenda at the business meeting in San Diego in October, 1987.

In order to keep the entire membership informed on the facts that should be considered before a decision is made on our status relative to the FPO, your Editor invited a pro-FPO advocate and an advocate favoring withdrawal to prepare a guest editorial on this subject.

Dr. Charles DuFort, Executive Councilor, has graciously supplied the **Newsletter** with the article appearing below. Members of the South Carolina Section of the ACP have also graciously consented to forward an article stating their reasons why leaving the FPO is the better choice. This article will appear in the September **Newsletter**.

It is hoped that with an issue this important, not only to the College's relationship with the FPO, but also to the future of the specialty, that a mail vote of the entire membership, not just the attendees, will be asked for if the matter does come to a vote.

I'm sure most of you have an opinion on this matter. I will be happy to carry as many letters as space permits in the September issue. Please have your letter to me by July 15th. My address appears in this issue.

Your Editor

—Kenneth L. Stewart



Executive Councilor Charles DuFort advocates remaining with the Federation of Prosthodontic Organizations.

large numbers of members, but it does provide a forum for members to express their rightful concerns and wishes. In Williamsburg a member speaking on behalf of his State Section requested a vote for the withdrawal of the ACP from the FPO. On the surface the issue seemed simple enough. Impassioned rhetoric debated the question in the past and always the vote resulted in cautious, grudgingly hopeful support of the FPO. Agitation usually centered around equitable representation, FPO dues and assessments and of course sponsorship of the American Board of Prosthodontics. Giving credit to the perseverance and skill of our officers and committees, inroads have been made but possibly not as rapid or significant enough for many. In any event the issue would have been voted on by a small percentage of the membership attending the business meeting and the absent majority would have little insight into the ramifications of such a decision if a ballot were mailed to them.

I doubt the issue had ever been objectively articulated until Dr. Ken Rudd made a report before the business meeting as the incoming president of the FPO. Ken Rudd has been a part of virtually every phase of prosthodontic evolution throughout his long career and served as president of the ACP and many other organizations. He possesses a noteworthy historical perspective. What made his report extraordinary was that he explored the strengths and shortcomings of the FPO and their implications for the ACP.

Before deciding to withdraw from the FPO consider the ramifications and questions that could attack such a move. The law of cause and effect has validity here, and I don't think enough discussion and awareness has been given to it.

## EDITORIAL A MATTER OF IMPORTANCE FPO — YES OR NO?

During the business meeting at the Annual Session in Williamsburg last

## WITHDRAW FROM THE FPO! THINK ABOUT IT

The business meeting during our annual session doesn't often attract



### 1. THE QUESTION OF SPECIALTY AND DISCIPLINE:

Most members would agree that the ACP should represent the **specialty** of prosthodontics before the ADA. However, other organizations represent their specialty before the ADA with one important difference. Each of these organizations has a category of membership for the non-specialist interested in the **discipline**. The ADA must represent all its members and would most likely not work with an organization that represents the specialty and not the interests of those involved in the discipline. This criteria is fulfilled by the FPO's structure of twenty member organizations of which only the ACP is specialty oriented. To assure the representation of prosthodontics before the ADA would require the ACP to develop a membership category for the non-specialist as other organizations have done.

### 2. ACP REORGANIZATION:

Withdrawal of the ACP from the FPO could ultimately foretell the collapse of the FPO. Eventually the ACP would take on a greater spectrum of responsibilities requiring an expanded organizational structure to accommodate them. It would task further the Executive Council, the committee structure and especially the Central Office. Serious consideration for a full-time, well trained, well paid Executive Director would have to be given. A search committee and a budget for an appropriate salary would be needed. All our efforts, duties and initiatives need to be managed, directed and carefully coordinated. Presently we're holding our own — in the future we'll need full-time dedicated help.

Some thought would have to be given as to location for the Executive Director. Would an office in the ADA Building be more appropriate than San Antonio? Should we keep the San Antonio office and a Chicago office? San Antonio is far more economical but a Director representing the ACP needs to be where the action is. Either way, it would require a substantial financial commitment from our members.

### 3. DUES:

Should the ACP drop from the rolls of the FPO and the FPO eventually falter from lack of funds and support would not the ACP be in a position through organizational structure, committees, representative membership, etc. to assume many of the duties previously administered to by the FPO? Interfacing with the ADA, formal legal support and counsel, Executive Director in

Chicago, working with the insurance industry for legitimate rates, relating to the concerns of the non-specialists, etc., all take finances that, at least for the present, are being collected and spent by the FPO. To some the FPO is gradually losing ground and in time many of its functions will fall to the ACP anyway. Dues is an important consideration especially in light of recent tax reforms. ACP dues could easily balloon and correspond to those of other specialty organizations whose dues reflect their activities and responsibilities. For example, those organizations that represent their specialty to the ADA require in addition to specialty dues, dues for membership to the ADA and constituent state and local societies. Some organizations levy assessments and may require registration fees to meetings or offer paid clinics. Considering services rendered by the ACP compared to costs, the ACP is a real bargain. Unfortunately, it's a bargain without formal representation of our specialty.

The ACP has seemingly reached a plateau where it has become well established and organized, financially stable (for the present) and maintains a significant membership and recognition within the prosthodontic community. The ACP is at a place in its history where it would seem obvious to have formal representation of prosthodontics before the ADA as have other specialty organizations not burdened with an FPO member organization structure. Keep in mind, however, that other specialty organizations have a membership category for non-specialist and in most cases require membership in the ADA and state and local societies, and most have formal representation residing within the ADA Building.

Does withdrawal from the FPO mean significantly higher dues for the ACP? Our numbers are smaller than other specialty organizations especially without a category of membership for non-specialists. Does smaller numbers mean a greater burden? Would we or could we levy member prosthodontic organizations as the FPO attempts to do now?

It's the responsibility of the ACP membership and the elected officers to be the instrument that looks to the future of prosthodontics and the rightful place of the ACP in that evolution. Over the years the ACP has developed steadily and carefully, gradually establishing its role in prosthodontics. Further growth and evolution must be preceded by the ACP's commitment to providing the representation and becoming the symbol for the **specialty** and **discipline** of prosthodontics. If the membership is to embark on this worthy enterprise it should do it by consensus, understanding all possible ramifications and accepting a period of unsettled turmoil.

In no way does this little piece anticipate all the complex challenges attending a decision to withdraw from the FPO but I hope it does stimulate some thought of what it could mean. Many members divorce themselves from formal knowledge and involvement in the "business" of the College and that is their right. But it is necessary that when a vote is taken that these same members not be surprised or shocked to learn that their vote may ultimately mean a greater commitment for the ACP, reorganization and dues increases.

THINK ABOUT IT

—Charles R. DuFort

Organization	Dues and/or Assessments	Required ADA/State/Local Memberships	Registration Fees for Annual Session paid clinics only
Amer. Assoc. of Oral & Maxillofacial Surgeons	\$620	No	
Amer. Acad. of Periodontists	\$373	Yes	-0-
Amer. Assoc. of Endodontists	\$200	Yes	\$150
Amer. Assoc. of Orthodontists	\$274	Yes	-0-
Amer. Acad. of Pedodontists	\$350	Yes	\$200
Acad. of General Dentistry	\$149	Yes	\$105
Amer. College of Prosthodontists	\$195	No	-0-

(Note: \$75 FPO dues)



## ELECTION TO THE AMERICAN BOARD OF PROSTHODONTICS EXAMINERS

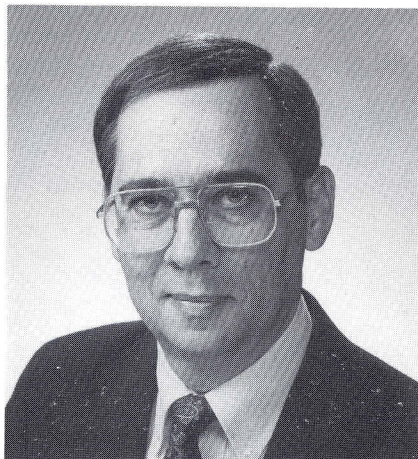
A ballot for the election of the new examiner in fixed prosthodontics for the American Board of Prosthodontics will be sent to all Diplomates in mid-June with a return date of mid-July. The candidate receiving a plurality will be elected to the American Board of Prosthodontics.

In the February issue of the **Newsletter** a resume of the two candidates proposed at that time, Drs. Ronald Woody and Howard Landesmann, was provided. Since then a third candidate, also a member of the College, has been nominated.

The third nominee, Dr. Frank Celenza, received his DDS degree from Georgetown University. He has had an active and distinguished career in the specialty. He is nominated by the Northeastern Gnathological Society.

The Executive Council directed that all nominees who are College members be recognized in the **Newsletter**. However, the Executive Council also stipulated that the official nominee of the College, Dr. Ronald Woody, be specifically acknowledged. Dr. Woody is also nominated by the American Academy of Crown and Bridge Prosthodontics.

Dr. Woody's resume follows:



Dr. Ronald D. Woody is Professor and Director of Graduate Prosthodontics at Baylor College of Dentistry. Dr. Woody received his dental degree from Marquette University School of Dentistry in 1963, Internship at Tripler Army Medical Center, Graduate Basic Science from Georgetown University and Residency program in Fixed Prosthodontics from Letterman Army Medi-

cal Center, San Francisco, California in 1970. He became a diplomate of the American Board of Prosthodontics in 1974. Dr. Woody had a postdoctoral fellowship in Biomaterials at NIH, San Francisco 1970-71 and was at the Institute of Dental Research, Walter Reed Army Medical Center in Prosthodontics Research 1972-1978. He was the Director of Dental Education and Chief and Director of Fixed Prosthodontics for the General Dentistry Residency program at Madigan Army Medical Center, Tacoma, Washington, 1978-82. He served as Chief and Director of the Fixed Prosthodontics Residency Program at Letterman Army Medical Center and as Consultant to the Army Surgeon General in Fixed Prosthodontics 1982-84.

Dr. Woody has presented over 120 international and national lectures, has authored over 20 articles in the professional literature and has served on the Editorial Board of the Journal of Dental Research and the Journal of Prosthetic Dentistry. He has numerous professional consultantships and is a consultant to the ADA Commission on Dental Accreditation for Advanced Prosthodontic programs. He has also served as a Board Examiner for the Specialty Board Examination in Prosthodontics in British Columbia, Canada.

