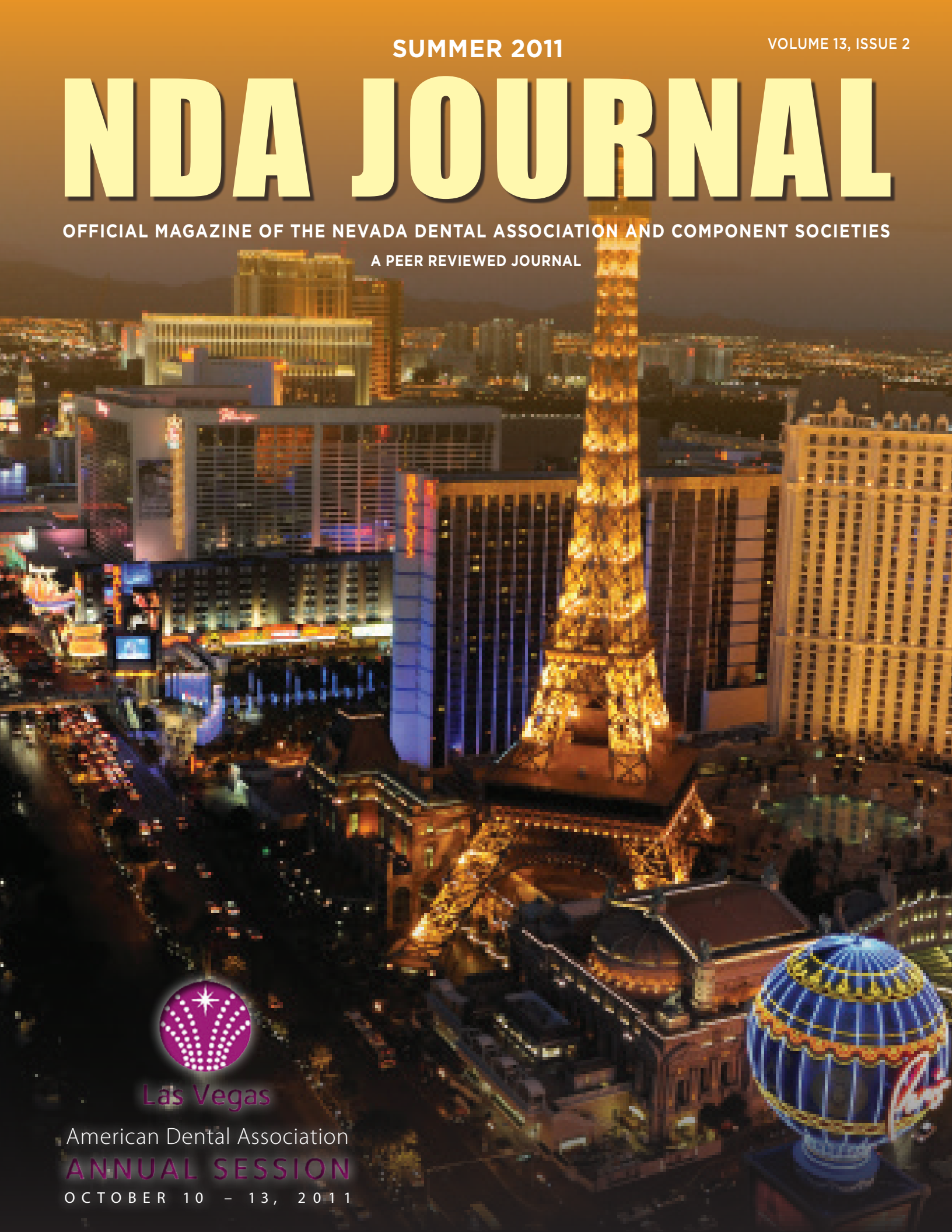
SUMMER 2011

VOLUME 13, ISSUE 2

NDA JOURNAL

OFFICIAL MAGAZINE OF THE NEVADA DENTAL ASSOCIATION AND COMPONENT SOCIETIES

A PEER REVIEWED JOURNAL



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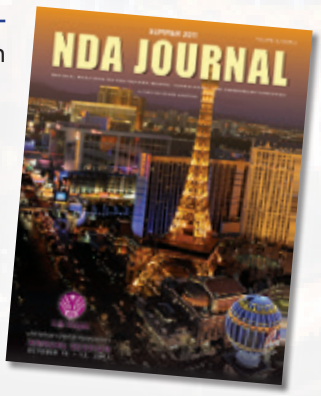

Photo: The Las Vegas Strip viewing North from the Paris. Courtesy of the LVCVA News Bureau.

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NDA JOURNAL

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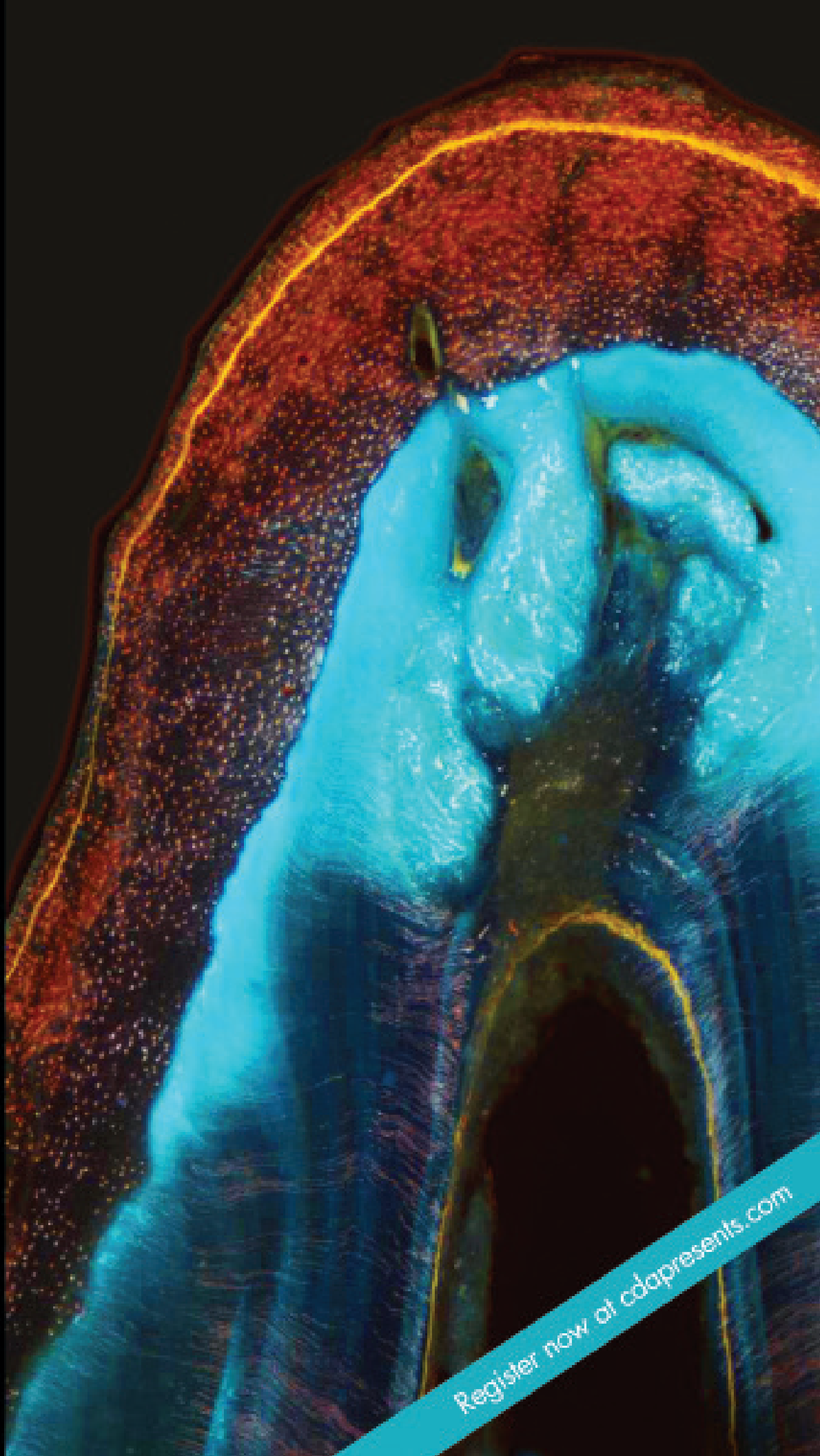

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Patient Turf

Recently at a local hospital, some students, residents, and a couple of faculty were discussing an interesting case (something one never wants to be), chit-chatting around the patient, checking the chart, radiographs, etc.—all in doctorese. There is nothing wrong with discussing an interesting case, but everyone involved seemed to be at least temporarily forgetting that there was an observant patient affiliated with the "case" being discussed.

The patient was looking from health professional to health professional, sending non-verbal signals that it would be nice to be included in the conversation. It didn't appear to be a comfortable situation for the patient, who was being provisionally ignored by the stewards of her health. She was probably tempted to raise her hand for permission to interrupt and speak. I maneuvered next to the bed, put my hand on the patient's shoulder, and asked, "What do you think about all this?" To everyone's credit, all the doctors took the hint and listened to her comment. The atmosphere in the room seemed to change for the better immediately.

We've all been in similar situations as this patient, and it is not a comfortable feeling to be ignored—whether it's as a patient or not—when one would like to, or should be, offering input.

Many of us have inadvertently put others in this uncomfortable position from time to time. I remember very well discussing my next patient in dental school with fellow students or faculty not as a patient but as a procedure by saying something like: "…my class II is coming in..." Worse, I once heard a patient referred to as a procedure in the patient's presence, instead taking the extra seconds to acknowledge that a human being was attached to the dental issue. That was terribly rude, at best.

Such callous conduct is exacerbated in patients who are compromised by anesthetized lips and tongues and restrained by rubber dams.

Dr. Orr practices Oral & Maxillofacial Surgery in Las Vegas, is a Clinical Professor of Surgery and Anesthesiology for Dentistry at UNSOM, Professor and Director of OMS at UNLV SDM, and is a member of the California Bar. He can be reached at editornda@nvda.org or 702-383-3711.

Patients are patients and as their dental advocates we owe them a fiduciary allegiance and our best efforts not only technically, but also socially and emotionally, while they literally lease our operatory space. While patients are in the chair, they are the landlords while the doctor and staff are invited guests, on patient turf. We shouldn't be discussing too much else other than our patient's issue at hand in front of our patient, while including them in the conversation as they give us initial verbal consent and implied continuing permission to treat as we occupy their oral cavities. Even when patients have anesthetized mouths full of materials, instruments, fluids, and maybe a couple of gloved fingers, they are still listening, ideally as the main focus of the conversation. A good number of patients simply aren't interested in matters that are important to the doctor while the doctor is on the patient's time. A really serious faux pas is a conversation in front of one patient about another "more important" patient or issue. Nothing is more important than the patient at hand. And don't try whispering about other matters, that just makes things worse.

Of course, some patients may require a bit more attention than others, such as those at the extremes of age or individuals who are simply very frightened at being in a dental office. Young children and older folks may have relatively more trouble expressing themselves than many, but it's our job, in fact our duty, to communicate as effectively as possible with them and to make their experience as comfortable as we can.

It is a given that a dentist's goal of offering the very best experience for a patient should not change depending on the time of day, ability to pay, clothing, tattoos, perceived lifestyle, or for any reason.

Even when patients are sedated or under general anesthesia, injudicious remarks can still be recalled by some patients—a phenomenon called anesthesia awareness. When such patients are actually unconscious, inappropriate remarks only undermine our professionalism with others who may be present and enduring the joke du jour.

A good rule of thumb is to treat and communicate with every patient as if they were your mom. If you happen to be mad at your mom, the Golden Rule works: Do unto others as you would have them do unto you. ◆

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Legislative Report 2011

Robert H. Talley, DDS, CAE
robert.talleydds@nvda.org

This table lists the final group of bills that we were monitoring at the end of the legislative session and their final outcome. Many bills that we watched throughout the session did not meet deadlines or failed in committee.