Dr. Woody is a member of Omicron Kappa Upsilon, International Association of Dental Research, Fellow of American College of Dentists, Dental Materials Group, American Association of Dental Schools, American Dental Association and related societies, prior Associate Member of Pacific Coast Society of Prosthodontists, Fellow American College of Prosthodontists with offices of Executive Councilor, Site Selection Chairman, Annual Sessions Chairman, Board, Education Foundation and member of American Academy of Crown and Bridge Prosthodontics with offices of Board of Directors, Annual Sessions Chairman, Chairman Research Committee, Chair-

### ANNOUNCEMENT

The **Newsletter** is published three times a year. The first issue is mailed February 1st, submission of material for printing should be no later than December 15th. The second issue June 1st, material for printing submitted to the Editor no later than April 15th. The third issue mailed September 1st, material should be received by the Editor by July 15th.

man Graduate Education in Fixed Prosthodontics.

Dr. Woody maintains an active two day private practice limited to Prosthodontics.

Dr. Woody is eminently qualified for the position and has a unique balance of Prosthodontic experience in clinical practice, education, administration, research in military and civilian institutions, and private practice environments. His background is strong in all phases of Prosthodontics with emphasis on Fixed Prosthodontics. The College is pleased to nominate and support Dr. Woody.

### DATES OF THE ANNUAL OFFICIAL SESSION

The 1987 Annual Official Session will be held at the Hyatt Islandia Hotel in San Diego, California.

The schedule will be:

#### Monday, October 5th

Executive Council Meeting

#### Tuesday, October 6th

Executive Council Meeting

#### Wednesday, October 7th

Private Practice Seminar  
Table Clinics (PM)  
ACP Sections Meeting (PM)  
Projected Clinics (PM)  
Commercial Exhibits  
Re-Acquaintance Cocktail  
Reception (6:30 PM)

#### Thursday, October 8th

Scientific Session  
John J. Sharry Prosthodontic  
Research Competition  
First Annual Table Clinic  
Competition  
Peer Review Update  
Spouses Program  
Annual Business Luncheon and  
Meeting  
Commercial Exhibits  
Evening Dinner and Trip

#### Friday, October 9th

ACP Jogging Event  
Scientific Session  
Affiliate/Associate Seminar  
Luncheon and Meeting  
Educators/Mentors Seminar  
Commercial Exhibits (A.M.)  
President's Reception and Dinner

#### Saturday, October 10th

Scientific Session  
For the Sporting Enthusiast,  
Fishing, Sailing, Tennis (PM)



# WHY COME TO SAN DIEGO?

feels  
san diego good  
all over™

Great weather. The Pacific Ocean. Palm trees and beaches. Friendly people. Abundant beauty. Excellent golf, tennis, fishing. Tropical climate . . . and the American College of Prosthodontists Eighteenth Annual Session.

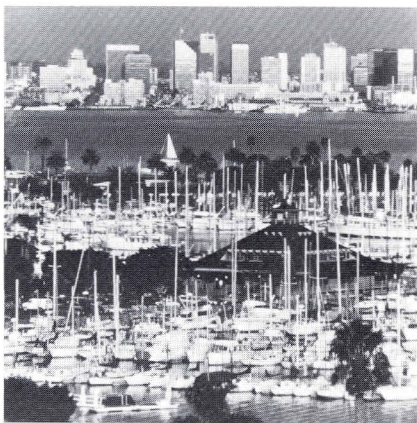
Visit the famous San Diego Zoo, Sea World, and the Wild Animal Park. Take a bay cruise, explore Old Town, where California began, or browse through dozens of museums with exhibits ranging from fine art and natural history to aircraft and sports memorabilia.

San Diegans spend a lot of time outside. You'll probably feel like joining them, when you see our dozens of golf courses, almost countless tennis courts, and the miles of scenic jogging, hiking and biking trails.

If this isn't your first visit to San Diego, you still have plenty of surprises in store. Downtown San Diego is an exciting, constantly changing showplace of department stores, shops, hotels, restaurants, galleries and theatres. One whole section has been converted to turn-of-the-century elegance, while several more blocks are filled with a multi-level center featuring more than a hundred-fifty stores.

Along the harbor, our waterfront theme village keeps growing more fun, and more cruise ships are pulling into port — including the Love Boat.

San Diego's location makes it especially appealing to the visitor. It is bordered on the south by Mexico, on the



San Diego's modern skyline is an imposing contrast to its surroundings, nestled between the mountains on the east and the Pacific Ocean on the west.

west by the Pacific Ocean and on the east by mountains and Anza Borrego Desert State Park — largest state park in the U.S. Ninety miles north is Disneyland and the beginning of the Los Angeles metropolitan area.

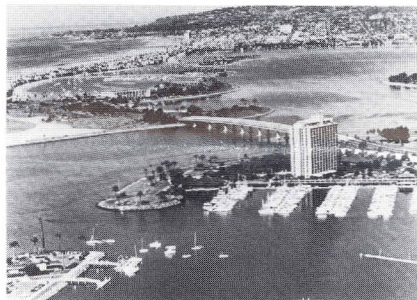
So whatever you like to do before, during or after a College meeting, you'll like to do it even better here in San Diego. Because we've got the climate for it!

## Climate

The United States Weather Bureau describes San Diego's weather as the most nearly perfect in America. The average early October temperatures are a low of 61° at night and a high of 75° during the day.

## What To Wear

San Diego will put a few demands on your wardrobe. Evenings are almost always cool, so be sure to bring a sweater or jacket. And days are frequently quite warm, so have shorts or swimwear handy. A few restaurants require coats and ties for gentlemen, but most welcome casual attire.



The Hyatt Islandia (foreground) hosts the College Annual Session. Located in Mission Bay Park, the largest aquatic park in the world, offers visitors a year-round melange of activities.

## Our Hotel

The Hyatt Islandia consists of 349 beautiful guest rooms. Of these 260 are located in an eighteen story high rise building offering unforgettable panoramic views of Mission Bay and the Pacific Ocean. The 2-story lanai section features 87 guest rooms in a lush garden setting overlooking the swimming pool and marina.

## Location

Our hotel convention site is located on San Diego's beautiful Mission Bay, 4,600 acres of grassy slopes and calm waters. The hotel provides courtesy transportation to and from San Diego's Lindbergh Field 7 miles away and nearby Sea World. Mission Bay is ideally located just 15 minutes from downtown and the Zoo, La Jolla, Old Town, 27 miles of Pacific beaches and the other many attractions San Diego has to offer.

## Leisure Time

**On Hotel Property** - Sailboat rentals, day deep sea sportfishing are available at the hotel dock. The swimming pool and adjacent whirlpool spa are heated year round. Jog, cycle or walk on the beautiful scenic paths that wind throughout Mission Bay. Located less than 1/4 mile from the Hyatt Islandia is the Marina Village shopping area. The center consists of several fine restaurants and has a variety of unique shops including men's and women's boutiques, art galleries, and specialty gift stores. The walkway connecting the hotel to the center overlooks Quivira Yacht Harbor where some of San Diego's most expensive boats are moored.



Mother and baby Koala welcome you to the world renowned San Diego Zoo.

**San Diego Area** - The options San Diego has to offer are many and varied. To name just a few: shopping in Old Town; La Jolla; Mexico sight-seeing; San Diego Zoo; Wild Animal Park; Sea World; Scripps Institute; Jai Alai; Harbor Excursion; white sandy beaches. The list goes on and on, but this should give you some idea.



Excitement is everywhere as Shamu the killer whale toys with a trainer at Sea World.

**The City** - As the birthplace of the Golden State, San Diego has grown to become the second largest city in the west. 1.8 million residents are scattered across a 30 mile stretch of rolling hills,



fertile valleys and sparkling beaches. Twenty-eight percent of the total United States fleet is based here and the Navy is the city largest single employer.

**Golf and Tennis** - There are 15 tennis courts within 5 minutes of the hotel. Twenty-five golf courses, several of which are of championship quality, are within 25 minutes of the Hyatt Islandia.

### Special Activities

#### "Beach Party"

Experience the thrill and excitement of the traditional reacquaintance cocktail party at a beach setting next to the hotel.

To keep the party going after all the sunshine and fresh air you'll experience that day, there will be liquid refreshment and hors d'oeuvres for you to enjoy as the sun disappears into the Pacific Ocean. While you eat, drink and meet old friends around the bonfire you'll listen to assorted California Dreamin' music supplied by a local Disc Jockey.

Come experience the classic California beach party — and be prepared for traditional Southern California fare of "fruits and nuts."

#### "Tijuana Ole!"

Join us as we head for exciting Tijuana — offering an opportunity to discover Mexico's native handicrafts, wonderful shopping finds, and to experience the culture of this land "south of the border."

Members and their guests will have free time to explore Avenida Revolution - "Main Street" for exciting happenings in Tijuana. Explore the many shops and arcades offering Mexican curios and duty-free import items (i.e., leather goods, wool blankets, clothing, crystal).

Enjoy authentic Mexican cuisine for dinner at one of Tijuana's finest restaurants. We will be greeted by lively Mariachis who will perform colorful and rhythmic songs about life, love and Mexico. This "Mexican street band," consisting of various string instruments and fabulous vocals, will add zest to the gathering.

After dinner a troupe of dancers will perform an exciting Ballet Folklorico featuring the native dances of Mexico. Colorfully costumed, three couples provide excellent entertainment in awe-inspiring movement.

#### "Larking In La Jolla For The 'Better Halves' "

Separated from San Diego proper by Mount Soledad, and bordering on the north and west by the Pacific Ocean, La Jolla is a unique area of coastline

parks, elegant shopping, and Mediterranean style homes.

Spouses will visit the Scripps Institution of Oceanography, a world-renowned site for research and graduate-level instruction in oceanography, where they will visit the Aquarium to view underwater exhibits featuring many species of ocean life. Walk through a San Diego kelp bed, past a submerged pier piling and through a coral reef without even getting your feet wet!

Also visited will be the La Jolla Bay and Cover area, where the bluffs meet the water. The famed La Jolla Underwater Park, maintained as an ecological reserve, is a favorite spot for scuba divers and snorkelers. Other points of interest include the magnificent cliffs of Torrey Pines overlooking Blacks Beach, the swimsuit-optional beach, and the Gliderpoint area where you may view dare-devils launching their gliders off the edge of the cliff.

Shopping is always a special experience in La Jolla. Among the many boutiques, import shops, galleries and specialty food shops, guests are sure to find unique and exclusive gifts.

La Jolla, with the tantalizing charm of a Mediterranean Isle, unique shops and breathtaking views of the Pacific, is a refreshing change of pace sure to delight even the most discriminating visitor!



San Diego was named "Sportstown USA" by Sports Illustrated. Over 78 golf courses, including the famous "Torrey Pines", attract millions of visitors.

#### "Fore"

For the avid golfer, there is nothing like a challenging course for the utmost in golfing pleasure.

San Diego, sometimes referred to as "Golfland U.S.A." is a golfer's paradise, offering 76 demanding and relaxing year-round golf courses. Join us for a round of golf at Torrey Pines, one of San Diego's beautiful championship courses!

We will provide the transportation and arrange the times and golf carts to ensure a smooth day of golf.

#### "Fun Run"

On your mark . . . get set . . . go!! And they're off — as the stopwatch begins the count down during an exhilarating run before breakfast.

Running, a sport that's as challenging to the inner self of an individual as it is between runners, is a fantastic way to start the day. If running is not your idea of fun, why not try a . . .

#### "Bicycle Rental"

Imagine touring around Mission Bay on none other than a true "Beach Cruiser". What a great way to feel the excitement, sunshine, and healthy atmosphere that makes Southern California so popular.

Enter the spirit of the great outdoors and join us in an invigorating program of physical fitness. We'll try to make exercising so attractive and convenient, so you can't say NO!

So Why Come to San Diego? Can you think of a better spot to develop both the mind and the body? Block out the week of October 5th and plan to join us in America's Finest City. San Diego feels good all over.

## EUREKA - PROSTHODONTICS IN 1987

### Scientific Session in San Diego

Following our general theme the Program Subcommittee has attempted to provide speakers whose topics will provide the most recent information about the "hot" subjects: implants, ceramic veneers, computers in dentistry, geriatrics, posterior ceramic inlays, product innovation, the temporomandibular joint and occlusion.

This year Drs. Stephen Schmitt and Frederic Brown, Chairmen of Prosthodontics and Periodontics at Keesler Air Force Base, respectively, will deliver the keynote address entitled "Periodontics Prosthodontics: A Special Relationship." Attendees will learn how current periodontal surgical techniques can create an environment allowing excellent prosthetic care to result.

Dr. Patrick Lloyd, Coordinator for Geriatric Dental Programs in the Veterans Administration, will update "The Geriatrics-Prosthodontics Alliance." In this presentation principles of comprehensive evaluation of our elderly patients will be reviewed and ideas for their functional rehabilitation will be suggested.

"Ultra-Thin Ceramic Veneers: Maximum Esthetics, Minimum Intraorals"



presented by Dr. Mark Friedman, Director of Advances in Resin Dentistry Study Group at USC, should convince those remaining pessimists that these restorations have advantages and can be a viable option when presenting patients with a treatment plan.

Dr. Michael Alfano, Senior Vice-President of Research and Development Block Drug Company and President of Block Professional Dental Products Company will present a unique lecture entitled "Product Innovation in Dentistry: The Dentist/Entrepreneur and Industry." Dr. Alfano's experiences as a periodontist, academician, researcher and administrator for industry should stimulate those among us with ideas for our own products. Factors which have advanced the rate of new products brought to market are microelectronics, increased emphasis on periodontal disease, mail order business, the willingness of corporations to license new technology and a greater consumer awareness of health issues. Dr. Alfano will discuss these and explain plaque control agents and devices so that we can make up our minds about using them.

What meeting would be complete in 1987 without some mention of computers? The approach for San Diego will be to present them both as a clinical research tool and as an aid in the clinical management of cases. Dr. Brien Lang, Professor and Chairman of the Department of Complete Denture Prosthodontics at the University of Michigan will present them as a research tool, "Computer Applications in Clinical Research." Dr. Charles Pappas, a Plastic Surgeon, will present them as an aid in managing the clinical outcome of extensive rehabilitation cases.

John Brunski, Ph.D., Associate Professor of Biomedical Engineering at the Rensselaer Polytechnic Institute, intends to lecture on the "Biomechanics of Dental Implants and Interfacial Tissues." Dr. Brunski will describe methods for direct measurement of in-vitro forces on implants and recent results concerning the response of interfacial tissue to biomechanical loading.

"The Relationship Between Osseointegration and the Implant Design" will be presented by Dr. George Hetson, Research Associate, Department of Restorative Dentistry, Tufts University Dental School. Since many designs are currently marketed, the Program Subcommittee felt that basic information on loading, design, surface texture, and

interfacial tissue response would give the clinician guidelines as to what and when implant dentistry can be an option. The how, why and where questions are material for other meetings.

Finally, Dr. Charles Greene, a private practitioner and a Clinical Professor in the Department of Orthodontics, Northwestern University will challenge us in his presentation "Does Expertise in Occlusion Make Prosthodontists Experts in Temporomandibular Disorders?" Recent findings suggest that little or no difference can be found in the occlusal relationships of TMJ patients and random populations. High rates of short and long term success in treatment can be obtained without occlusal alterations. The significance of these findings will be discussed.

Dr. David Eggleston, a Clinical Associate Professor at the University of Southern California and a private practitioner, has graciously agreed to be ready to speak if one of our speakers encounters difficulty (perish the thought). His topic would be "Correlation of Dental Amalgam With Mercury in Brain Tissue." This presentation will review his autopsy essay research.

The Annual Official Session in San Diego will also host the Affiliates and Associates Seminar, The Educators and Mentors Seminar, the John J. Sharry Prosthodontic Research Competition, a Peer Review Update, and the Sections Meeting.

Dr. J. Crystal Baxter will act as moderator of the Affiliates and Associates Seminar. This year's format will be similar to that of last year's. Members interested in challenging the American Board of Prosthodontic Examination will gain useful up-to-date information about the exam.

Dr. Richard Grisius will act as moderator of the Educators and Mentors Seminar. Many post-doctoral prosthodontic programs are considering instruction in Implant Dentistry for their students. Dr. Glen McGivney, Marquette University of Dentistry, will lecture on implementing implant dentistry in your institution — what the post-doctoral student should know. Dr. Muriel Bebeau from the University of Minnesota will conduct a discussion of the ethical issues inherent in implant dentistry — what all concerned parties (post-doctoral student, faculty, patient, administration, insurance carrier) should know.

Dr. Richard Seals, Chairman of our Research Committee, will be the moderator for the John J. Sharry Prosthodontic

Research Competition. Three investigators will present their research topics and compete for first place in this annual event. Each year these presentations seem to improve. The three finalists will be announced soon.

Dr. David Eggleston will update members interested in a very important aspect of our College, Peer Review. Refinements in the process have been made which should help members when called upon to serve on their local committees.

Dr. Dana Kennan will moderate the Sections Meeting. Please note that this year at the request of Dr. Kennan's committee, the Sections Meeting will be scheduled on Wednesday afternoon. It will follow the Private Practice Seminar. Dr. Kennan and his committee believes that the private practitioners have much to contribute to the Sections Meeting and that by scheduling it back to back with their meeting it will facilitate attendance.

Obviously, the week is full. By presenting you the membership with as much information about this meeting as possible it is hoped that every member of the American College of Prosthodontists can arrange their schedules to come to San Diego in the Fall. The Hyatt Islandia is beautiful, the weather will be great, come get involved in your organization.

## PRIVATE PRACTICE SEMINAR IN SAN DIEGO

This year's Private Practice Seminar promises to maintain the excellence of former years. Two exciting speakers have been engaged, one in the area of fiscal management, and the other in marketing.

Dr. L. Donald Guess is the founder and President of Xélan, the Capital Accumulation Plan for Health Professionals. He will present his program of cash-flow management techniques used successfully by physicians and dentists for the last ten years. Fiscal strain is a reality for most private practices. My premise is that the less it impacts on your practice, the greater your flexibility in treatment planning and fee structure can be. This ultimately can allow us to do more comprehensive and sophisticated treatments for more patients. His theme will be "Prosthodontics would be a fun practice if I just didn't have to earn my living with it."



Dr. Guess will be our morning speaker and our luncheon guest.

Mr. Joseph J. Lancellotti, founder and President of Lanmark, Inc., will be our afternoon speaker. Lanmark is a marketing and advertising company with extensive experience in the dental field. Many of the dental ads, product pamphlets, brochures and package designs we see everyday, stem from Lanmark, Inc. The Executive Council was pleased and impressed with a presentation by him at our meeting in Chicago.

Mr. Lancellotti will be speaking on professional marketing tips and techniques with a sensitivity to ourselves as specialists. His theme will be "What makes a Prosthodontist different from my general dentist?"

The seminar will be held all day Wednesday, October 7, 1987 with our luncheon from 12:15 to 1:15. Plan to attend, with your spouse, both these important and provocative talks.

## NON-CHEW COOKBOOK AVAILABLE

The **Non-Chew Cookbook**, a collection of 200 recipes for persons having trouble chewing solid food, is now available. Over 40 million Americans suffer from some sort of jaw disorder that makes chewing difficult. These include cancer and stroke patients, denture wearers, Alzheimer's, Parkinson's and multiple sclerosis patients, and people undergoing oral surgery and dental treatment for TM problems.

Recipes include 30 kinds of soups, 43 vegetable dishes, 22 seafood selections, 17 beef entrees, 20 ways to serve chicken, turkey, pork or lamb, and about 50 desserts and beverages. A nutritional analysis accompanies each recipe.

The **Non-Chew Cookbook** is available from: Wilson Publishing, Inc., P.O. Box 2190, Glenwood Springs, Colorado 81602, 303/945-5600. The price of \$17.45 includes postage and handling.

## NOTICE

If you have moved, would like to add your telephone numbers to the roster, or change your codes in the roster, please contact Linda Wallenborn, Central Office Director, as soon as possible. The only way to keep the roster up-to-date is to notify Linda of any changes.

## WIVES WANTED! IN SAN DIEGO

As you members know, the various committees for the successful planning and operation of the October San Diego meeting are in full gear. The Registration Committee planning is no exception.