As of the writing of this we have begun the process of interviewing candidates for a new contract lobbyist. This is about a two month process and we should have a lobbyist in place around September 1. ◆

AB55	Makes various changes relating to dentistry. (BDR 54-498)	Signed by Governor
AB98	Enacts the Uniform Emergency Volunteer Health Practitioners Act. (BDR 36-56)	Signed by Governor
AB149	Makes various changes concerning medical and dental malpractice claims. (BDR 3-762)	*Failed deadline*
AB172	Requires the employment of certain persons in the Department of Health and Human Services and the Office of Energy. (BDR 18-706)	*Failed deadline*
AB243	Creates the position of State Grants Coordinator within the Budget Division of the Department of Administration. (BDR 31-585)	*Failed deadline*
AB280	Requires the adoption of patient safety checklists and patient safety policies at certain medical facilities. (BDR 40-517)	Signed by Governor
AB286	Establishes the Advisory Committee on Medicaid Fraud. (BDR S-693)	*Failed deadline*
AB537	Revises provisions governing prohibited acts for certain health care practitioners. (BDR 54-1115)	Signed by Governor
SB36	Revises provisions governing health care providers. (BDR 54-502)	Signed by Governor
SB43	Makes various changes relating to electronic health records. (BDR 40-443)	Signed by Governor
SB114	Revises provisions relating to controlled substances. (BDR 40-190)	Signed by Governor
SB206	Requires legislative lobbyists to file reports concerning lobbying activities when the Legislature is not in session. (BDR 17-1004)	*Failed deadline*
SB207	Authorizes the imposition of an administrative penalty against an employer under certain circumstances. (BDR 53-165)	*Senate vetoed*
SB208	Creates the Task Force on Employee Misclassification. (BDR 53-164)	*Senate vetoed*
SB233	Makes various changes concerning the administration of grants. (BDR 18-1058)	Signed by Governor
SB267	Revises provisions governing personal information. (BDR 52-110)	Signed by Governor
SB278	Revises provisions relating to health care and health insurance. (BDR 57-253)	Signed by Governor
SB354	Makes various changes to regulatory bodies of professions, occupations and businesses. (BDR 54-254)	*Failed deadline*
SB367	Requires certain health care practitioners to communicate certain information to the public. (BDR 54-625)	*Failed deadline*
SB379	Revises provisions governing the inspection by the Health Division of the Department of Health and Human Services of certain facilities and offices regulated by the Health Division. (BDR 54-625)	*Failed deadline*
SB419	Establishes provisions relating to safe injection practices. (BDR 40-518)	Signed by Governor

NDA President's Message

John C. DiGrazia, DDS

Summer is finally in full swing. I hope this report finds you and your family enjoying the warm weather. My year as your NDA President has passed quickly, and I wish to extend my sincere thanks to all of you for allowing me the honor of serving in this position. By time this message finds you, your new president, Dr. Michael Banks, will have been sworn into the office. Dr. Banks is a passionate, hard working dentist and I am confident he will serve the NDA and its members well into the next year.

Reflecting on this past year, I am proud of NDA's numerous accomplishments. A few of the highlights include:

- Raising over $14,000 for our Nevada PAC Fund to assist our voice at the Nevada legislature.
- Implementing a long term strategic plan for the NDA that will help develop our future leaders.
- Working with many legislators and educating them on the importance of maintaining dentists as the leading authority for the standard of oral care for the citizens of Nevada.
- Developing and circulating NDA member talking points to assist our members in understanding what steps they can take to help promote the issues that are important to the NDA and our members.

During the year, we also successfully introducing a bill before the Nevada Legislature known as SB350 to prevent health insurance companies from dictating fees for non-covered services. Although the bill was not ultimately passed into law, it did provide significant opportunities to educate our legislative representatives of the issues that the dental community is facing, and laid a critical foundation upon which we can continue to pursue legislative measures to protect and enhance the ability of our profession to serve our community. The NDA is planning to continue to build upon the communication framework we have laid, and Dr. Banks will be actively seeking to interview and retain a professional lobbyist so that we can redirect our limited resources to a productive end result.

You play an important role in where the NDA goes from here so our association can continue to push forward to assist our members in the areas of need. We need and want to hear from you so that the direction of the association continues to maintain a focus directed on the needs of our members. We encourage you to get involved, and sincerely hope to see you at association meetings, conference phone calls, and at the House of Delegates.

The dental profession as you know it is at risk. Entities are currently working on workforce models for Nevada that exist in neighboring states and seek to implement dental practice models that stand to undermine the integrity and professionalism that we have historically known. This is the time to begin zealously planning for the next Nevada Legislative session and is the time when your voices means so much. Whether it is bill you

Continues ➲

want the NDA to introduce, or a grassroots effort to dismantle a misconceived effort that will undermine the quality of dental care in our community, please let the NDA know.

In signing off, I extend a sincere thanks to NDA Executive Director, Dr. Robert Talley and the entire NDA Executive Board, for the effort and support provided to me this past year. We are all fortunate to have such dedicated individuals assisting us.

And a very personal thank you to my wife, Jeffie, and my father/mentor, Dr. Peter DiGrazia, for all of the support and guidance they have provided to me over this past year. ◆

NDA Membership

By Brad Wilbur DDS
NDA Membership Chair

One area of benefits that NDA members can reap rewards from is the ADA Legal Resources Department. A wide variety of services can be found on-line or person-to-person at the ADA office.

Chief among these benefits is the contract analysis department. Since the service began in 1987, over 4,100 dental provider contracts have been reviewed. The process can be initiated in one of two ways:

- Submitting the contract to your state dental association, who then forwards it to the ADA for a no-charge review.
- Submitting directly to the ADA and paying a $50 charge.

In most cases, the evaluation is completed within a couple days if the plan has been already researched, and within a couple weeks if not previously viewed.

Related resources on legal affairs can be found online. These articles provide an excellent glimpse into parts of the contract which often can be detrimental to the unsuspecting dentist. Merely reading these articles should be enough to convince members that signing a contract without professional review is fool-hardy.

Some helpful articles are:

- "What Every Dentist Should Know Before Signing a Dental Provider Contract"
- "Considering a Dental Benefit Contract"
- "What Every Dentist Should Know Before Affiliating With a Dental Management Service Organization"

One focus of the ADA legal department online database is reviewing advertising. The ADA tries to elucidate foggy areas so that dentists placing advertising do not risk being held liable for deceptive or illegal advertising. Another area covers anti-trust laws, to prevent dentist from being guilty of price-fixing.

More help can be found in the Law Article and Risk Management databases. Both of these areas have subject matter applicable to dentistry.

All in all, the ADA can help the member dentist in a multitude of ways. ◆

NDA Treasurer's Report

By Dwyte E. Brooks, DMD
NDA Treasurer

When comparing the budgets of 2010 and 2011, in consideration of the current economic situation, both income and expense projections were decreased by approximately 4%. With some significant cutbacks in expenses we were able to establish a budget with a very small surplus. At the mid-point in the 2011 budget year, our income is about 91% of total budget and the expenses are slightly over 60%. In general, we are on line for the projections. Our current reserves are slightly less than 8% which is significantly less than the desired goal of 40%. Although we projected in the budget to have less than a 0.5% increase in reserves in 2011, the hope is that with a smaller budget for 2012 we might be able to realize a greater reserve increase.

The CPA firm we engaged to perform periodic evaluations of internal controls and procedures and a general audit submitted its report on May 12, 2011. There were no significant deviations noted and the general internal controls and procedures were considered excellent for an organization with a small staff. The suggested changes noted in the report were minor in nature. Dr. Talley deserves acknowledgement for his efforts in this area.

The Executive Committee is considering significant changes in governance and current policies to address current economic issues. From the financial management viewpoint, I hope all members will be receptive to changes in our operational model with the goal of creating a more streamlined and relevant association. ◆

By Kenneth J. Versman, DDS, MS
14th District ADA Trustee

ADA 14th District Report

Dear Friends,

It is with mixed emotions that I write this report, as this is my last year as your ADA Trustee and that of the 14th District of the ADA. For the last two years, the ADA Board of Trustees has been working to develop our vision, our mission and our goals for the years 2011–2014. I would like to share with you what we have created and I present it to you with genuine enthusiasm.

ADA Vision Statement

The American Dental Association: To be the recognized leader on oral health.

ADA Mission Statement

The ADA is the professional association of dentists that fosters the success of a diverse membership and advances the oral health of the public.

ADA Goals for 2011–2014

- Provide support to dentists so they may succeed and excel throughout their careers.
- Be the trusted resource for oral health information that will help people be good stewards of their own oral health.
- Improve public health outcomes through a strong collaborative profession, and through effective collaboration across the spectrum of our external stakeholders.
- Ensure that the ADA is a financially stable organization that provides appropriate resources to enable operational and strategic initiatives.

Please believe me when I tell you we tweaked every word and spent a tremendous amount of time on the above. We established a list of beliefs and also established the outcomes/objectives that are the core of the ADA's strategic plan. In an attempt to make the strategic plan a living document, we strive to make sure all budgetary items must relate to the plan. Quarterly, the Board of Trustees compares our results and actions to the plan itself. The success of this plan will be measured by those results.

So, as your association leaders deliberate the many decisions that have to be made during the 2011 Nevada House of Delegates, I must ask you, what are your beliefs and plans for the future of our beloved profession?

What are you?

What are we going to do to break down the barriers to care for those who are in need and underserved?

What are you?

What are we going to do to improve the ethics of our dental professionals?

Are we going to continue to allow outside entities interfere in the doctor-patient relationship?

Are we going to let third parties tell us, the doctors, how to treat our patients?

Are we going to make our treatment decisions and our utilization of equipment and materials based on what sales people tell us, or on sound, biologic science?

What are you?

What are we going to do about our student debt that frequently ranges from $300,000–$400,000 upon graduation?

Are we going to be the leaders of the dental team?

Are we going to allow non-doctors to do surgical procedures on our patients?

Are we going to ensure that our young and minority dentists are going to join and participate in our tripartite system?

Are you going to participate in the legislative process in Carson City and Washington D.C.?

I could go on and on with the challenges we either currently are or will be facing in the years ahead.

It has been said that, "Excellence is the result of caring more than others think is wise, risking more than others think is safe, dreaming more than others think is practical and expecting more than others think is possible."

I have the greatest confidence—in fact I know—that the dental leaders in Nevada will not only take on these challenges but that they will lead us to that excellence. As the House of Delegates make their decisions, they will shape and guide our future. We all share a common love for our profession and, united together, we will continue to be good stewards for that future. I personally thank you for all that you do and wish all of you continued success and happiness in the many years ahead.

Edgar Allen Poe wrote in "The Raven":

Deep into that darkness peering, long I stood there, wondering, fearing, doubting, dreaming dreams no mortal ever dared to dream before.

I thank you for allowing me to live my dream. I thank you for the honor and privilege that I have had to serve you as your trustee and I wish you the very best for all of your future endeavors and dreams. ◆

By Dwyte E. Brooks, DMD

CEBJA…Say what?

CEBJA is the acronym for the Council on Ethics, Bylaws and Judicial Affairs. Although the acronym is sometimes confused for a profanity, a former ADA President once said that the Council on Dental Practice is the soul of our profession and the Council on Ethics, Bylaws and Judicial Affairs is the conscience. The CEBJA functions are stated in the name, but they do differ from ADA to NDA to SNDS, NNDS and NENDS. This article will discuss the ADA activities of CEBJA and those more local variations will be discussed in future articles.

CEBJA is a council composed of 17 voting members, one from each ADA district. The members are nominated by the Trustee of each district and after review of their credentials, the President appoints the members who begin their four year term after approval by the House of Delegates at the annual session. There are four rotations of four or five members in each class and each member is limited to a single term. Additional non-voting members of the CEBJA include an ASDA representative, a Trustee from the Board of Trustees and a member of the Committee on the New Dentist. At this time, there are two staff members assigned to the Council and one attorney although additional support is normal according to workload. The Council meets in Chicago twice a year and the various committees and task forces continue to work throughout the year via the telephone, internet and occasionally by mail.

The first responsibility of the Council is ethics. The Council regularly reviews the Principals of Ethics and the Code of Professional Conduct, initiates changes and provides examples to these guidelines. The members are charged with authoring regular submissions to the *JADA* "Ethical Moments" as well as the *ASDA Journal*. Many members also provide lectures and presentations on ethics. Component and constituent CEBJA or Ethics Committees can appeal decisions to the ADA CEBJA. These hearings represent the final decisions on complaints, appeals and sanctions.

The CEBJA is also involved with the regular review and modification of the Bylaws. After each House of Delegates, and some Board of Trustees meetings, resolutions and other items are referred to the CEBJA for review, revision, and analysis. It often requires dozens of revisions and re-writes to prepare a resolution for submission to the House of Delegates.

The least understood aspect of the CEBJA's work is judicial affairs. When a member is disciplined by a component or the component upholds a decision from a constituent, a final appeal can be made to the Council. When this occurs, a very formal hearing process is initiated and full hearings can be heard before the Council in Chicago. Some members take the rights and responsibility of ADA membership lightly, but when you experience the intensity of a CEBJA appeal and hearing, an appreciation of the worth and value of being a part of our association sinks into your psyche.

In a future article, I will highlight the activities of the CEBJA at the state and local level. Bet you can't wait. ◆

Dwyte E. Brooks, DMD, is Chair of the NDA Council on Ethics, Bylaws and Judicial Affairs and a member of the ADA Council on Ethics, Bylaws and Judicial Affairs.

American Dental Association Annual Session Sites

Compiled by the Archivist of the ADA, Source: Historical Record, Transactions of the ADA

1859 Niagara Falls, NY
1860 Washington, DC
1861 *No meeting*[1]
1862 Cleveland, OH
1863 Philadelphia, PA
1864 Niagara Falls, NY
1865 Chicago, IL
1866 Boston, MA
1867 Cincinnati, OH
1868 Niagara Falls, NY
1869 Saratoga Springs, NY
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1899 Niagara Falls, NY
1900 Old Point Comfort, VA
1901 Milwaukee, WI
1902 Niagara Falls, NY
1903 Asheville, NC
1904 St. Louis, MO
1905 Buffalo, NY
1906 Atlanta, GA
1907 Minneapolis, MN
1908 Boston, MA
1909 Birmingham, AL
1910 Denver, CO
1911 Cleveland, OH
1912 Washington, DC
1913 Kansas City, MO
1914 Rochester, NY
1915 San Francisco, CA
1916 Louisville, KY
1917 New York, NY
1918 Chicago, IL
1919 New Orleans, LA
1920 Boston, MA
1921 Milwaukee, WI
1922 Los Angeles, CA
1923 Cleveland, OH
1924 Dallas, TX
1925 Louisville, KY
1926 Philadelphia, PA
1927 Detroit, MI
1928 Minneapolis, MN
1929 Washington, DC
1930 Denver, CO
1931 Memphis, TN
1932 Buffalo, NY
1933 Chicago, IL
1934 St. Paul, MN
1935 New Orleans, LA
1936 San Francisco, CA
1937 Atlantic City, NJ
1938 St. Louis, MO
1939 Milwaukee, WI
1940 Cleveland, OH
1941 Houston, TX
1942 St. Louis, MO
1943 Cincinnati, OH
1944 Chicago, IL
1945 *No meeting*[2]
1946 Miami, FL
1947 Boston, MA
1948 Chicago, IL
1949 San Francisco, CA
1950 Atlantic City, NJ
1951 Washington, DC
1952 St. Louis, MO
1953 Cleveland, OH
1954 Miami, FL
1955 San Francisco, CA
1956 Atlantic City, NJ
1957 Miami, FL
1958 Dallas, TX
1959 New York, NY
1960 Los Angeles, CA
1961 Philadelphia, PA
1962 Miami, FL
1963 Atlantic City, NJ
1964 San Francisco, CA
1965 Las Vegas, NV
1966 Dallas, TX
1967 Washington, DC
1968 Miami, FL
1969 New York, NY
1970 Las Vegas, NV
1971 Atlantic City, NJ
1972 San Francisco, CA
1973 Houston, TX
1974 Washington, DC
1975 Chicago, IL
1976 Las Vegas, NV
1977 Miami, FL
1978 Anaheim, CA
1979 Dallas, TX
1980 New Orleans, LA
1981 Kansas City, MO
1982 Las Vegas, NV
1983 Anaheim, CA
1984 Atlanta, GA
1985 San Francisco, CA
1986 Miami, FL
1987 Las Vegas, NV
1988 Washington, DC
1989 Honolulu, HI
1990 Boston, MA
1991 Seattle, WA
1992 Orlando, FL
1993 San Francisco, CA
1994 New Orleans, LA
1995 Las Vegas, NV
1996 Orlando, FL
1997 Washington, DC
1998 San Francisco, CA
1999 Honolulu, HI
2000 Chicago, IL
2001 Kansas City, MO
2002 New Orleans, LA
2003 San Francisco, CA
2004 Orlando, FL
2005 Philadelphia, PA
2006 Las Vegas, NV
2007 San Francisco, CA
2008 San Antonio, TX
2009 Honolulu, HI
2010 Orlando, FL
2011 Las Vegas, NV

Endnotes

1. Session not held due to the American Civil War
2. Session not held due to WWII

NDA Past Presidents

1922 George H. Marvin
1923 John V. Ducey
1924 Thomas H. Suffol
1925 George A. Carr
1926 Samuel T. Spann
1927 Bruce Saulter
1928 Frederick H. Phillips
1929 Frederick J. Rulison
1930 William H. Cavell
1931 Harold E. Cafferata
1932 Louis M. Nelson
1933 Carlton E. Rhodes
1934 Pliney H. Phillips
1935 Harold R. McNeil
1936 Lawrence D. Sullivan
1937 Alexander A. Cozzalio
1938 Charles A. Cozzalio
1939 George A. Carr
1940 George A. Steinmiller
1941 George A. Steinmiller
1942 Omar M. Seifert
1943 Stephen W. Comish
1944 Quannah S. McCall
1945 Oliver M. Wallace
1946 Gilbert Eklund
1947 Robert H. Gatewood
1948 E. Ross Whitehead
1949 Howard W. Woodbury
1950 Roy P. Rheuben
1951 Leonard G. Jacob
1952 Clifford A. Paice
1953 Walter R. Bell
1954 Raymond J. LaFond
1955 Jack E. Ahlstrom
1956 J. D. Smith
1957 Kern S. Karrash
1958 Vincent J. Sanner
1959 Wallaxe S. Calder
1960 John B. Hirsh
1961 David W. Melarkey
1962 David W. Melarkey
1963 Fae T. Ahlstrom
1964 Morris F. Gallagher
1965 Wayne L. Zeiger
1966 Mario E. Gildone
1967 William D. Berry
1968 James F. Archer
1969 Philip J. Youngblood
1970 Carl M. Hererra
1971 George P. Rasqui
1972 William H. Schaefer
1973 Robert L. Morrison
1974 John S. McCulloch
1975 James M. Jones
1976 Harry P. Massoth
1977 Leeland M. Lovaas
1978 Blaine R. Dunn
1979 Louis J. Hendrickson
1980 Duane E. Christian
1981 Dwight Meierhenry
1982 Clair F. Earl
1983 R. D. Hargrave
1984 James L. Davis
1985 N. Richard Frei
1986 Lloyd Diedrichsen
1987 Gerald Hanson
1988 Gerald C. Jackson
1989 James C. Evans
1990 Whit B. Hackstaff
1991 William E. Ursick
1992 Dennis J. Arch
1993 A. Ted Twesme
1994 Bruce Pendelton
1995 J. Gordon Kinard
1996 Joel F. Glover
1997 Rick Thiriot
1998 Jade Miller
1999 Patricia Craddock
2000 William C. McCalla
2001 Robert H. Talley
2002 Susan Jancar
2003 Dwyte Brooks
2004 Peter DiGrazia
2005 Robert Thalgott
2006 Arnie Pitts
2007 George Rosenbaum
2008 Joel T. Glover
2009 Peter Balle
2010 John C. DiGrazia

Letters to the Editor

NDA JOURNAL, EDITOR
DANIEL L ORR

CONGRATULATIONS ON SUCH A FINE JOURNAL WHICH IS NO DOUBT A GREAT HELP TO THOSE WHO RECEIVE IT.

AFTER FORTY THREE OF PRACTICE THERE IN LAS VEGAS, I RETIRED TO THIS BEAUTIFUL STATE OF KENTUCKY AND HAVE HAD THE GOOD FORTUNE TO BE ABLE TO DO A LOT OF TRAVELING TO FOREIGN COUNTRIES.

LAST YEAR WAS ONE OF THE FINEST AND MOST INTERESTING WHERIN A BIT OF DENTISTRY WAS PUT BEFORE ME.

I VISITED SEVERAL COUNTRIES IN EUROPE AND ENDED WITH A WEEK IN POLAND. I VISITED THE CONCENTRATION CAMP OF AUSCHWITZ, WHERE OVER A MILLION PEOPLE WERE KILLED. WE WERE LED INTO THE VERY CHAMBER WHERE THE XCLON GAS WAS DROPPED ONTO THE PRISONERS. THE PORTALS IN THE CEILING ARE STILL THERE.

WHILE WALKING WITH THE GUIDE, HE FOUND THAT I WAS A DENTIST AND HE TOLD ME THE STORY OF A FRIEND OF HIS WHO WAS IN HIS TEENS AS A PRISONER THERE. THIS MAN'S FATHER WAS A DENTIST WHO WAS KILLED THERE, SO THE NAZIS, THINKING THIS MAN, SON OF DENTIST, WOULD KNOW HOW TO EXTRACT TEETH. THE TASK HE WAS FORCED TO DO WAS TO REMOVE ALL TEETH WHICH HAD GODD OR SILVER. THIS MAN LIVES NEAR THERE YET AND THE GUIDE SAID THAT HE HAS NEVER BEEN NORMAL ALL OF HIS LIFE. "MAN'S INHUMANITY TO MAN."

ANOTHER EXPERIENCE DENTAL RELATED TO ME BECAUSE OF A PATIENT I HAD IN VEGAS.

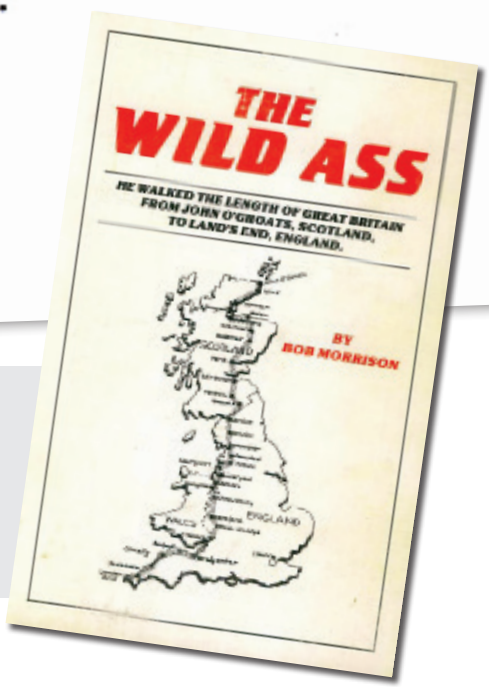
WE VISITED WHAT WAS KNOWN AS THE WARSAW GHETTO WHERE THE NAZIS KEPT THOUSANDS OF JEWS IN A SMALL AREA AND ALLOWED THEM TO STARVE TO DEATH. MY DENTAL PATIENT WAS A TEEN AGE GIRL AND ESCAPED THROUGH THE SEWERS AND EVENTUALLY MARRIED ANDAMERICAN AND CAME TO LIVE IN LAS VEGAS. A STATUE THERE DEPICTS THE SCENE OF ESCAPING THROUGH THE SEWERS. KNOWING THE STORY OF MY PATIENT MADE IT A VERY EMOTIONAL TIME FOR ME.

DR. ORR, YOUR JOURNAL IS WELL APPRECIATED. I WISH THAT WE COULD HAVE HAD ONE LIKE IT WHEN I PRACTICED THERE.

SINCERELY,

Dr. Bob Morrison

ADA FOUNDATION
Dr Robert Lee Morrison
407 Brice Ave
Glasgow, KY 42141-2207



Editor's Note

Dr. Morrison was the chairman of the general Committee on Local Arrangements for the first ADA meeting in Las Vegas in 1965 and NDA President 1973. He is also the author of *The Wild Ass*, a wonderful book on some of his travels.

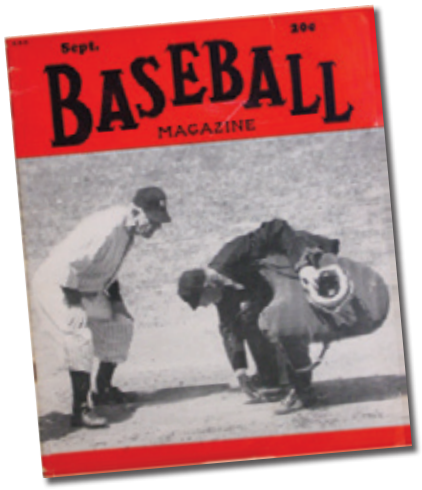
Letters to the Editor

Dear NDA Journal Editor,

When I was in dental school at Kansas City Western Dental College (now UMKC) the Chief of the Clinic Floor, Operative Dentistry, and Endodontics was Dr. Carl Sawyer. He had been a classmate of Casey Stengel at KCWDC in the teens. Dr. Sawyer was awarded the 1966 Alumni Achievement Award from UMKC in 1966.

Casey Stengel stopped by to visit Dr. Sawyer every year when the Yankees were in town to play the Athletics. When Casey reached the clinic in his third year, being left handed was a great disadvantage as the dental units were only set up for right-handed operators.

I remember well when Casey was called to testify before the U.S. Senate about baseball's anti-trust issues. He had the Senators so confused they did not know what he said.



I enjoyed the editorial "Too Many Refs." I graduated in 1959 and since I grew up in Bishop, California, took the Nevada Board. Only 7 of 22 passed. I feel anyone who graduates from an accredited dental school should be entitled to practice where they are needed.

One of my classmates failed the Colorado Board, he shot and killed himself.

Yours respectfully,

Dr. Dayton McDonald
Sparks, NV

Editor's Note

Unlike dentistry in the early 20th century, in baseball being a southpaw has always been a singular advantage. To read and/or hear Casey's 1958 Senate testimony, see *www.baseball-almanac.com/quotes/casey_stengel_senate_testimony.shtml*.

Casey's testimony took 45 minutes—including this 121 word insight about his team's future success: "Well, I will tell you I got a little concern yesterday in the first three innings when I saw the three players I had gotten rid of, and I said when I lost nine what am I going to do and when I had a couple of my players I thought so great of that did not do so good up to the sixth inning I was more confused but I finally had to go and call on a young man in Baltimore that we don't own and the Yankees don't own him, and he is doing pretty good, and I would actually have to tell you that I think we are more like a Greta Garbo-type now from success."

Fellow MLB Hall of Famer Mickey Mantle was called to testify immediately after Casey Stengel. He knowingly stated: "My views are just about the same as Casey's."