As Chairman of the Registration Committee, I would like to encourage all members to bring your wives to the next Annual Session meeting and to ask them to spend some time with me at the registration desk. Many of your wives do not seem to realize they can offer their help — in fact, that it is being sought! Although I had adequate and enthusiastic assistance in Williamsburg, I still feel the message is not getting to all those who would enjoy the camaraderie of my committee!

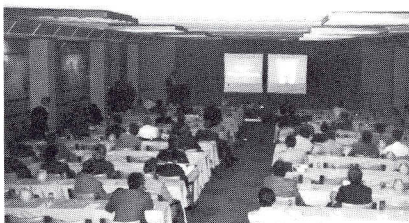
So, please encourage your wife to contact me as soon as possible telling me when she will be able to help. I will then be able to set up a schedule that will allow her to assist the College and still be able to see and do San Diego.

Please write or call: Nancy Fowler, 12519 Chateau Forest, San Antonio, Texas 78230; (512) 492-4147.

## PROJECTED CLINICS NEEDED FOR SAN DIEGO

The projected clinics that proved so successful in Williamsburg will be offered again this fall in San Diego. The clinics should be 15 minute slide presentations on research, technique or short topics. The scope of the topic must be limited so that the subject matter can be covered completely in the 15 minutes allotted.

For further information or to volunteer your service contact: Dr. Robert F. Baima, Director of Postgraduate Prosthodontics, Loyola University School of Dentistry, 2160 South First Avenue, Maywood, IL 60153.



The projected clinics attracted excellent audiences in Williamsburg. The same is expected in San Diego.

## AMERICAN BOARD OF PROSTHODONTICS CHANGES BOARD EXAMINATION

The American Board of Prosthodontics has announced a change in the suitability of patients for the Phase I, Part 2 case presentation. The new policy states:

All candidates must submit a history and treatment record of a patient for whom the required fabrication of at least two partial dentures involving the maxilla and/or the mandible has been completed. One of the partial dentures must be fixed, replacing one or more teeth, and one must be removable incorporating a unilateral or bilateral distal extension base. **If both of the required partial dentures are in the same arch, the opposing arch may include (1) an appropriate restored natural dentition which may or may not incorporate fixed or removable partial dentures, or (2) a complete denture or overdenture.**

## ACP TABLE CLINIC

All members of the American College of Prosthodontists interested in presenting a table clinic at the annual session to be held in San Diego (October 7-10, 1987) should contact Dr. Lee M. Jameson (Northwestern University Dental School 312-908-5945) for further information.

## TABLE CLINIC COMPETITION

Members interested in the table clinic competition should submit the following information to the **Central Office** (1777 N.E. Loop 410, Suite 904, San Antonio, Texas 78217) prior to July 15, 1987.

- A. Title
- B. Problem - identify reasons for investigation and provide background information.
- C. Methods - report how study or technique was developed
- D. Results - the bulk of the information should be listed here along with possible significance
- E. **The clinician should indicate that he/she wishes to be considered for the competition.**

Ten finalists will be selected for the competition and notified by August 15, 1987. The presentations for the **table clinic competition** will be held on



**October 8, 1987 from 11:15 a.m. - 12:20 p.m.** They will be judged according to the table clinic rating criteria established by the Alumni Association of the Student Clinician of the American Dental Association according to one of the two categories listed below:

- A. Clinical Application and Technique
- B. Basic Science and Research

Those not selected will be notified and encouraged to present their **table clinics** on **Wednesday, October 7, 1987 from 3:00 - 5:00 p.m.**

All presenters will receive a certificate of acknowledgement and the winners will receive:

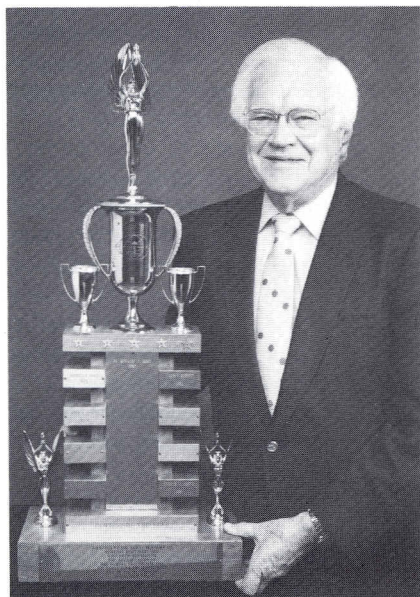
Fellow/Life/Honorary Member: 1st Place-\$200, wooden plaque, pocket patch; 2nd Place-\$100, wooden plaque, pocket patch; 3rd Place-\$50, wooden plaque, pocket patch.

Associate/Affiliate Member: 1st Place-\$200, wooden plaque, pocket patch, study guide; 2nd Place-\$100, wooden plaque, pocket patch, study guide; 3rd Place-\$50, wooden plaque, pocket patch, study guide.

The awards will be presented by President De Steno at the Annual Business Luncheon.

## **KENNETH D. RUDD, D.D.S. 1986 TEXAS DENTIST OF THE YEAR**

Kenneth D. Rudd, Associate Dean for Continuing Dental Education at the University of Texas Health Science Center at San Antonio, Dental School,



was selected the Dentist of the Year from among twenty-two nominees who represented District Dental Societies and Academy of General Dentistry (AGD) Chapters throughout the State of Texas. The trophy was awarded at the AGD luncheon on the first day of the Greater Houston Dental meeting on February 26, 1987 in the Hyatt Regency Hotel in Houston.

The Texas Chapter of the Academy of General Dentistry originated the tradition, and Dr. Charles K. Emery was the first recipient of the Texas Dentist of the Year Award in 1965.

The trophy is kept by the incumbent for one year then passed on to the new selectee. When each dentist is selected, his name is engraved on a brass plate attached to the trophy. The list of names on the trophy is indeed impressive. Dr. Rudd is the first institutional dentist to receive this honor.

Dr. Rudd is Professor of Prosthodontics and is a Diplomate and Past President of the American Board of Prosthodontics of which he was an examining member. He is a Fellow and one of the Ten Founders of the American College of Prosthodontists which he served as Secretary and President. Dr. Rudd is Past President of the Southwest Prosthodontic Society and of the Southwest Academy of Restorative Dentistry. He is currently President of the Federation of Prosthodontic Organizations and the Academy of Denture Prosthetics. He served as President of the American Equilibra-

tion Society in 1981, and is a member of the American Prosthodontic Society. He is a Fellow of the American College of Dentists and the International College of Dentists.

Dr. Rudd has lectured extensively in the United States and several foreign countries and has authored over 45 articles. He is a recipient of the Distinguished Lecturer Award presented by the Greater New York Academy of Prosthodontics Research Foundation in December, 1982. He is co-author of recently published books (1980-1981) titled *Laboratory Procedures for Complete Dentures*, Volume I, *Laboratory Procedures for Fixed Partial Dentures*, Volume II, and *Laboratory Procedures for Removable Partial Dentures*, Volume III, now in their 2nd Edition (1986). Dr. Rudd is also co-author of the book *Clinical Removable Partial Prosthodontics*, September, 1982. All were published by the C. V. Mosby Co. In addition, he is Editor of the Dental Technology section of the Journal of Prosthetic Dentistry.

### **CAR RENTAL DISCOUNT**

Hertz has been appointed the official car rental supplier for our upcoming meeting. Special low rates have been negotiated for this event, to help economize on travel costs.

For reservations and further information call the Hertz Convention Control Center at 1-800-654-2240.

### **ATTENTION: AMERICAN COLLEGE OF PROSTHODONTISTS MEMBERS. . . .**

United Airlines and the American College of Prosthodontists are offering special discounted fares that are not available to the general public. ***This includes the Ultra-Saver fare and can mean discounts ranging anywhere from 40 to 50% off regular Y coach fares!!!***

#### **Refer to Account #7059B**

United's convention desk is open for calls 7 days a week from 8 a.m. to 9 p.m. One call from you or your travel agent will put you in touch with our meeting experts who will offer you the lowest discount for which you are eligible *plus* - an additional 5% off that fare! Remember, this *Discount* is *Only Available* when you or your travel agent book your reservations thru United's toll-free number. Call today for more details.

You will be automatically eligible for a raffle to win two free round trip tickets good anywhere on United's system within continental United States when you call and book your reservation through the 800 number (800-521-4041).



## GEORGETOWN DENTAL SCHOOL CLOSING DOES NOT INDICATE TROUBLE

The American Dental Association expressed its disappointment over the announced closing of the Georgetown University School of Dentistry.

"The dental profession will be losing a valuable educational and research program," said ADA president, Joseph A. Devine, D.D.S. "We have asked that the university reconsider its decision and conduct a feasibility study that might identify options for keeping the school open," he added.

Dr. Devine also expressed concern about misinformation regarding the demand for dental services and the academic quality of students that the announcement has generated.

"Total spending by Americans on dental care has shown steady and significant increases throughout this decade," commented Dr. Devine. In 1980, total expenditures on dental care reached \$15.4 billion. By 1985, that figure had increased to \$27.1 billion. The projection for 1986 is \$28.6 billion. According to a recent federal government survey on dental visits, the average American makes 1.8 visits to a dentist per year. This is up from 1.6 visits in 1964 and 1978.

The percentage of people who have visited a dental office within a year also has increased and the number of people whose last visit was two or more years ago has declined, according to the survey.

The U.S. Department of Labor and other health administration experts have projected a continued increase in demand for dental services into the next century. Department of Labor statistics project that job opportunities for dentists will increase by 25 percent in the next 10 years.

While there has been a decline in the number of applicants to dental schools since 1978, dental schools have reduced first-year openings by 28 percent since 1978. In 1963, based on a projected shortage of health professionals, the federal government established a grant program tied to mandatory enrollment levels. The program had the desired effect of artificially boosting dental school enrollment and the number of dentists by expanding facilities and curriculum. The program ended in 1981. Meanwhile, the anti-

pated growth in the population did not occur.

"Dental schools in the United States continue to graduate students who are competent and qualified to maintain the highest standard of dental care provided anywhere in the world. To continue to ensure the high quality of dental students, the ADA and the American Association of Dental Schools have created SELECT, a nationwide network of dentists who will work in their communities to encourage talented and qualified students to consider dentistry as a career," Dr. Devine added.

## SECTIONS

**SOUTH CAROLINA:** The current officers of the South Carolina Section are Thomas F. Martin, President; James A. Rivers, Vice-President; and William D. Kay, Secretary. There are 19 active members and the roster is available from the Central Office.