The Editor took the Nevada Board in 1978 when 6 of 36 passed. The candidate in the next cubicle failed when his denture patient didn't show up the second day. While unsure about the patient's current condition, the candidate is a now an Oral and Maxillofacial Pathologist who only comes to Nevada for meetings.

Heads Up!

By Phil R. Devore, DDS, and William A. Bloink, DMD

Post-it notes, hand signals, facial expressions, and other attempts at sharing patient information frequently fail. Sharing key information among the dental team sends the patient a clear message that says 'we care.' A simple technique that has shown great success is the patient transfer, our way to give a "Heads Up" to the next dental team member. Patients frequently share with team, dental assistants in particular, and give them information that they would not ordinarily give to the dentist. This information is very useful in terms of treatment planning and patient care, but often gets lost and goes un-communicated to the dentist. A powerful opportunity to create value and a co-diagnosis environment is for the clinical team member to always brief the dentist on what information has been shared either on the phone or in the office prior to the examination.

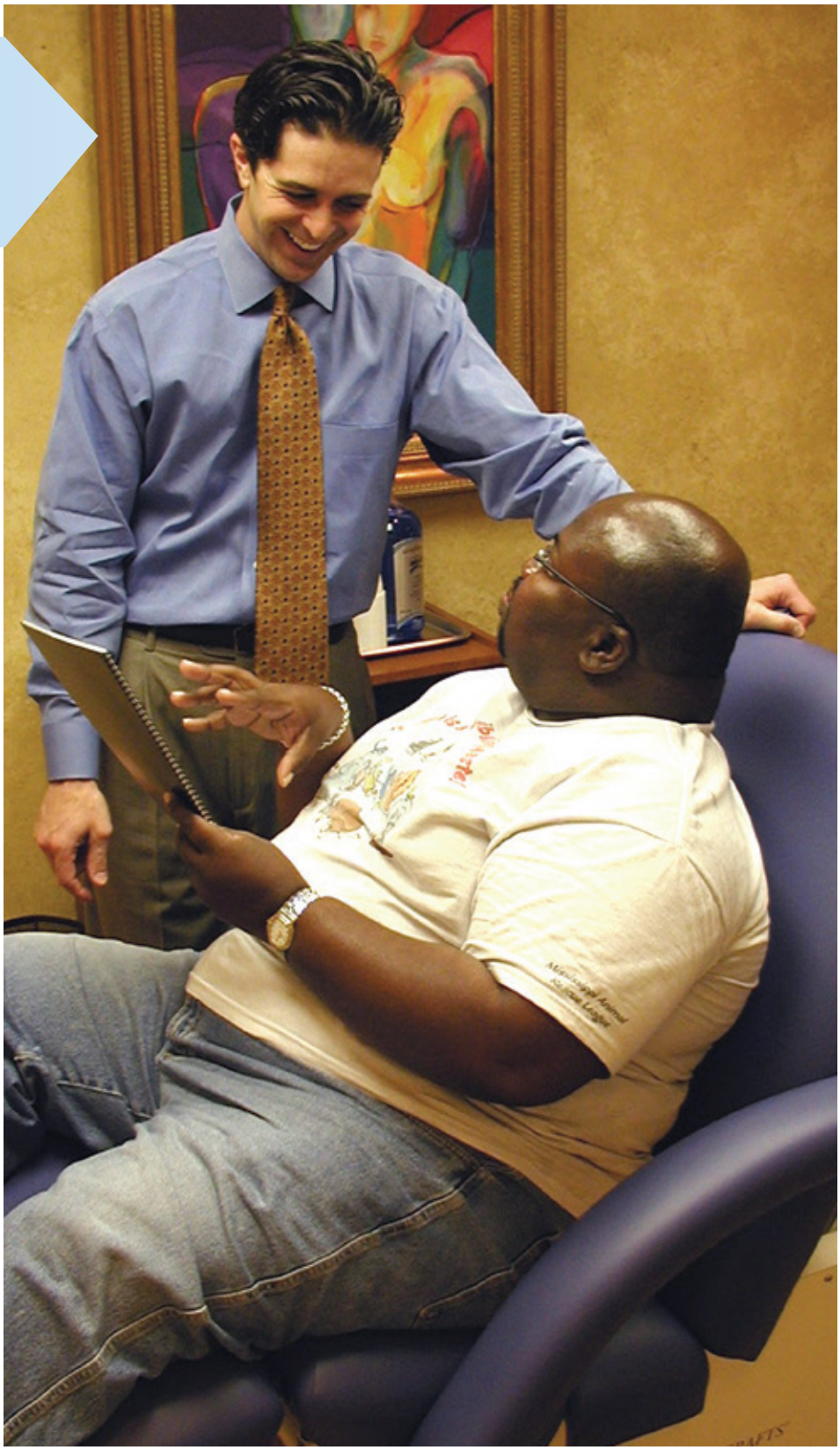
Dr. Devore is in private practice associated with Heartland Dental Care in Las Vegas, NV and serves as Course Director of Practice Management at UNLV School of Dental Medicine.

William A. Bloink, DMD is in private practice in Springfield, IL and a founding partner of Heartland Dental Care.

As the doctor enters the treatment room, after having been introduced to the patient, the clinical team member delivers the "Heads Up." Whatever has transpired between the team member and the patient can be encapsulated and delivered to the doctor in an efficient manner, but more importantly, the patient perceives what has transpired between himself and the team member to have been important. By summarizing and sharing this information with the doctor, the team member demonstrates that the practice considers communications with the patient to be highly valued and that the doctor is interested in knowing everything that there is to know about the patient. A key point in this process is reducing the technical message and embracing the emotional one. Patients want and need to know how much we care about them as unique individuals. When their emotional needs, wants and desires are shared, it sends a clear message to our patients that we see them as a person and not just a mouth or teeth.

With new patients, this should take place as the doctor is introduced to the person for the first time. The team member would say, "Dr. Smith, this is Mr. Jones. Mr. Jones, this is Dr. Smith. Mr. Jones is an attorney here in town. He is married and has two children that keep him busy! In fact, you have met his wife Mary, who has been here with both of their children." (This gives the doctor the opportunity to say something complimentary about the new patient's wife and also acknowledge the fact that he appreciates the referral). "Mr. Jones has a broken tooth that has been keeping him from sleeping well. His business is very busy and not being well-rested is tough for him. I let him know that you will focus on that area today and that we will get him out of pain. We have the photo and x-ray on the screen and he sees that this is something we need to take care of right away." By having the assistant go over the material first with the patient and then introducing the patient to the doctor it creates an atmosphere of caring that otherwise would not be present as well as emphasizing to the patient that he is important to us.

Ongoing treatment patients also benefit from the "Heads Up" at various times during the treatment sequence. As an example, a patient coming in for a crown preparation who is nervous and who has confided in the assistant, might hear the assistant say, "Mrs. Smith has had an experience in the past where she felt pain during an appointment. I assured her that we would be communicating throughout the appointment to make certain that never happens here. I shared with her that she is in great hands!" This gives the doctor an opportunity to address this issue directly and immediately as well as reassure the patient that he/she will be able to make the procedure comfortable for the patient. Sometimes during the course of a procedure, the doctor may leave the room and return to hear the dental assistant say, "Mr. Jones has let



me know that both his lip and tongue are numb. Everything is ready to go to make certain he leaves here today comfortable and ready to get a great night of rest." This tells the patient that the doctor and the assistant are communicating about him, are concerned about the degree of numbness, and are coordinating their efforts to provide the best treatment possible.

There are numerous examples of comments that the dental assistant might make demonstrating to the patient that we are focused on both the clinical treatment and their overall experience, however, the dental hygienist can also utilize this communication approach as well. At recall visits, there is oftentimes pending treatment or areas that have been "watched." This time in the treatment cycle presents an opportunity for the hygienist to reinforce the need for this treatment to the patient by pointing it out to the doctor directly over the patient in lay terms. The doctor can then reintroduce this treatment into the diagnosis and treatment plan, assuring that the recommended procedures do not "fall through the cracks."

The "Heads Up" is a simple technique that allows the dental team members to communicate to the doctor any and all information that he/she has obtained from the patient while the doctor was not present. When employed routinely, this approach allows for the doctor and assistant to communicate about the patient directly over the patient, reinforcing their concern about the quality of care and improving the dental experience for this individual. By employing this "Heads Up" during every interaction, the communication is enhanced, but just as importantly, the patient's perception of quality of care is improved so that the practice and the patients benefit from the use of the "Heads Up." ◆

Dental Establishments in Nevada

By H. Barry Waldman, DDS, MPH, PhD and Steven P. Perlman, DDS, MScD, DHL (Hon)

ABSTRACT

Census Bureau data indicate a continuing national increase in the number and size of dental establishments. These developments are reviewed for the State of Nevada during the past decade, a period of marked increases in the state's population, the number of dentists, and the number of individuals employed in dental establishments.

Introduction

Between 2000 and 2009, the resident population of Nevada increased by 31 percent (from approximately 2.0 million to almost 2.6 million residents).[1,2] Between 2000 and 2009, the number of dentists in Nevada increased from 690 to 1,935 individuals, (an increase of 180 percent) resulting in a decrease from 2,880 to 1,450 residents per dentist).[3,4] In 2000, Nevada ranked 48th among all the states, 27th in 2009, in the number of dentists per 100,000 population.[3,5]

Changing number of establishments

Mirroring the marked increase in the number of dentists in the state, there was an increase of 337 dental establishments (from 671 to 1,088 facilities) between 2000 and 2008, and a 53 percent increase in the number of dental employees in the state (from 4,670 employees in 2000 to 7,158 employees in 2008).* The overwhelming increase in the number of dental establishments was in Clark County—an increase of 364 establishments. There was an increase of 20 establishments in Lander County and 31 in Washoe County. (TABLE 1)

Statewide, between 2000 and 2008, there was a decrease of almost 600 residents per dental establishment (a decrease from approximately 2,980–2,390 residents per establishment). Among the 14 counties (with dental establishments) and Carson City in the state, only Churchill, Humboldt and Lincoln counties experienced sizeable increases in the population per dental establishment.† (TABLE 2)

* An establishment is a single physical location where services are performed. It is not necessarily identical to a company or enterprise, which many consist of one or more establishments. In addition, one or more practitioners may be present in an establishment. Throughout this presentation, (except where specified) the term "dental establishment" refers to those facilities 1) with employees and 2) subject to federal income tax. Government agency programs (hospitals and health department clinics) are not included. [6]

Table 1. **Nevada dental establishments by county and independent city: 2000, 2008** [6]

	2000	2008	Change 2000–08
Total State	**671**	**1,088**	**417**
Churchill	3	3	–
Clark	435	799	364
Douglas	18	24	6
Elko	15	16	1
Esmeralda	No dental establishments		
Eureka	–	1	1
Humboldt	5	5	–
Lander	1	2	20
Lincoln	1	1	–
Lyon	4	7	3
Mineral	1	1	–
Nye	5	9	4
Pershing	1	2	1
Storey	No dental establishments		
Washoe	156	187	31
White Pine	3	3	–
Carson City	23	28	5

† The review was carried out at the state and county levels to emphasize the developments from the perspective of individual practitioners; i.e. in their communities. The county level was used as it is the smallest unit for which some consistent data are available regarding dental establishments. Nevada was selected as a specific case because of the dramatic population growth it has experienced and the accompanying increase in the number of dental practitioners. Such a review is important as the profession (and nation) attempts to come to terms with the new efforts by the government to transform the system of health services. The goal is to provide meaningful information for individual dentists who are swept up in the immediacy of their practices and may have limited time and access to developments beyond the proverbial walls of their operatory.

Table 2. **Population per dental establishment by county and independent city: 2000, 2008** [6-8]

	2000	2008
Total State	**2,978**	**2,389**
Churchill	7,994	8,297
Clark	3,162	2,335
Douglas	2,292	1,882
Elko	3,019	2,941
Esmeralda	No dental establishments	
Eureka	–	1,628
Humboldt	3,221	3,552
Lander	5,794	2,543
Lincoln	4,165	4,898
Lyon	8,625	7,564
Mineral	5,071	4,684
Nye	6,497	4,930
Pershing	6,693	3,145
Storey	No dental establishments	
Washoe	2,176	2,194
White Pine	3,060	3,066
Carson City	2,280	1,959

Variations in the number of employees

There has been a progressive increase in the number of employees in dental practices in states throughout the country during the past decades. At the national level (between 1900 and 2008), despite an overall increase of more than 23,000 establishments, there was an actual decrease in the number of "smaller" establishments (with less than five employees); a decrease of approximately 5,800 smaller dental establishments. By 2008, 40 percent of U.S. and 39 percent of Nevada dental establishments had less than five employees.

In 2008, the "average" U.S. and Nevada dental establishment* had an average of 6.5 employees. The "average" annual salary of dental employees in Nevada was $44,800 (nationally, $44,000). (Employees may include dentists, dental hygienists, dental assistants, office staff, etc.) (TABLE 3)

In 2008, in Nevada counties with more than ten dental establishments, the proportion of dental facilities with less than five employees ranged from 21 percent in Carson City to between 40 percent and almost 44 percent in Clark, Elko and Humboldt counties. (TABLE 4)

Continues ➲

Table 3. **Distribution of dental employees by size of dental establishments. Nevada and United States: 1990, 2000, 2008** [6,7,9]

	NEVADA (Number of establishments)				UNITED STATES (Number of establishments)			
No. of employees	**1990**	**2000**	**2008**	**Percent change 2000–08**	**1990**	**2000**	**2008**	**Percent change 2000–08**
1–4	206	231	424	83.5 %	57,209	52,036	51,417	- 1.1 %
5–9	207	278	424	52.5	35,750	44,815	51,284	14.4
10–19	51	140	204	64.0	9,971	17,007	21,688	27.5
20–49	5	21	35	66.6	1,290	2,464	3,288	33.4
50+	1	1	1	–	111	172	220	27.9
Total	**470**	**670**	**1,088**	**62.3**	**104,654**	**116,494**	**127,877**	**9.7**
Employees per establishment	6.0	6.9	6.5		5.1	6.1	6.5	

	NEVADA Percent distribution of establishments			UNITED STATES Percent distribution of establishments		
No. of employees	**1990**	**2000**	**2008**	**1990**	**2000**	**2008**
1–4	43.8 %	34.4 %	38.9 %	54.9 %	44.6 %	40.2 %
5–9	43.8	41.4	38.9	34.2	38.4	40.1
10–19	10.8	20.8	18.7	9.5	14.5	16.9
20–49	1.0	3.1	1.0	1.2	2.1	2.5
50+	< 0.1	< 0.1	< 0.1	0.1	0.1	0.1

* While there is no such thing as an "average" dental establishment, comparisons between averages (over time and between locales) do provide a picture of the evolving practice of dentistry. The "average" number of employees was determined by dividing the total number of dental employees in Nevada (7,158) by the number of dental establishments (1,088). The "average" salary was determined by dividing the total annual state payroll figure for dental establishment employees ($320,989,000) by the total number of employees (7,158 individuals).

Table 4. **Nevada dental establishments by number of employees: 2000, 2008** [6]

	Total no. establishments		Less than 5 employees		Percent less than 5 employees	
	2000	2008	2000	2008	2000	2008
United States	116,494	127,877	52,036	51,417	44.6 %	40.2 %
Nevada	671	1,088	231	424	34.4 %	38.9 %
Churchill	3	3	–	–	0.0 %	0.0 %
Clark	435	799	163	335	37.4	41.9
Douglas	18	24	3	8	16.6	33.3
Elko	15	16	8	7	53.3	43.7
Esmeralda	No dental establishments					
Eureka	–	1	–	1	–	100.0
Humboldt	5	5	2	2	40.0	40.0
Lander	1	2	–	–	–	–
Lincoln	1	1	1	1	100.0	100.0
Lyon	4	7	1	–	25.0	0.0
Mineral	1	1	–	–	0.0	0.0
Nye	5	9	3	3	60.0	33.3
Pershing	1	2	1	–	100.0	0.0
Storey	No dental establishments					
Washoe	156	187	41	60	26.2	32.0
White Pine	3	3	2	1	66.6	33.3
Carson City	23	28	6	6	26.0	21.4

Dental establishments with no employees

In 2008, there were an additional 411 Nevada dental establishments which were subject to federal income tax, but with no employees. These non-employee dental facilities represented 27 percent of the total number of dental establishments in the state (i.e. 1,088 dental establishments with employees and 411 establishments with no employees). The Nevada dental facilities with no employees reported a total of $50.3 million in gross receipts (an average of $122,000 in gross receipts per establishment).[10] Nationally, in 2008, there were 40,106 dental establishments with no employees that reported almost $2.9 billion in gross receipts (an annual average of $74,400 in gross receipts per establishment).[10] Eighty-two percent of dental establishments in Nevada (338) with no employees was located in Clark County.

During 2008, in Nevada, most non-employee dental establishments were individual proprietorships (322 facilities) which had average annual gross receipts of $57,400. A smaller number of corporate arrangements (85 facilities) had average annual gross receipts of $372,000). Four non-employee establishments were partnerships. (In an effort to maintain privacy, the Census Bureau does not report gross receipt figures for these smaller numbers of facilities[10]). Given the increasing numbers of employees per dental establishment with employees, how does one account for the great number of facilities with no employees?

Suggested establishment arrangements might include:

- Recent graduates just starting practices
- Older practitioners who are decreasing their time commitment to practice as they prepare for eventual retirement.
- An establishment that serves as a secondary activity for an individual who works full-time for someone else.
- Contracts with independent outside firms for auxiliary personnel.
- Use of family members as auxiliary personnel and where no reports are made for Social Security and income tax purposes.
- Establishments of independent corporate arrangements for in-house auxiliaries.
- Any number of other alternative practice arrangements (including practice in private homes and other locations) that do not file required quarterly payroll tax reports.

Commentary

Monitoring just the numbers of residents, the numbers of dentists, the numbers of establishments and the numbers of employees becomes just so many numbers with limited attention to the actual delivery of care and the population's needs for services. For example, results from nationwide telephone interview surveys (*note: no professional evaluation or diagnoses were involved and surveyors were not dentists*):

- In 2007, based on parents/guardians reporting about their children, Nevada, ranked 34th (1st is best, 51st is worst) among all the states and District of Columbia in the proportion of children (1–17 years) with one oral health problem and 51st with the greatest percent of children who had two or more oral health problems.* (The four oral health problems asked about in the survey were toothaches, decayed teeth/cavities, broken teeth, and bleeding gums.[11])
- In 2008, Nevada ranked 45th in the percent of adults who visited a dentist in the past year.
- In 2008, Nevada ranked 43rd in the percent of adults who had their teeth cleaned in the past year.

In 2008, Nevada ranked 22nd in the percent of adults age 65 and over who had all their natural teeth extracted.[12] (See TABLE 5 for variations in national and state proportions)

Yes, it is important to monitor the increasing size of dental establishments which may continue in response to 1) continued third party inroads into dental practice, and 2) the attraction of the next generation of dental students, whose personal experience with dental care would be in a dental establishment with 10, 15, 20 or more employees. But so too is the reality of the need to ensure that the delivery arrangements for care meets the needs of the state's residents. ◆

* In addition to survey questions regarding medical and dental health status, parents/guardians were asked their opinions about their child's emotional and mental health, health insurance coverage, health care access and quality, community and school activities, family health and activities, and neighborhood safety and support. [11]

Table 5. **U.S. and the high and low state range for the proportion of oral health status and use of dental services: 2007, 2008** [11,12]

	United States	High	Range Nevada	Low
Child oral health 1 problem	18.3 %	21.6 % (DC)	18.6 %	14.7 (ND)
Child oral health 2+ problems	8.4	12.7 (NV)	12.7	4.4 (MN)
Adult with dental visit in past year	71.3	80.2 (CT)	63.7	57.9 (OK)
Adults with teeth cleaned in past year	68.4	79.4 (CT)	62.0	55.9 (OK)
65+ years all natural teeth extracted	18.5	37.8 (WV)	17.6	9.6 (HI)

Note: DC = District of Columbia ND = North Dakota NV = Nevada MN = Minnesota CT = Connecticut OK = Oklahoma WV = West Virginia HI = Hawaii

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An Auspicious Development:

ADA Sesquicentennial

By Dr. Clifton O. Dummett

Reprinted from the **Journal of Health Care for the Poor and Underserved,** *Volume 21, Number 3, August 2010*

The ADA Sesquicentennial celebrations in Hawaii in October 2009 bode well for both the profession's future and the annals of dental history. The industry of the 2009 ADA House of Delegates was reflected in several accomplishments that included such matters as the resolution supporting tobacco-free school environment policies, the collaboration with other health professionals in addressing the obesity issue, and support for legislative action to prevent dental plans from capping the amount dentists can charge for services not covered by plans.

One of the significant accomplishments[1] of the House of Delegates in the 150th year of ADA's existence was the election of the Association's first African American President-Elect. For this honor the delegates chose Dr. Raymond Gist of Flint, Michigan [Personal communication from Dir. of Development Foundation, ADA, D. Edwards, Oct. 28, 2009]. Coming on the heels of ADA's 2009 appointment of its first female Executive Director, the Honolulu achievement looms large and confirms the observation that the Association has not been among "the last to lay the old aside."[2] Furthermore, in 1991 when it selected Dr. Geraldine T. Morrow of Anchorage, Alaska as its first female President and in 2003 when it selected Dr. Eugene Sekiguchi of Monterey Park, California as its first Japanese American President, the ADA and other exemplary health professional organizations were among the "first by whom the new are tried."

This time at the sesquicentennial observances, Delegates elected one of ADA's most loyal, dependable and productive members from an equally loyal and dependable constituent Association. Thirty-five years ago, the Michigan State Dental Association joined its fellow constituent in composing a New York/Michigan State Dental Associations' resolution[3] that embraced adoption of a strong anti-discrimination requirement and penalizing state and local dental societies for "nonconformance with the spirit, intent and letter of ADA bylaws." Dr. Gist, a past president of the contemporary Michigan Dental Association, is a 1966 dental alumnus of the University of Michigan. Incidentally, it is uncanny and of more than passing interest to note that Dr. Gist is the first Michigander to be elected ADA President-Elect since President F. Darl Ostrander served as ADA President in 1967–1968. A highly valued and popular dental professor in the University of Michigan School of Dentistry, Dr. Ostrander was one of Dr. Gist's dental teachers. Ostrander's election and year of service as ADA President-Elect coincided with Ray Gist's year of graduation as a dentist in 1966. Dr. Gist has been a private practitioner of general dentistry in Flint, Michigan, since completing his service in the U.S. Air Force Dental Corps in 1968. An ADA member for 35 years, he has been a delegate to the Federal Dental International Congress, is a member of the Board of Directors ADA Political Action Committee, is chairman of the ADA Committee for the Institute for

Diversity, served as the Ninth District member of the ADA Board of Trustees, and is a member of the National Dental Association.

The historical importance of this first-time development prompts a brief review[4] of the long road organized dentistry has traveled towards this particular milestone.


Photo courtesy of Flint Journal

Dr. Raymond Gist, 2010 ADA President

Eventful background

The ADA was organized in 1859, just two years prior to the start of the U.S. Civil War.[5] Inimical relations between the North and South were reflected in the health professions. After the war (in 1869) dentists from the South organized the Southern Dental Association to represent dentists of that region. This separate organization persisted until August 5, 1897, when in the spirit of reconciliation, a merger occurred following a resolution that called for members of both associations to reorganize themselves into the initial National Dental Association (which later became the ADA). At that time, only White dentists were accepted as members of the National Dental Association. Solely on the basis of race, minority group dentists were rebuffed by local and state dental societies whose approval was essential for ADA membership.

However in 1895, two years before designation of the initial National Dental Association (NDA), African American physicians had organized the National Negro Medical Association[6] to afford its members opportunities to interact, to discuss advances in medical and health information, and to protect their professional interests. Of special significance was the fact that this organization included Black dentists and pharmacists. The inclusive action of membership countered a tendency toward health professional exclusivity and set a unique example of empathy, tolerance, and cooperation for the public good at a time when such unity was sorely needed to present a united front against isolation, injustice, and other invidious practices. Thus it was that in the new century White dentists were represented nationally by the NDA, while African American dentists found a national home in the National Medical Association (NMA). The historical record verifies rare instances of Black dentists in northern states who became NDA members, but these were exceptions to the situation at the time. Established Black dentists quickly became bona fide NMA members and were enthusiastic about their social participation in the annual conventions.

Local dental groups

Five years after NMA's beginning, a local organization of Black dentists was established in 1900 in Washington, D.C. This was the Washington Society of Colored Dentists and its success prompted Dr. David A. Ferguson, a talented dentist from nearby Richmond, Virginia, to propose forming a national organization for Negro dentists. The early efforts were unsuccessful, but he continued working industriously within NMA and ultimately in 1918 he became the first dentist elected president of NMA.

In the five years preceding this singular development in NMA, Ferguson had successfully assembled an organization of Black dentists from Maryland, Virginia, and Washington, D.C., to form the Tri-State Dental Society of which he was president.[7] He resigned this presidency when he took up the NMA presidency. Rivalries between NMA and Tri-State for Black dental members continued until 1922 when NDA relinquished rights to the title and reverted to its original ADA title.

Later, the Interstate Dental Association adopted a new name at its annual conclave in 1932 in Bordentown, New Jersey—National Dental Association (essentially NDA II, as the original NDA had changed its name to ADA). It was of major significance that the name change would occur simultaneously with the election of Dr. Ferguson to be the first president of the new NDA. This was 14 years after he had served as NMA President and 19 years after initiating the Tri-State Dental Society and serving as its president. His selection as the first NDA President was a gesture of appreciation and goodwill inasmuch as Ferguson had now advanced in age and was not in good health.

The new NDA

The new NDA was popular and enjoyed several blessings.[8] At its conventions, there were endorsements by the American Dental Trade Association, and for the 1931 convention there were contracts for exhibit space with leading dental manufacturers. Steadily, dentists departed from the NMA to associate with NDA. At the 1932 NMA meeting, Peter M. Murray, MD, analyzed the compound character of that organization as being "necessary in 1897 but became a handicap in 1932." He suggested that professional problems could be served by the best medical, dental, and pharmaceutical minds and leadership available.