In the Section's last meeting a review of the goals of the ACP were discussed and recommendations will be made concerning them. President Martin made a report on the College's annual meeting in Williamsburg. An agreement with the South Carolina Dental Association concerning Peer Review was also considered.

The next meeting is being planned and will be a combination dinner-business meeting.

**TEXAS:** The mid-winter meeting of the Texas Section was hosted by the U.S. Army at Fort Sam Houston Officers' Club on January 27, 1987. After an excellent social hour and dinner, Dr. DuFort welcomed everyone and made some opening remarks. This was followed by three outstanding presentations - the first by Dr. Sonny Pilgram on "Staining and Characterization of Denture Bases"; the second by Dr. Robert Yard on "The Mandibular Staple Implant"; and the third by Dr. Charles Netti on "Effect of Adding Colorant to Composite Resins".

The Business meeting opened with Dr. Troendle giving the financial statement.

He reported that the Section had in its bank account, as of the first day of 1987, a total of \$511.37. New officers for the Section for 1987 were elected, sworn in and congratulated. They are: President, Dr. Edmund Cavazos, Jr.; Vice President, Dr. G. Roger Troendle, Jr.; and Secretary-Treasurer, Dr. Leo F. Broering.

Dr. Cavazos then made his opening

remarks and presented Dr. Charles DuFort, Immediate Past President of the Section, a plaque in recognition of the outstanding contributions he had made as President of the Section the past year.

The Texas Section met again on March 31, 1987 at the University of Texas Health Science Center. A social hour was followed by dinner.

President Cavazos introduced the host for the evening, Dr. Jim Fowler, who in turn introduced the three speakers for the evening, graduate students of the Health Science Center.

Dr. Sheryl Green spoke on Periodontal Consideration for Crown-Margin Placement. Dr. Gordon Mahanna presented Internal Attachments: Their Value and Indications, and Dr. Don Reikie presented a literature review on Vertical Dimension. The program was well received.

## ACP EDUCATION FOUNDATION UPDATE

There may be some College members who have heard of the ACP Education Foundation, but are unaware of what it is, what it does, and how it may ultimately affect them.

The ACP Education Foundation was formed in 1985 as an entity separate from the American College of Prosthodontists. It is composed of a Board of Directors of nine members of the College who are responsible for the orderly pursuit of the philosophy of the Foundation. The purpose of this non-profit Foundation is to educate the general public with regard to prosthodontic care, prevention and correction of prosthodontic problems. Emphasis is directed towards improving dental health and prosthodontic care to the general public through dissemination of information and educational activities. The Foundation is organized exclusively and specifically for charitable and educational purposes within the meaning of Section 501 (c) (3) of the Internal Revenue Code of 1954.

Since 1985 the ACP Education Foundation has been operating in a low-key fashion pending approval of the tax qualification by the IRS. On December 10, 1986 the IRS ruled that the Foundation is exempt from Federal income tax under Section 501 (c) (3) of the Internal Revenue Code.

The Foundation will now actively develop its plan for fund raising activities under advisement of legal counsel. Although the Foundation has not formally initiated its fund raising cam-



paign, any College member can now make a donation at any time. Monetary gifts should be made to the ACP Education Foundation and mailed to:

Dr. John B. Holmes, Treasurer  
ACP Education Foundation  
279 Sandringham North  
Moraga, CA 94556

## AVOIDING MALPRACTICE LITIGATION

When I entered private practice some thirteen years ago, my malpractice insurance was about \$600.00 per year. Today, it approaches \$10,000.00. If you asked me thirteen years ago if I would ever be sued during my professional career, I would have responded 'No way'. After all, I am one of the good guys who really tries to do things right, never cuts corners, is motivated by what is best for my patients regardless of the economic impact, provides the best treatment, executes it with a high degree of skill, keeps upgrading techniques, tells the patient the truth, and cares for them in the same manner I would my own family. Unfortunately, that does not mean anything in our society today. I know because I was sued. It was a gut-wrenching experience. I did not, however, give into the temptation that it was merely an expected business inconvenience, let's settle it and get it over and done with because in my heart I knew I was right. I went to trial and I won. The price in terms of emotions, energy, time and money was substantial. Along the way I lost a good deal of respect for our Judicial System and discovered that being right does not guarantee a successful defense or justice. It's a crap-shoot and it could have gone either way. The saving grace was that I kept accurate detailed treatment records.

This factor, along with many others, was again brought to my attention recently when I attended a Malpractice Prevention Seminar hosted by T.D.I.C.. T.D.I.C. is my insurance carrier, the independent company formed by the California Dental Association to fill the void created by the mass exodus of major carriers several years during the "malpractice crisis". Insurance rates in California and across the nation attest to the fact that this crisis is far from over, and that litigation is still on the increase. Fact is, so the experts tell us, that each of us is very likely to be sued at least once during our professional career, and perhaps even more than once.

As Prosthodontists, we are in a high risk group because we treat problem cases, and systemically compromised patients. We are, after all, the last resort. We deal with patients, that regardless of technical excellence, may never be pleased and we deal in big ticket items, such as dentures, precision partials, complete rehabilitations, craniomandibular dysfunction and implants. Statistics indicate that the number of claims per year per 100 practitioners makes us the second highest risk group (Figure 1). The severity in claims dollars is also second only to the oral surgeons (Figure 2).

The prime ingredients leading to malpractice litigation are bad manners and bad results. Some 50% of the 4,157 litigant actions involve bad results and 12.5% involve failure to diagnose and/or refer out for treatment. Of the 878 cases involving failure to diagnose/refer, 15 involved Prosthodontic Specialists.

History records that Socrates was a great orator who gave advice, and as a result, they poisoned him. At the risk of suffering a similar fate, I would like to offer some advice on how to prevent problems. Keeping detailed, accurate records is an excellent start. In the chart, write down the date complete with the year, the time, the patient's prime complaint, all subjective and objective clinical findings, any test results, the radiographic findings, your diagnosis, your plan of action - what you did and how you did it, etc.. List medications administered, such as anesthesia (name, dose and site). Post-operative instructions, advice given, prescriptions written, when and what the next visit is for. Dictating the notes to your assistant helps to reduce the obvious time element. At the conclusion of each entry, have her initial it. Your chart should document the care administered, any complications such as the symptoms, the severity of symptoms, what to do in case the advice doesn't relieve the symptoms, and any drug side effects. Document all phone calls and messages, failed appointments, noncompliance by the patient, and any complaints about your treatment in the chart. Also, keep neat records. If your records are sloppy and incomplete, it can very often be inferred that your treatment was sloppy as well. This may sound elementary, but it is surprising how many dental charts are notoriously sparse on recording detailed information.

Review the entries at the end of your workday. Correct any errors and add

pertinent comments and information that may have been missed and initial all additions. Review any incorrect or incomplete entries with your staff so they become as vigilant as you in recording details. Make certain that your receptionist and dental assistant do not make diagnoses and give advice. If advice is to be given, it should be with the consent of the dentist. Call the patient that had extensive and difficult treatment in the evening to check on their status.

Implement a plan for your office in the event of an emergency. Have practice drills periodically, so that every member of the team knows what to do. Document these reviews and drills in your staff meeting agenda and notes. Since you are responsible for the actions of your staff, make sure they are skillful and properly trained. Make sure they are tactful and discreet in how they deal with patients. Inadvertent and innocent comments can and do lead to a loss in confidence on the part of the patient, and conjure up all kinds of imagined problems in their minds that can lead to litigation.

Since Prosthodontists deal routinely with difficult cases, make a written outline of the treatment for each case. Detail the treatment plan, and give the patient a copy and have them sign it. On very complex cases, write a confirmation letter to the patient detailing what was discussed during the consultation and review the accepted treatment plan and the expense involved. Make certain that you obtain permission to treat and document it in the chart. When discussing treatment with the patient, review the risks and benefits and document it in the chart as evidence of **informed consent**. On the more extensive procedures, have a printed treatment consent form that is signed by the patient, this holds true for endodontics, surgery, implants, TMJ, extensive reconstruction and any areas where there are legitimate risks. In addition, as part of your treatment record, consider preoperative and post-operative photographs on every case.

**Informed refusal** is just as important. If the patient does not want to have radiographs taken, have them sign a release form, or if they don't want a regular cleaning or refuse to be referred to a periodontist after diagnosing active disease, have them sign a periodontal release form, or dismiss them from your practice. If you do dismiss the patient, do it properly to avoid abandonment. Ask your attorney or your insurance carrier to provide a



sample letter for proper dismissal.

When you refer a patient for care, document it in the chart. Send a short note or letter to the physician or dentist stating what problems you diagnosed and what concerns you have. Follow up on the referral to make sure they went. If not, document it in the chart. If you are the one receiving the referral, send a letter noting what you found during the examination, the treatment you planned, your recommendations and if the patient has accepted or rejected treatment.

If you perform surgery, endodontics, periodontics, or any procedure that can be considered in the sphere of a specialist, you are held accountable to the level of treatment the patient would have received in a specialty setting. You, therefore, have to refer the patient out, or make certain your skill levels in that area can match the specialist. This also hold true for the general dentist. The prosthetic treatment they perform will be judged on a level commensurate with that which would have been provided by a prosthodontic specialist. General dentists are also learning that the hard way. In time, it will be a stimulus to refer more difficult cases to us the first time. Naturally, we must learn from this also. Be realistic in evaluating your skill levels outside your expertise. If you are uncertain about a treatment plan, ask a colleague to examine your patient and the projected treatment plan. Some of us are blessed with rather large egos, and if this consideration is untenable, think again. It's much better to defend your treatment plan to a colleague before embarking on treatment than to a jury after treatment has been rendered and problems arise. It's far worse to be made a fool during a deposition or on the witness stand when the hard questions hit home such as "Doctor, why didn't you do this, or doctor, why didn't you do that?" Instead, let's do everything we can to minimize getting caught up into the litigation frenzy that has infected our society. Keep in mind both good guys and bad guys get sued. If you cover all your bases, you're much less likely to be hit with a frivolous suit.

What if you do get a letter from an attorney stating that a malpractice action is being considered against you? What then? First, call your carrier immediately and give them a cursory history of the situation. Call a staff meeting immediately and tell your staff what is happening and seal the patient's chart. Do not make any further entries

into it from that point on. Make a xerox copy of the entire chart content and put the copy in a safe place at home or in a safety deposit box. Above all, do not make any corrections, additions, or deletions to the chart. If the chart record is altered you are dead in the water and you have no defense. Review the chart and on a separate sheet of paper record as much detail of the history and treatment as possible that is not documented in your records. When you are discussing the case with your attorney at a later date, you can use these notes to refresh your memory.

The best action, however, is not reaction, but prevention. Treat your patients well and protect yourself with detailed documentation. Good records and accurate documentation are the nemesis of the plaintiff's attorney. They will think hard and long before initiating nuisance litigation if your records are clear and concise as to what exactly happened. In this day and age, it can and probably will happen to you. Keep these factors in mind and make it as easy as possible for you and your attorney to defend yourself.

—Paul P. Binon, D.D.S., M.S.D.

**Figure 1**  
NUMBER OF CLAIMS PER YEAR  
100 PRACTITIONERS

General Practice	11
Oral Surgery	39
Prosthodontists	19
Endodontists	16
Periodontists	12
Orthodontists	12
Pedodontists	8

**Figure 2**  
SEVERITY OF CLAIMS  
PER 100/PER SPECIALTY

General Practice	\$60,500
Oral Surgeons	\$455,500
Prosthodontists	\$139,500

## MILITARY DENTAL COVERAGE TO BEGIN

The Pentagon will award a \$10 million contract in April for dental services to military dependents. Coverage will begin August 1. Service personnel will pay a monthly premium of no more than \$10 for diagnostic, examination and preventive services.

## SYNOPSIS OF PAPERS PRESENTED AT THE WILLIAMSBURG ANNUAL OFFICIAL SESSION

By Dr. Don Garver

**TITLE:** The Utilization of Specially Programmed Computers for Diagnosing and Treatment Planning Patients

**Lecturer:** Dr. Rudolf Slavicek

Dr. Slavicek discussed controlled therapeutic dental treatment utilizing a computer as a diagnostic and treatment aide. This Computer Aided Diagnostic System (CADIAS) enables the doctor using the system to receive cephalometric evaluations, incisal guidance determinants, mandibular repositioning values, graphic displays of skeletal types for the analysis of proper vertical dimension, and computer aided instrumentation for the waxing and fabrication of fixed and removable prostheses.

Dr. Slavicek discussed the computer's value in clinical dentistry. The following is a list of things available through computer evaluation of any dental patient: (1) to collect data; (2) evaluate data; (3) the correlation of that data; (4) interpretation of the data; (5) present a diagnostic dialog; (6) interactive planning; (7) suggested therapy; (8) present a concept of therapy; (9) collaborate therapy; and (10) the management of the total patient.

In the **collection of data**, the patient and the doctor must discuss a historical review of the dental problems and the doctor must have a clinical functional analysis which is then plugged into the computer. There is an analysis of the muscles of mastication, the movement of the mandible, the temporo-mandibular joint. An occlusogram is accomplished, the nerve responses are evaluated and placed into the computer and even the posture of the patient is fed in for further programming of the diagnostic treatment. Involved in this clinical collection of data is an instrumental analysis whereby a special articulator using axiography is utilized to give a three dimensional facebow electronic measurement. With this type data, the computer can assist in the second phase of treatment which is the **evaluation of the data**. The computer now calculates where and what the condyle is doing, any motion or position, and displays



this on the computer screen in all the different planes of jaw movement involved in a dental rehabilitation.

Dr. Slavicek then discussed the cephalometric analysis which is important in the utilization of his computer system. He used a two dimensional digitizer to put landmarks into the computer and correlated this information to give the doctor all related bits of information such as condyle angles, occlusal planes, occlusal guidances, and the occlusal vertical dimension. The computer can tell you the curves of Spee and Wilson, the facial contours of the patient, the incisal guidances, and as to whether surgery or orthodontics is necessary to change the skeletal bony angles for the betterment of the patient treatment program.

In the diagnostic and treatment phase, the computer gives a **suggestion of therapy**. This enables the doctor to know the incisal table, the occlusal plane, the Bennett angles, the vertical dimension of occlusion, and the best occlusal plane for the setting of teeth as to angulation and balance for a mutual protected occlusion. Amazingly, Dr. Slavicek showed how an articulator is set, occlusal record bases are made, centric and eccentric relation records are made, and the computer then tells you how to set the teeth utilizing these particular records. With the proper type of diagnostic input, the computer has the ability to tell the doctor how to set his occlusal planes, where to place the centric stops, gives a graphic three dimensional relationship of where the teeth are during function, discusses and describes the cuspal inclination necessary for this patient, and finally establishes the incisal table and protrusion pattern for better occlusal harmonies.

In summary, Dr. Slavicek described the research and development of the complete diagnostic module instrumentation system and related computer services. Based upon an extensive data base collected from the patient by the doctor, Dr. Slavicek is able to program a computer to assist the prosthodontist in treating his patient better via computer aided diagnostic treatment implementation and exacting therapeutic treatment plans.

Further correspondence with the speaker can be obtained by writing Dr. Slavicek at the following address: 4 Widerhoffer Platz, Wien, Austria.

**TITLE:** Five year Progress Report On  
Alternative Fixed Partial  
Denture Alloys

**Lecturer:** Dr. David A. Irvin  
Dr. Warren M. Stoffer  
Dr. Dennis J. Weir

Drs. Irvin, Stoffer and Weir presented a review of a Veterans Administration's study comparing three base metal alloys and a silver paladium alloy to a control alloy of gold paladium used for metal ceramic crowns and fixed partial dentures. The project involved 664 patients. After five years, 517 of the patients are still in the project. The metals evaluated were Ticon, Micro-bond NP2, Ceramalloy 2, Wilceram W1, and Olympia - the control alloy. The purpose of the project was to monitor tissue health, evaluate the quality of the castings and assess the physical performances of the alloys. In developing the project, the restorative criteria were, (1) all crowns or fixed partial dentures would have opposing dentition; (2) the fixed partial denture spans would be long enough to require a solder joint; (3) the periodontal health had to be normal to average; and (4) the preparations for the crowns were to be a beveled shoulder or a beveled cantilever shoulder preparation. At the laboratory level, (5) an articulator was to be used in all cases; (6) all provisional restorations were to be heat cured; and (7) each patient would receive one control restoration alloy (Olympia) and one random sample alloy. The evaluation times were four in nature — after fabrication, prior to cementation, after cementation, and follow-up evaluations of one month, six months and annually. Of restorations accomplished, 395 fixed partial dentures and 945 full coverage crowns were cemented. In evaluating the processing times and the dollar values, it was found that, for Olympia, an average dollar value was \$54.70, and for the other metals used, the dollar value was \$23.00.

The clinical prosthetic evaluation involved many factors. With each factor listed below, there will be a rating behind the factor which is the result of the five year program.

- (1) **Marginal integrity** - good for all - no significant difference.
- (2) **Porcelain to marginal integrity** - excellent for all - no significant difference.
- (3) **Porcelain esthetics color** - perfect to acceptable for all - over a period of time, all got worse and

there was no significant difference.

- (4) **Polish/tarnish of the metal surface** - except for Ticon all surfaces were glossy at cementation and resulted in a dull finish at evaluation time.
- (5) **Polish/tarnish of solder connector** - all cemented in a glossy condition turned to a dull finish - no significant difference.
- (6) **Smoothness and pitting of the restoration or connector** - no significant difference.
- (7) **Wear of study restoration** - no observable wear - no significant difference.
- (8) **Porcelain glaze** - no significant difference.
- (9) **Crazing and fracturing of porcelain** - evaluated in the aspect of the porcelain fracture only, porcelain to opaque fracture, porcelain to oxide fracture, and porcelain to metal fracture - no significant difference between the alloys - all alloys deteriorated over a period of time.
- (10) **Metal sensitivity and metal taste** - no significant difference on any of the metals. In these particular tests, there were involved evaluations as to whether the gold or non-gold alloy materials tended to have a metallic taste or not. It was shown that there is no significant difference.
- (11) **The periodontal variables:** (a) **plaque index** - the non-precious alloys appeared to have a less amount of plaque but was not discernible; (b) **gingival index** - increased gingival irritation probably due to crown contour, and pocket depth - no clinical significance. A question in summary was do alternative alloys affect periodontal tissues. The answer was no.

The three doctors presenting this program have done an exhaustive study on the variability of base metal alloys, silver paladium alloys and a gold paladium alloy. They presented the description and results of this longitudinal study comparing these alternative alloys as to clinical performance and acceptability of marginal integrity, porcelain metal integrity, fit, retention, color, metal surface characteristics, and periodontal acceptance. Further information pertaining to this report can be obtained by writing Drs. Irvin, Stoffer and Weir at 7122 Obelisco Circle, Carlsbad, CA 92008.



**TITLE:** A New Shade Analysis and Porcelain System

**Lecturer:** Dr. C. Wayne Caswell

Dr. Caswell discussed the Spectratone Porcelain System. In his initial comments, Dr. Caswell stated that an ideal porcelain system should have a logical shading and colorant arrangement, adequate distribution, it should be able to match natural tooth shades, the opaquing qualities should enhance the body porcelain, there should be fluorescence, and the porcelain should have a metal interface compatibility that is excellent.

As to logical arrangement, Dr. Caswell stated that most systems available today have all the different components arranged in value, hue (yellow to red), and chroma. Most of the shade guides are in a line or a wheel. In the Spectratone System, however, there are 216 tabs, and by a methodical process of elimination using Feldspathic tabs we are able to pick porcelains that will give us tooth shades that are predictable. The Spectratone System has color tabs, enamel tabs, effect tabs, dentinal tabs, and opaque tabs. In using this system, you first select the hue tab that is closest to the tooth color that you wish to achieve. There are three sets of tabs for each hue. Following your chroma desires, you go from left (low chroma) to right (high chroma) tabs and end at the intensity of the color necessary. After selecting chroma, you go down the tab scheme to a tab that has either a lot of value or little value. Once you have done this, you have a tab which can now be designated as your hue tab. Following the selection of the hue tab, an effect tab shade tab is picked. An enamel selection tab is selected next, and a transparency tab selection follows. Because of this particular type of selection process, you are able to match the natural tooth structure. Communicating this selection to the lab is essential and is done with a lab chit that is comprehensive. Your lab authorization form also states the type of lighting that was used in the selection of your shade.