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He therefore recommended that NMA welcome NDA as a professional organization and an indispensable health care agency. The new NDA continued its numerical growth and prestige into the 1950s. Nevertheless, both NDA and NMA continued to harbor basic interest in affiliation and acceptance by the established representative mainstream organizations of American medicine and dentistry.

In 1957 following completion of active duty in the USAF and impressed with the diminution of interracial discrimination in the U.S. Armed Forces, the NDA editor prepared a resolution on the subject of discrimination against membership in the ADA and presented it for consideration by the NDA Board of Trustees.[9,10] The Board approved and forwarded it to the ADA for consideration. In essence, the resolution urged ADA to request its constituent and component societies to eliminate membership restrictions on the basis of race. It directed attention to recent actions by the American Medical Association (AMA), which had changed its policy to include African American physicians; to the American Public Health Association, which had consistently urged the integration of minority health professionals; and the laudable 1951 decision of the American Nurses Association in fully integrating the National Association of Colored Graduate Nurses.

Legacy of the sixties

During the 1960s, across the country, there was tangible evidence that the nation's Civil Rights Movement was influencing perceptions and subsequent actions of the populace. The nation's physicians, nurses, and dentists were involved and became more vocal and visible in accepting their responsibilities to patients regardless of race and encouraging their representative organizations to be more outspoken on matters involving race.

The AMA had long suffered from a reputation for lagging in the promotion of racial diversity within its ranks, even though in 1948 it had officially welcomed African American physicians to membership. In 1958,[11] Dr. Lonnie R. Bristow, an African American internist, joined AMA. He became a loyal supporter of organized medicine and recognized the fact that in several matters and attitudes the Association was reflecting characteristics about race that were common nationally. His hard work and industry enhanced his popularity and influenced the Association in banning racial discrimination in its ranks in 1968.[12] Up to that time, both the AMA and ADA had defended the rights of state and local societies to deny membership to African American physicians, a practice that in turn denied them access to AMA. In time, AMA initiated efforts to reach out to NMA and as the years passed established the groundwork for significant progress. In 1985, the AMA governing Board of Trustees elected Dr. Bristow as its first African American physician member.[13] Dr. Bristow was the recipient of this action which later developed into his designation as Chairman of the Board of Trustees. In 1994, he was elected AMA President-Elect, and in the following year became the first African American president of AMA.[12]

In dentistry (while basic differences in goals and objectives existed) cordial relations between the movers and shakers in ADA and NDA were the order of the day.[14] Of the several people playing preeminent roles in eliminating dentistry's racism at the time were ADA's Harold Hillenbrand and NDA's James C. Wallace. Their superior skills and performances combined to bring about eventual racial integration in American dentistry. Dr. Hillenbrand was ADA's Executive Director, and he knew that racial discrimination in dentistry was inherently wrong, and that as long as it existed adversarial relations would continue.[15] He believed ADA should represent dentists regardless of race and insisted that ADA's constitution and bylaws should be adhered to. Dr. Wallace,[16] who had served in all of NDA's top offices, worked closely with Hillenbrand and together they eventually established an ADA/NDA Liaison Committee whose negotiations ultimately led to the adoption of ADA resolutions that called for suspension of any constituent society if it was determined that ADA bylaws were being violated.

A schedule of interracial responses to the 1958 NDA membership resolution documented an October, 1958 communication from the ADA Board of Trustees. It informed NDA of the ADA request to constituent societies to study ADA bylaws to ensure that licensure and adherence to the principles of ethics were the essential qualifications for attaining membership in ADA. In February, 1961, ADA[17] confirmed the fact that at the 1960 sessions of its House of Delegates the Board of Trustees requested that presidents and president-elects of all constituent societies study their bylaws and ensure that there were no provisions that restricted membership on the basis of race, creed or color.

The 1960s is often referred to among dentists as NDA's Golden Years. It was a time when interracial confrontations increased openly. The Civil Rights Movement was at its zenith and professional organizations tended to respond immediately when challenged.

The 1962 ADA House of Delegates adopted a policy that authorized sanctions against any state society with bylaws in conflict with ADA bylaws. The policy specifically was directed at the states refusing to consider membership applications from African American dentists. All but three state dental societies agreed and implemented ADA policy. Louisiana, Mississippi, and South Carolina dental societies were the states that did not admit African Americans

[Hillenbrand H. ADA correspondence to NDA president re: ADA response to NDA resolution and mailing to all constituent and component societies. 1961 Feb. 20]. The ADA sanctions were not immediately imposed as the parent organization sought to extend a reasonable time period for organic changes in traditional habits.

The greatest impetus creating definitive change in many injustices affecting African American dentists in the South from becoming ADA members came through U.S. federal legislation in 1964. Title VI of the 1964 Civil Rights Act mandated the loss of both federal tax exemptions and federal funding of organizations engaged in discriminatory practices based upon race. Wide publicity accompanied this development. On October 29, 1965, *The New York Times*[18] reported that the U.S. Government was "prodding ADA to desegregate…" The U.S. Department of Health, Education, and Welfare confirmed the fact that the federal government was quietly seeking to force removal of all racial barriers in ADA. It said that failure to integrate fully would lead to the federal government cutting off funds to ADA research laboratories in Chicago, and the ADA program at the National Bureau of Standards.

So it came to pass that ADA resolutions were buttressed by the 1964 Civil Rights Act of the federal government. This ensured an immediate compliance of ADA component and constituent societies with ADA bylaws.[19] Membership exclusions for ADA on the basis of race were thereby nullified. Forty-five years later the ADA House of Delegates has elected its first African American to be the Association's President-Elect.

Coda

Though the mills of God grind slowly, yet they grind exceeding small,

Though with patience He stands waiting, With exactness grinds He all.

—Friedrich von Logau, in Sinngedichte *(1653), III.ii.24, translation by Henry Wadsworth Longfellow*[20(p.4748)]
*A proverb first cited in text by Sextus Empiricus (*Against Professors, *i. 287)*

Implementation of federal laws against racial distinctions in ADA membership has been effective and welcome. Since 1964, various minority group applicants have been accepted for ADA membership and many have served the Association in assigned and elected capacities with satisfaction and grace.

In 2009, during the Association's 150-year celebrations in Hawaii, the ADA House of Delegates elected the first African American member to be the 2010 ADA President-Elect. For this auspicious development, the Association has extended to Dr. Raymond Gist its warmest congratulations and best wishes for successful leadership in the forthcoming years. ◆

The Editor was recently reunited with his USC SD Professor Dr. Clifton O. Dummett—a mentor second to none.

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Orthodontic-Restorative Treatment to Enhance Smile

By Peter S. Balle, DDS, FAGD

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Background

Age at Initial Presentation 27

Initial Presentation April 2008

Active Treatment Completed August 2008

The patient's chief concern was that her teeth appeared too small, and she was unhappy with her smile (FIGURE 1 AND FIGURE 2). She said she has never been satisfied with her smile and wanted bigger teeth. The patient has been a dental assistant for several years, working for a few dentists. Her dental literacy was higher than the average patient. The patient desired conservative dentistry.

Medical history

The patient's medical history was unremarkable.

Dental history

When she was an adolescent, orthodontic treatment with brackets and bands were used to close spaces of anterior teeth. Shortly after treatment concluded, the spaces reopened as teeth relapsed because she had stopped wearing her removable retainer.

In her late teens, a removable orthodontic appliance was used to close the spaces again. A permanent bonded wire retainer was placed on the lingual surfaces of teeth Nos. 7 to 10 to retain the incisor and prevent proclination and spacing (FIGURE 3). The patient had direct and indirect restorations placed on her posterior teeth before and after orthodontic treatment. All restorative needs had been addressed, with no decay or defective restorations.

Extraoral Incisors were in reverse arc to lower lip. Lip length and mobility was normal. Teeth in repose were 0.5-mm display (FIGURE 4).

Temporomandibular Joints (TMJ) History and signs of reciprocal click for at least 10 years.

Intraoral Localized mild attrition to the lower anterior incisors. Few direct composite restorations on posterior teeth and one ceramo-metal crown. Gingival architecture was symmetrical, and probing depths were normal: 1 mm to 3 mm.

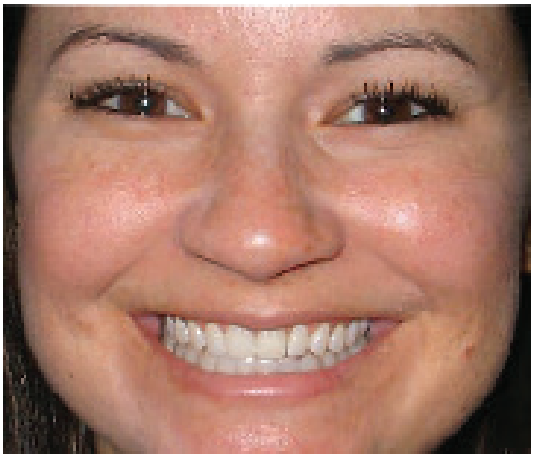

Figure 1 *Full-face smile diagnostic for facial symmetry and proportions of smile related to face.*

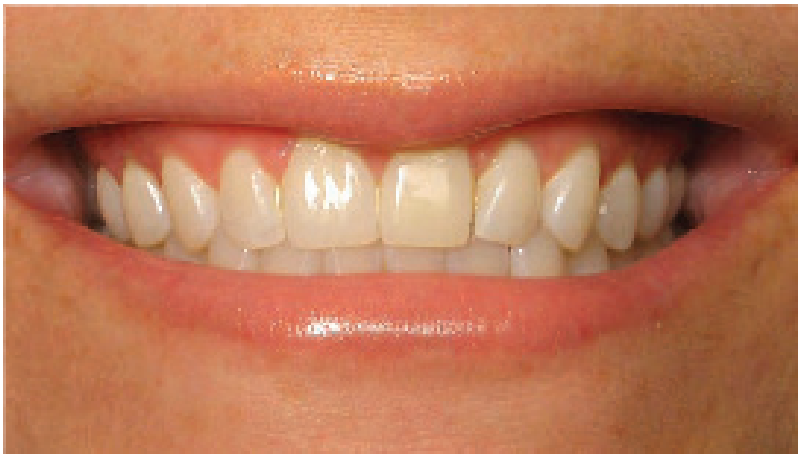

Figure 2 *Close-up smile details proportions of tooth display and relative proportions to lips and symmetry bilaterally.*

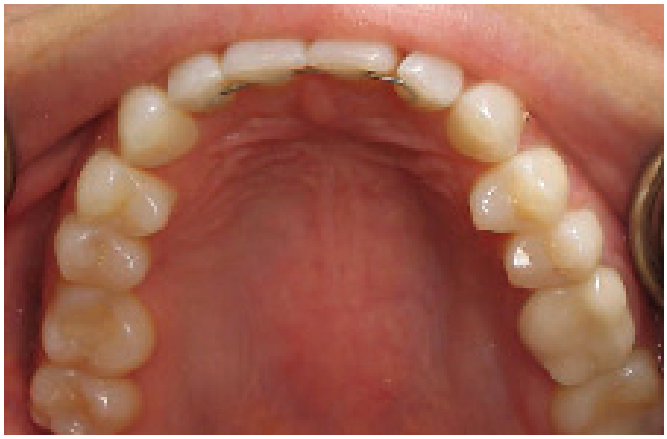

Figure 3 *View of arch-occlusal bilateral characteristics.*

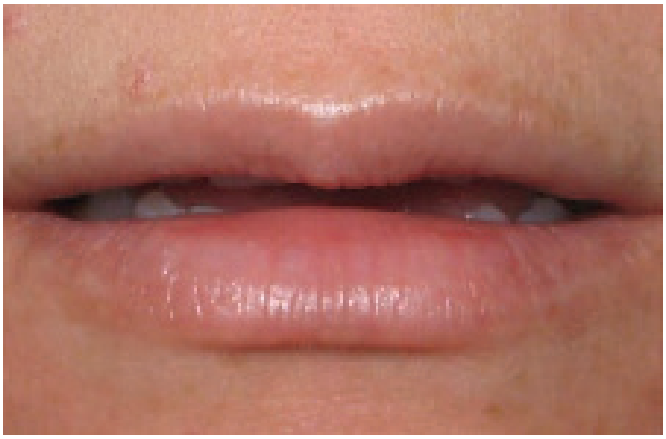

Figure 4 *View of how much incisors display or do not display when lips are in a relaxed state slightly separated.*

Symptoms Patient indicated long periods of chewing were uncomfortable, and her jaw clicked when chewing gum. She also indicated she chewed gum for long periods.

Signs Fremitus was noted on teeth Nos. 7 to 10.

Diagnosis

Periodontal AAP type I

Biomechanical No caries; restorations in good condition.

Functional Constricted chewing envelope; history and sign of right-side TMJ click that she had noticed for years. She stated that her jaws were uncomfortable when chewing gum for long periods.

Dentofacial: Inadequate incisor tooth proportions (FIGURE 5).

Risk assessment

Periodontal Low

Biomechanical Low

Functional Medium risk

Esthetics Medium

Radiographic assessment

Bone level appeared excellent. The shape of incisors appeared to be deficient in proportion mesial-distally.