Once the exact tab has been selected, the laboratory technician can mix the feldspathic powder exactly and can scientifically reach a formulation for all 216 tabs. There are only four powders — one opalescence, one yellow, one pink, and one gray. The opalescence powder is the chroma changer. Since all the enamel powders do have blue in them, the yellow and

the pink powders are responsible for changing the hue, and the gray powder is responsible for changing the value of the selected formula. The opaque that is involved in this system can be either sprayed or brushed on and is very plastic — not runny at all — and stays where it is placed. One of the most interesting things cited by Dr. Caswell is the fact that there are marginal porcelains available which we can change the hue at the margin without affecting the rest of the crown.

In an evaluation of the fluorescence of the new porcelain system, Dr. Caswell stated that the 400 nanometer Spectratone refractory range is good for fluorescence. Unfortunately though, by grinding on the finished crowns, the prosthodontist many times changes the fluorescence of the crown. However, in the system discussed, the fluorescence is in the body porcelain. We then have a much better natural esthetic result when enamel contours are changed than if the fluorescence were in the enamel porcelain. Dr. Caswell very briefly discussed the porcelain to metal compatibility and assured us that in tests run by the company and in his evaluation, the new Spectratone porcelain is compatible with most all the metals available today for our fixed partial dentures.

In summary, Dr. Caswell gave a very organized presentation on a new shade analysis system offering us a systematic means of selecting hue, chroma and value for porcelain fused to metal restorations. By predictable formulation of the selected shade, it is easy to educate the new dental student on the importance of learning a system such as this. Further information pertaining to this report can be obtained by writing to Dr. C. Wayne Caswell at 2606 N.W. 37th Terrace, Gainesville, FL 32605.

**TITLE:** Centric Relation: Redefined

**Lecturer:** Dr. William H. McHarris

While centric relation is a commonly used term, it remains one of the most controversial subjects in dentistry. By definition, it is an enigma. What do we mean? Is it a maxillomandibular relationship? Is it a craniomandibular relationship, a retruded mandibular relationship? Is it a rearmost, uppermost relationship, or is it a condyle fossa relationship? It has been defined as a maxillomandibular relationship, a mandibulocranial relationship, and a mandibular posture with no vertical

dimension. Some dental educators define it with respect to condyle fossa relationship with no mention of the mandible, yet some have tried to define this three dimensional posture with two dimensional x-rays. Centric relation must be considered in three dimensions. It should be defined as a mandibular posture to include both its condyles and their articular discs. Unfortunately, centric occlusion is a bad term because anything besides one centric relation position is eccentric.

Dr. McHarris discussed the anatomical requirements of centric relation. First, he stated that the muscles of mastication were responsible for mandibular movements. The rest position is a condition when all of the muscles are relaxed. Toxicity can influence the vertical dimension of occlusion because of this muscular relation. Secondly, he stated that the discs and the condyles are one assembly. The disc acts as the third bone, not as a meniscus — it is attached all the way around. The translation of the temporomandibular joint occurs in the upper compartment and the rotation of the joint occurs in the lower compartment. Because of these attachments at the joint, the meniscus does not squirt around like a watermelon seed, but stays placed and moves purposefully due to the movements of the mandible and the muscles in that location. Dr. McHarris went on to state that there are blood vessels and nerve bundles throughout the entire temporomandibular joint **AND** the capsule is a perfect example of form conforming to function in that it has a bioconcave form, thus acting as an intermediary between the glenoid fossa and the condylar head. He mentioned that the teeth act as protectors to this particular bioconcave form and that the rest position of mandibular motion is the most therapeutic for the disc assembly. Interocclusal interferences can cause: (1) joint problems; and (2) tooth intrusion.

Dr. McHarris stated that centric relation is a muscle position. The limiting factors to obtaining centric relation position are: (1) the lateral pterygoids, the inferior heads; (2) edema in the temporomandibular joint compartments; and (3) occlusion. In order to achieve a proper centric relation position: (1) The muscles must be bilaterally relaxed in both of the inferior heads of the lateral pterygoids. This takes time to achieve. (2) We must not have any synovial fluid in the compartment. It takes



two to three months to reduce the inflammation in a patient that arrives at your office with temporomandibular joint disorder syndrome pain. (3) We must create an environment to effect the first points of muscle relaxation and decreased inflammation. Our goal in establishing these things is a true centric occlusion position which is the second most therapeutic position for the disc compartment.

Dr. McHarris then discussed the therapeutic requirements of centric relation. He stated there must be a facebow transfer in order to orient the maxillary cast in space and in relation to a transverse axis. He made a point that a seated centric relation position must be obtained by preliminary treatment (muscle control and corrective occlusal adjustment) prior to a proper axis location and ultimate upper and lower cast relations.

Techniques to achieve a proper centric relation position were discussed in depth. The **Chin Point Guidance** technique is only good in the hands of an experienced operator. Operator error, inability of the patient to relax and posterior force pressures in the condylar area will cause poor results. In **Bi-Manual Manipulation**, accurate results depend upon: (1) material selection to allow muscles to react physiologically (wax is best); (2) patient cooperation; and (3) operator experience. Dr. McHarris feels that the **Anterior Deprogramming Devices** are the best for obtaining a centric relation final seated posture. By deprogramming the posterior teeth via controlled anterior contact only, there is no stimulation of the proprioceptors of the posterior teeth, and no muscle action of the power muscles. He feels that quadrant wax records are best and that time must be taken to assure patient relaxation.

A discussion of joint radiography showed that two dimensional radiographs will often give poor information. Cephalometric corrected laminograms are the method of choice for obtaining accurate condyle/disc relationships.

Proper pre-treatment regimen, as defined by Dr. McHarris, involves the unloading of the joint initially, thereby decreasing the pressures to the joint. This can be done by construction of a pivotal splint (a vacuum formed device, contoured until the pain is relieved). This vacuum formed splint is worn at night only so that the patient cannot swallow it, so that the patient will not depress their teeth, and so that the

uncovered teeth will not erupt. Secondly, Dr. McHarris believes in physical therapy of the muscles in order that the patient can get ready to be treated and/or cured.

In summary, this overview of centric relation position was well received by the audience and was a testimony to the thoroughness and exactness of Dr. William McHarris. His continuance in the perfection of the establishment of centric relation position, and thus the resultant establishment of correct occlusal patterns during dental treatment for the patient requiring occlusal redefinition is to be complimented.

Further information can be obtained by writing Dr. William H. McHarris at the following address: 3100 Walnut Grove Rd., Suite 302, Memphis, TN 38111.

## **CORRECTION TO SYNOPSIS OF INFECTION CONTROL IN PROSTHODONTICS BY DR. ROBERT R. RUNNELLS**

Because of what the lecturer feels to be an important aspect of prosthodontic treatment and also because of what he perceives to be a general sense of confusion in infection control, Dr. Runnells has offered some important points of clarification of the synopsis of his lecture as it appeared in Vol. 17, No. 1 of the **Newsletter**.

The points he wishes to make clear are as follows:

1. Tuberculosis will not be eradicated in the U.S. by 2010. The CDC had stated that by that year "TB would no longer be considered a health threat." Their point was that TB would still exist but at substantially lowered levels.
2. There is only one AIDS virus. It was previously known as HTLV-III and has now been renamed HIV.
3. Of acceptable disinfectants, phenolics do not have an objectionable odor; however, they are often sticky when used on surfaces, therefore, I find them less practical for surface disinfection.
4. I do not recommend use of chlorinated disinfectants for immersion...they are too corrosive to metals. Rather, I recommend phenolics or glutaraldehydes for liquid immersion.
5. I do not recommend the iodophors (Wescodyne & Biocide) for cleaning cutting instruments or as an immersion disinfectant. Iodophors are also corrosive to metals. Iodophors are much more suited for surface disinfection,

use in pumice, for immersion of dentures and certain impressions, spraying of other impressions, and certain other applications.

6. Polyethers impressions should not be immersed but are disinfected more safely by spraying; otherwise, some dimensional change may occur.

7. It is very difficult, in some cases impossible, to practically sterilize most laboratory appliances and prothesis; however, a high level of disinfection may be attained.

## **WASHINGTON NEWS BRIEFS**

### **ADA PUSHES FOR DENTAL BENEFITS IN CATASTROPHIC CARE**

The ADA is an active participant in the catastrophic health insurance debate, which has become the number one health issue in the 100th Congress. The House and Senate have begun hearings on several bills.

Rep. Bob Michel (R-IL) and Sen. Robert Dole (R-KS) have introduced bills, H.R. 1245 and S. 592, on behalf of the Administration. The bills call for extended Medicare to cover long hospital stays. The Michel-Dole bills would be financed by raising Medicare premiums by \$4.92 a month for those who sign up for the extra coverage.

Sen. Edward Kennedy (D-MA) has also introduced a bill S. 210, which is very similar to the Administration's proposal.

Reps. Fortney "Pete" Stark (D-CA) and Bill Gradison (R-OH) have introduced H.R. 1280 and H.R. 1281 as an alternative to the Administration's plan. The key difference between the plans is that the Stark-Gradison proposal would pay for the increased care by taxing some Medicare benefits, which the ADA has consistently opposed. Dr. William Allen, ADA Washington office director, told Stark, "We do not think it appropriate to impose a tax on Medicare beneficiaries related to the value of the Medicare package."

Both the Administration's plan and the Stark-Gradison bills would take effect once the beneficiaries have met a cap on out-of-pocket expenses. Neither calls for allowing the dental expenses to be counted toward that cap. Dr. Allen told Stark that the ADA feels it is vital that dental benefits be included as out-of-pocket expenses. "Recognizing that dental care, while not expensive, is necessary for the health and well being of older persons,



we strongly urge that you allow expenditures for dental services," he said. The ADA has also urged that the cap, which varies from \$1,700 to \$3,100, be scaled to income.

Rep. Claude Pepper (D-FL) has also introduced a catastrophic care bill, H.R. 65. The Pepper proposal would establish a new Medicare Part C to cover catastrophic health care costs as well as numerous other benefits including dental care. H.R. 65 would require that all covered services be provided on a capitation basis.

While pleased with the inclusion of dental coverage, the ADA has objected strongly to limiting the provision of benefits through a single delivery mechanism, i.e., a capitation plan.