Prognosis

The prognosis for this patient was good. A series of diagnostic digital photos and four vertical bitewing radiographs were taken during the examination. A panoramic radiograph was obtained from her orthodontist before treatment (FIGURE 1–FIGURE 10).

After examination and review, it was determined mesial-distal width of maxillary central and lateral incisors were deficient for the arch form. Esthetically, the overall appearance of the incisors were small, especially the undersized lateral incisors.

To eliminate the diastemas, the incisors were retroclined and the overall arch was constricted. Closing the spaces between the incisors resulted in a reverse contour of the incisal edges relative to upward arc of the lower lip (FIGURE 5).

Concerns

1. Would increasing overjet by predominantly proclining incisors be sufficient for elimination of fremitus and to relieve constricted chewing envelope?
2. Would moving the incisors facially still allow conservative preparation of tooth structure?

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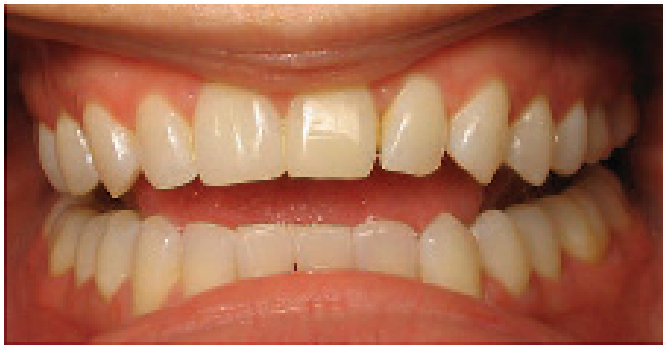

Figure 5 *Retracted view of close-up of teeth separated to view mandibular occlusal plane.*

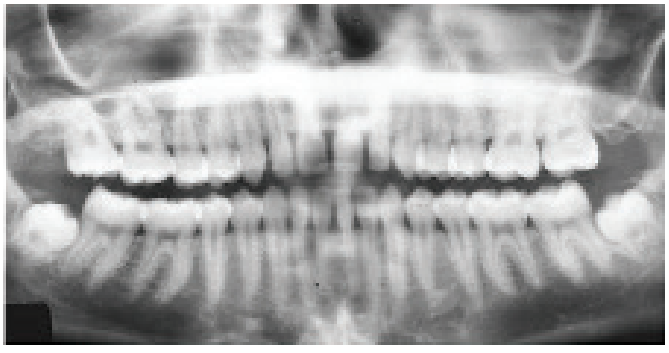

Figure 6 *Panoramic film.*

A key concern prior to initiating treatment was the fremitus on the anterior maxillary teeth. Increasing the horizontal parameter of overjet was expected to relieve the constricted envelope of function. The overjet change was more important for allowing normal function despite the increase in visual vertical display and increase of overbite relationship of anterior incisors. The vertical parameter of overbite was less a concern of function and more a concern of esthetics. Increased overbite as well as overjet was expected to result in improved esthetic and functional goals of treatment.

Treatment goals

1. Create space between incisors.
2. Increase length, width, and ideal proportions of incisors.
3. Improve overjet relationship of anterior teeth and eliminate fremitus.
4. Restore as minimally as possible, and be conservative in tooth preparation.

Treatment plan

In the treatment planning, the goals were to increase visual display, improve proportion of incisors, and correct the reverse smile appearance of the incisal edge. Key diagnostic determinants were used to plan a more desirable display of incisors. Factors, such as lip length, lip reveal or dynamic movement, and display of teeth at smile and repose, were all used to determine desirable incisal edge. Also, the patient's desires for appearance were calculated in the treatment planning. Other factors, such as age and facial type, were also considered. In a dolichocephalic type, a clinician can further increase the length of teeth to match the face. Shorter teeth may be more appropriate for brachiocephalic faces because they are broader. The key factor in determining incisal edge length is repose. In this case, the patient had a repose display of 0.5 mm (FIGURE 4). It is more desirable for a young female to display more incisal edge at repose, which is a more youthful attribute. The patient's incisors were undersized in both length and width. Expansion of the dental arch and proclination of the

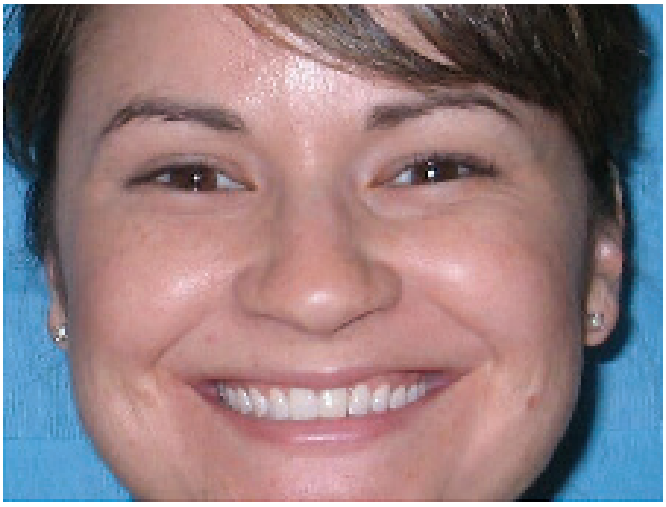

Figure 7 *Full-face smile.*

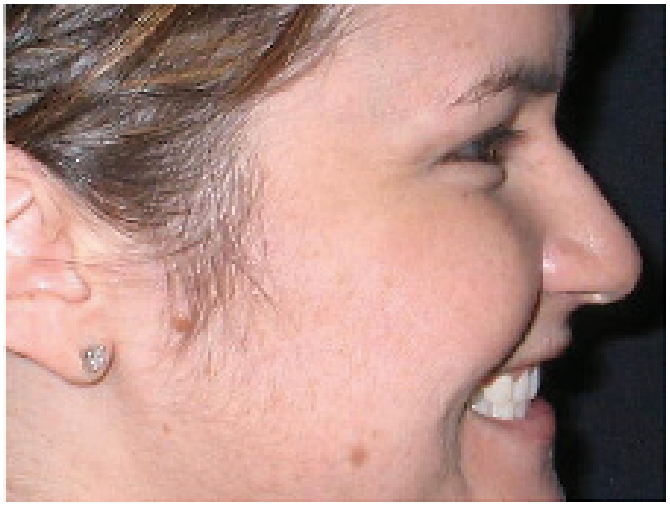

Figure 8 *Profile view of full-face profile while smiling demonstrates incisal edge position and inclination relative to profile of face.*

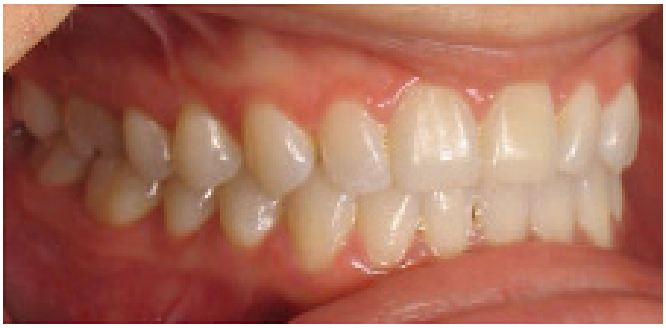

Figure 9 *Right side close-up lateral view of maxillo-mandibular relationship when jaws are in maximal intercuspation.*

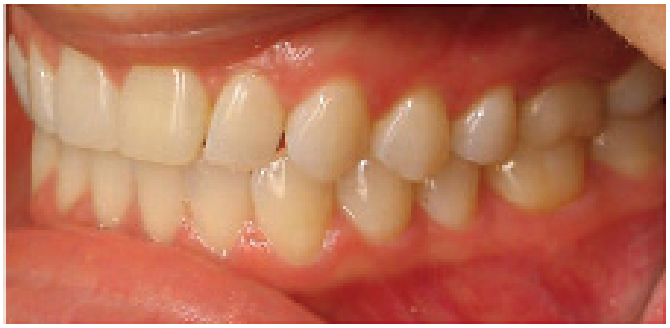

Figure 10 *Left side close-up lateral view of maxillo-mandibular relationship when jaws are in maximal intercuspation.*

incisors are desirable to achieve the necessary interproximal room to allow for increased proportion of the incisors. Proclination and arch expansion increase the overjet, which creates the necessary space to alleviate the constricted envelope of function and eliminate the fremitus on the maxillary incisors.

After measuring width and length of incisors, it was determined that length of incisors would improve size and increase display by increasing length by 2 mm. Increasing space between all incisors by 1 mm was planned to allow greater width and improve proportions to compensate the added length. Feldspathic porcelain is a coreless ceramic restoration, and feldspathic porcelain veneers allow for minimal thickness as low as 0.3 mm and have the highest amount of translucency. Because no major value change was planned and minimal teeth preparation was desired, feldspathic veneers were determined to be the best choice. The patient also chose teeth-whitening prior to restorations. Because the lateral incisors are disproportionately smaller than the central incisors, the space volume that would be created mesial and distal of the lateral incisors would be used to increase the dimension more so of the lateral incisors than the central incisors. The space created between the central incisors would be divided equally to increase the width of the central incisors.

Phase I: Orthodontic phase

From study casts, a polyvinyl putty index was made of the incisal edges. The cast was cut vertically between the incisors, using a dental laboratory hacksaw. When the vertical cuts were made down apically approximately 3 mm to 4 mm past the cervical portion of teeth, a horizontal cut was done, separating the teeth from the cast. More stone was removed between the teeth and the cast to allow wax to flow into the space. The teeth were then placed back on the incisal jig, which was made from the original unaltered cast of the incisors. Pink base plate wax was added to reattach the incisors that were cut away from the model.

The incisors were attached by wax to create a wax-altered cast to manipulate position of model teeth and plan the patient's orthodontic tooth movement. To accomplish spacing and proclination of the incisors, the wax-altered cast was warmed and the incisors were prolined and spaced in small increments (FIGURE 11–FIGURE 13). A duplicate cast was then made from each incremental change to the wax-altered cast. After each incremental change in position of the incisors, a duplicate cast was created. A vacuum-form thermoplastic aligner was made on each of the duplicate casts. These appliances were trimmed and then given to the patient to wear continually, except when

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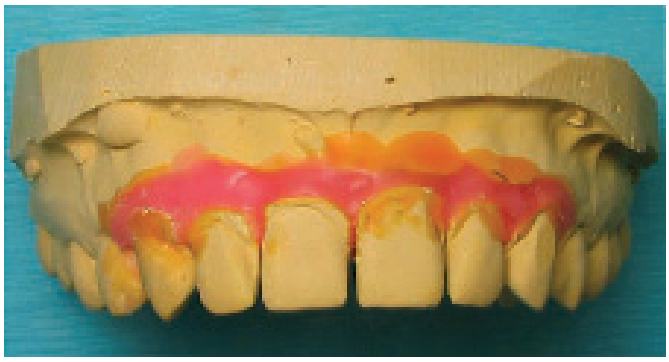


Figure 11 *Frontal view of modified models of teeth set in wax and separated to produce aligner to accomplish planned movement.*

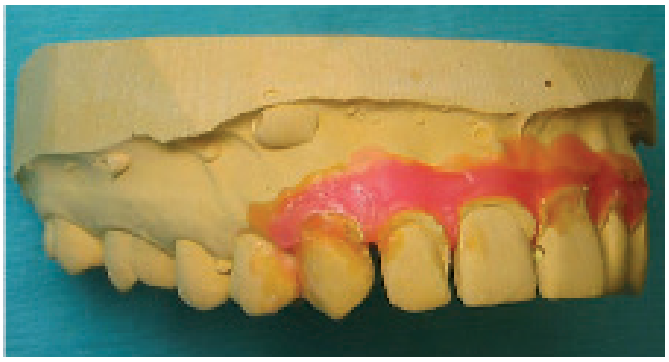


Figure 12 *Right side view of modified models of teeth set in wax and separated to produce aligner to accomplish planned movement.*

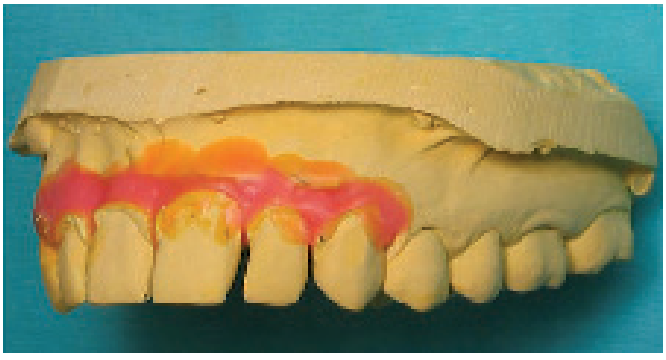


Figure 13 *Left side view of modified models of teeth set in wax and separated to produce aligner to accomplish planned movement.*

eating, to procline her incisors into the desired restorative position. The amount of movement was accomplished with four aligners. She was instructed to wear each aligner for two weeks and to remove them for meals. The patient chose to use carbomide peroxide gel for whitening while undergoing orthodontic treatment in the thermoplastic aligner trays (FIGURE 14). When the desired amount of space was attained, the patient was instructed to wear the last aligner for six weeks to retain the desired positioning in preparation for restorative treatment (FIGURE 15).