### **NIDR TELLS CONGRESS OF STRIDES IN DENTAL HEALTH AND RESEARCH**

Dr. Harold Loe, director of the National Institute of Dental Research (NIDR), reported to Congress that "the dental health of Americans is getting better all the time."

Appearing before the House and Senate appropriations subcommittees on health, Dr. Loe released results of a \$3 million national adult study, which also were reported in Chicago at the American Association of Dental Research annual scientific meeting.

Dr. Loe testified on the Reagan administration's fiscal year budget request for dental research.

The administration is asking Congress to appropriate \$113 million for the NIDR in FY 1988, which is \$5 million less than last year's appropriation.

Referring to the NIDR adult survey, Dr. Loe said it indicated a dramatic savings in denture costs. "We calculate that for the period from 1974 to 1981 alone Americans saved close to 5.5 billion dollars," he told Congress.

A children's survey showing that more than a third of the nation's children have never had a cavity represents an additional \$2 billion a year savings in the nation's dental bill. Despite enormous improvements in the dental health of the nation's children and young adults, "we still face serious oral health problems among mature adults and especially in our older citizens," Dr. Loe told Congress.

The Association expects to testify later this year on behalf of continued strong federal support for dental research and other dental-related programs.

### **STATE ISSUES**

**Dental Hygiene:** Hygienists in South

Carolina and Texas have used the tactic of direct mailing to dentists in their legislative campaigns this year. Hygienists in South Carolina are pushing for general supervision in institutional settings, a move opposed by the South Carolina Dental Association. The South Carolina hygienists claimed that they were writing dentists to clear up misunderstandings about general supervision and unsupervised practice. Texas hygienists, who are fighting a proposal by the Texas Dental Association to require direct supervision of all hygiene functions, were more straightforward. Their letter urged dentists to actively oppose the TDA's position.

The 1986 ADA House of Delegates adopted a policy requiring direct, indirect or personal supervision of dental hygienists by a licensed dentist in all settings and called on constituent societies to work toward changes consistent with this policy. To provide direction, however, to those states where general supervision is firmly entrenched, the House adopted criteria for general supervision which are designed to discourage unsupervised practice under the guise of general supervision. These require that any patient treated by a dental hygienist must first become a patient of record of a licensed dentist, the dentist must provide the dental hygienist prior written authorization for the services, and the dentist must examine the patient after the services are provided. The House also adopted definitions of direct, indirect and personal supervision.

**Denturism:** The hopes of denturists in Washington for authority to deal directly with the public are fading, despite support from the State Health Coordinating Council. Hearings were held in March on a bill to authorize the practice of denturism, but no vote was taken. The Montana House voted in February to accept the recommendation of the state audit commission and merge the Board of Denturistry into the Board of Dentistry. The Senate is expected to follow suit.

**Tax on Professional Services:** Proposals to tax professional services are receiving serious attention this year in Texas and Washington. A bill introduced in Washington would impose a tax of 1.25% on the retail sale of all services, including dental services. Texas is still drafting its tax measure. The Texas Dental Association hopes to carve out an exemption for dental services before a bill is introduced.

A bill has been prefiled in the Florida legislature to reinstate the sale tax

exemption for dental and other professional services that was repealed last year. In Tennessee, where proposals to tax professional services appear routinely in every legislative session, a bill has been introduced that would impose a tax of 1/6 of 1% on gross income from dental and other professional services.

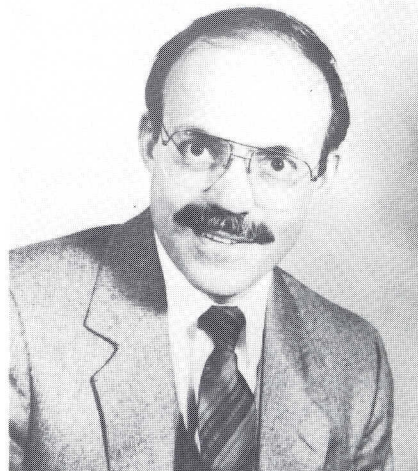
Legislation is pending in Hawaii to exempt income from the sale of health aids and devices used by a dentist from the state's 4% privilege (gross income) tax. The legislation also would exempt amounts received from professional services. Hawaii is one of only two states that now imposes a tax in the nature of a sales tax on professional services. The other state, New Mexico, taxes gross receipts from professional services at the rate of 4.75%.

### **PUBLIC RELATIONS EFFORT BY COLLEGE HAVING EFFECT**

In the March 9th issue of the Miami Herald newspaper, Columnist Harry F. Rosenthal, a well known feature writer, devoted his column, "Over 50", to a lengthy discussion of the use of implants in making the loss of teeth less traumatic.

Mr. Rosenthal quoted extensively from an interview with Dr. Thomas Balshi, Chairman of the Public and Professional Relations Committee of the College. The article closed with an excellent mention of the College. The final paragraph read as follows:

"There are specialists around the country who can do the procedure (implants), Balshi said. They are listed in the Yellow Pages under prosthodontists. Their addresses are available from the American College of Prosthodontists, 1777 N.E. Loop 410, Suite 904, San Antonio, Texas 78217."



Dr. Thomas J. Balshi interviewed in the Miami Herald.



## GERIATRIC DENTISTRY NEWSLETTER

Dr. Robert R. Rhyne, Assistant Chief Medical Director for Dentistry of the Veterans Administration, recently welcomed a new publication, "The Geriatric Dentistry Newsletter". Dr. Rhyne believes the Newsletter fills a critical need to disseminate in a timely way, VA dental staff contributions in geriatric dentistry. The publication should be looked on not only as a source of information but as a vehicle to share research results, educational activities and patient experiences with VA colleagues.

Dr. Rhyne feels the immediate challenge presented by the older veterans, the growing numbers of dental staff specially trained in geriatrics, and an administrative system that lends itself to cooperative efforts, offers a unique opportunity for the VA to assume a leadership role in geriatric dentistry, designing responses to the oral health needs of the older persons.

Dr. Patrick M. Lloyd, currently chairman of the Ad Hoc Committee on Geriatrics for the American College of Prosthodontists and coordinator for Geriatric Dental Programs, Veterans Administration, is Editor in Chief for the Geriatric Dentistry Newsletter.

### 1987 SURVEY DEPENDS ON DENTISTS' RESPONSE

The 4 percent of the nation's general practitioners and specialists who are being sent the 1987 Survey of Dental Practice are encouraged by the ADA Bureau of Economic and Behavioral Research to complete their questionnaires.

The 1987 Survey is the latest in a series conducted by the Bureau every two to three years since the 1950s and annually since 1982. The survey provides the most complete source of information on all aspects of the private practice of dentistry in the United States.

Data obtained from the survey are used to determine trends in dentist income, practice activity, employment of auxiliary personnel, and other characteristics of importance to the dental profession.

"As with all surveys conducted by the Association, response is voluntary, and complete confidentiality of the responses is maintained," commented Ms. Karen Schaid Wagner, Head of Survey Operations.

Because only 4 % of the U.S. dentists are being sampled, accurate and prompt completion of the questionnaires is vital to the survey's result. Dentists who have questions about the survey or who are unable to respond to it may contact the Bureau on WATS extension 2569.

### AMERICAN FUND FOR DENTAL HEALTH APPROVES GRANTS FOR 1987

The American Fund for Dental Health has awarded more than \$200,000.00 for new and existing dental research projects in 1987.

Highlighting those items approved for funding is a new, two-year research project on AIDS (Acquired Immune Deficiency Syndrome) and its risk to dentists. Conducted by the School of Dentistry at the University of California, San Francisco, the project is aimed at decreasing the dental practitioner's risk in dealing with AIDS patients. Plans are for the project to initiate a national information network that will provide dentists with the latest news on AIDS and its control.

Other new projects funded for 1987 include an economic assessment of the dental use of the elderly by the University of Colorado; a program to educate dentists on the advantages of using sealants by the University of Michigan; a project that focuses on efforts to increase utilization of dental services among underserved groups by the University of Washington.

Projects renewed for funding in 1987 encompass a plan to help patients to overcome their fears of seeing the dentist by the University of Kentucky, and a program to increase accessibility for the handicapped dental patients by the

National Foundation of Dentistry for the Handicapped. Two projects at the University of Florida - one to increase clinical dental research, and the other to coordinate a national faculty development curriculum - also were reappraised. Another project refunded for 1987 is a study of urban adult's dental patterns being conducted at the University of Connecticut.

Projects approved for assistance have undergone extensive scientific and technical review by a board of highly respected dental professionals. Funding is provided through the American Fund for Dental Health, the only national non-governmental, non-profit agency supporting projects designed to better the dental health of the American public through research, education and service. These projects are underwritten through the contributions of dental practitioners, the dental trade and laboratories.

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## ABSTRACT

"Patients' Perceptions of Gloves as a Disease Transmission Barrier Technique." J. Uldricks, H. Whitacre, F.M. Beck, and J. Odom, The Ohio State University, Columbus, Ohio

Currently, recommended disease transmission barrier techniques within the profession of dentistry include the use of gloves, masks and protective eyewear. The purpose of this study was to assess patients' perceptions of the use of gloves as a barrier technique. A total of 277 patients who had appointments in the dental hygiene clinic participated in this study and were administered a written survey. The 19 items contained within the questionnaire were chosen to assess the patients' understanding of the purpose of the gloves, their likes and dislikes of the gloves and their expectations of the use of gloves by hygienists and dentists in both an educational and a private practice setting. The results indicated that 61% liked the gloves, 4% did not like the gloves and 35% responded that the use of gloves made no difference to them. The main reason cited for liking the gloves was protection from disease transmission. Smell and taste were the most often cited objections to gloves. Patient expectations of the use of gloves in the future by dental personnel were as follows: Educational Setting - 58.9%. Patient refusal of treatment from dental personnel not wearing gloves in the future was: Educational Setting - Dentist 26.8%, Hygienist 28.1%; Private Practice - Dentist 22.2%, Hygienist 23.3%. **Although patients indicate they like gloves and feel that gloves protect them from disease transmission, it seems that patients do not view gloves as a necessary, routine, protective measure. Thus, the results suggest a need for consumer education regarding the use of gloves as a protective barrier utilized by dental personnel.**

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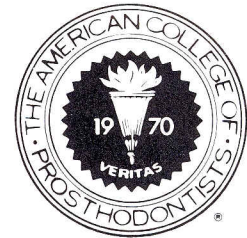


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