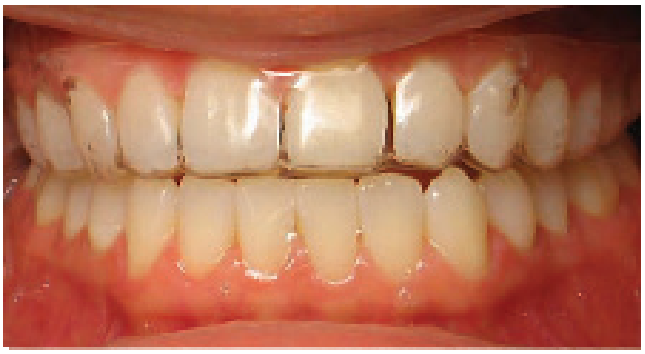


Figure 14 *View of aligner in place over maxillary teeth, created on modified casts.*

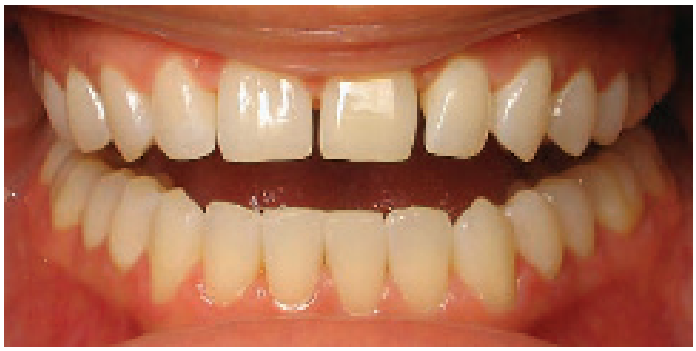


Figure 15 *View of incisors spacing achieved by wearing aligner in preparation of restorative treatment.*

Phase II: Restorative phase

New casts were made of the teeth and sent to a local laboratory for a diagnostic wax-up. The laboratory was instructed not to make any reduction to the cast but only add volume to increase proportions to the incisors. The Kois Dento-Facial Analyzer System (Panadent®, Grand Terrace, CA) was used to communicate to the facility the steepness and tilts of the occlusal plane. This information was now transferred to the articulator in all three planes of space related to an average axis-incisal distance of 100 mm. A jaw relation record was made with Jet Bite (Coltène/Whaledent®, Cuyahoga Falls, OH) in maximal intercuspation.

It was initially determined that four veneers of the incisors would be sufficient to achieve desired results. The patient wanted to include the canines as well for veneers so the diagnostic wax-up returned with Nos. 6 to 11 modified. Even though the mesial distal width of the canines was adequate, it was thought that placing thin veneers on the canines would change the shape from a less pointed triangular to a more oval and softer appearance.

A temporary silicone putty matrix (Sil Tech, Miamisburg, OH; Ivoclar Vivadent, Inc., Amherst, NY) was made of the diagnostic wax-up cast. Provisional veneers (Integrity™, DENTSPLY Caulk, Milford, DE) were placed over the patient's incisors for her to evaluate esthetics.

When the provisional restorations were modified and approved by the patient, the provisional veneers were removed and the teeth prepared ultra-conservatively prior to final impression. The preparation consisted of flattening the cusp tip of the canines and incisors. An Aquasil light viscosity (DENTSPLY Caulk) impression was made of the maxillary arch. The Sil Tech putty impression of the wax-up model was used for placement of temporary veneers.

Impressions were made of the provisional restorations and photos (FIGURE 16) taken to communicate to laboratory the desired contours and length of the definitive veneers. The polyvinyl impression of the temporary veneers produces a "go-by" impression for the laboratory to follow the contours and shape of approved provisional veneers.

No facial enamel was removed in the preparation of the incisors and canines. The veneers were prepared with Interface (Apex Dental Materials, Inc., Lake Zurich, IL) and Simplicity bonding resin (Apex Dental Materials, Inc.).

The teeth were prepared with 35% phosphoric etch (Ultradent Products, Inc., South Jordan, UT), Interface, and Simplicity bottle No. 2 bonding, 3M RelyX™ translucent light-cured veneer bonding resin (3M ESPE, St. Paul, MN). The laboratory services were donated by Donnell Brox of Performance Dental Lab, Las Vegas, Nevada, who is a family friend of the patient.

Although restorations are not exactly symmetrical, they met the patient's expectations. The authors were able to bond to enamel and minimize irreversible tooth structure changes.

In regard to symmetry, the patient said the incisors are "sisters" not "twins" (FIGURE 17 AND FIGURE 18).

Phase III: Maintenance phase

A vacuum-form thermoplastic 0.8 mm was made of the maxillary arch for nightwear to retain maxillary teeth.

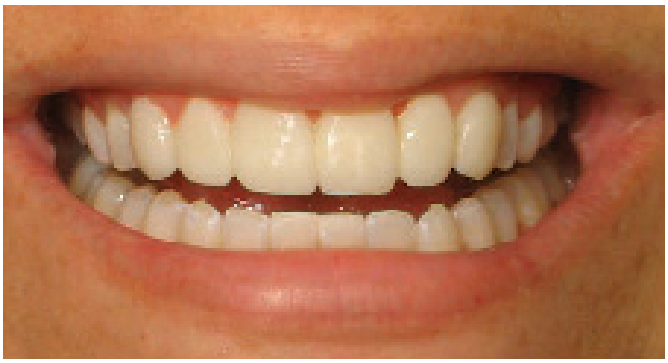


Figure 16 *View of provisional veneers bonded in place close-up to communicate to ceramist dimension shape and the changes to make.*

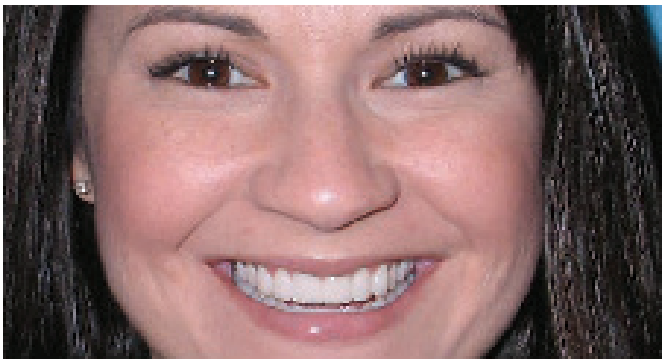


Figure 17 *View of definitive veneers in place to demonstrate relation of proportions of teeth and smile as they correlate to the face.*

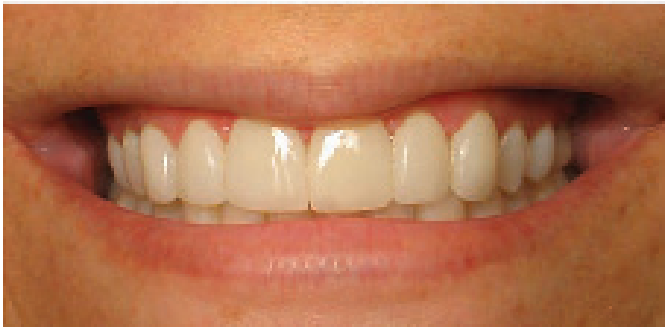


Figure 18 *View close-up of definitive veneers in relation to lips, smile, and overall proportions.*

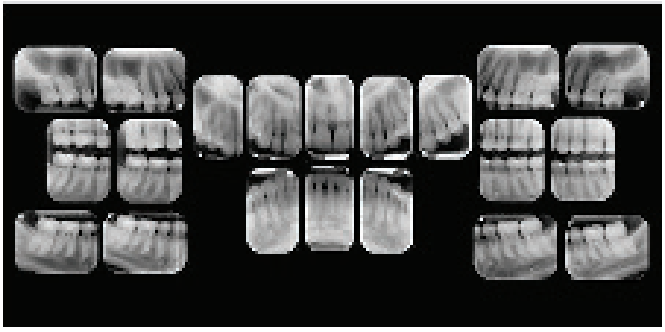


Figure 19 *Full-mouth series radiographs.*

Commentary

The final results met the patient's expectations. The treatment met the patient's goal for larger teeth and a more pleasing smile with very conservative dentistry. She smiles more and has more confidence in her appearance.

Most of the risk in this case was in areas of function and esthetics. Her occlusion was compromised. The retainer bonded to hold the incisors in a retroclined position directly contributed to the constricted envelope and resulted in fremitus and more attrition to the incisors. Posttreatment radiographs can be noted in FIGURE 19.

By understanding all the factors in esthetics of tooth length, lip dynamics, lip length, repose, patient age, facial types, and esthetic tooth proportions, a desirable smile can be achieved.

Clearly, this is a case that required an interdisciplinary approach to achieve an ideal outcome. When orthodontics alone was performed to correct the problem of spacing because of a lack of adequate incisor proportions, torquing, retroclining, and bonding a metal wire retainer were required. The treatment achieved closure of diastemas but resulted in unesthetic and functionally compromised incisors position. The long-term effects could be detrimental. With the evidence of TMJ clicking, greater incisor wear compared with the rest of the dentition may have been a direct result of the compromised limited disciplinary treatment. Had the spaces never been closed, the functional risk may have been lower.

For planning, all risk factors must be considered. Functional risk can sometimes directly conflict with esthetics. Increasing length can impact the chewing envelope. Phonetics must not be overlooked when changing esthetics. ◆

Acknowledgements

Ceramics by Donnell Brox, Performance Dental Lab, Las Vegas, NV

Dr. Balle is in private practice in Las Vegas, teaches part-time at UNLV SDM, and is the immediate Past President of the NDA.

SNDS Executive Director's Message

Robert Anderson

For everything there is a season, so the saying goes. Now that it's summer, we are past the membership renewal season, and our results are very encouraging. The SNDS ended 2010 with just over 500 members, and we have already exceeded that number. This is very encouraging as it means that the attrition we experienced as a result of the economy has leveled off. Hopefully, next year at this time I can write that it has turned around! For now, I want to thank Drs. Richard Carraba and Lydia Wyatt for their efforts in contacting member to remind them about their membership renewal.

This is also the busiest season for SNDS as we are putting the final touches on our meetings, programs, and events. Watch for upcoming information on our Continuing Education series. We have an outstanding line up taking shape.

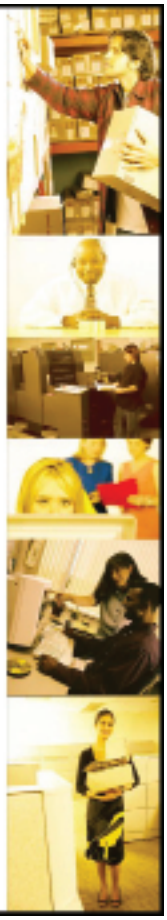
We are also working on our annual Community Night on Tuesday, Sept. 13. This is always our biggest event of the year, and this year should be no exception. We have space for 60 or so exhibit tables, so if you have a vendor that you think should be there, have them contact the SNDS office, or give us a call and we'll follow up.

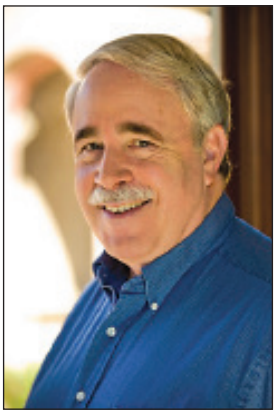
And while we don't usually have any events or meetings in the summer, this year we are having a special Continuing Education seminar on July 15. Dr. Renato Leonardo will be speaking on "Technological Resources Applied to Biological Endodontics." Dr. Leonardo is coming to us from Brazil, thanks to help from Ultradent. We hope you'll take advantage of this unique opportunity. The flyer, with full information is on our website at www.sndsonline.org, or you can call the SNDS office.

We held one CE seminar on Infection Control in 2010 that was very well received, but we will be holding others. These will be geared toward dentists, hygienists and the entire office staff. The next one will be held August 5, and, again, the flyer and details are on the CE page of our website.

The ADA Annual Session will be held here in Las Vegas in October, and volunteers are needed to host speakers as well as other tasks. If you are interested in volunteering, can go to the NDA website at www.nvda.org and click on the link, or browse directory to www.nvda.org/volunteerada2011.shtml. Your help will be *much* appreciated by our committee on local arrangements.

I encourage you to take advantage of these opportunities, and save the date for Community Night in September. If you have a colleague who is not a member, or who has not renewed, we encourage you to invite them to attend as a guest. We just ask that you contact the SNDS office in advance. We have some great events scheduled, we just need to get the word out to make it an even better year! ◆





Joel Casar, DMD

Every incoming president has specific goals that they hope to accomplish to strengthen the SNDS. My goals for this year are:

1. To utilize the attraction of Las Vegas as a tourist destination for dentists around the country who want to combine their needed Continuing Education with their desire to come here to vacation.
2. To generate non-dues income for our Society allowing us to serve our membership with more and better CE at a very low cost.
3. To increase our market-share of membership in organized dentistry.

The big news is that our high attrition rate of the last two years has leveled off. As of December 31, we had 502 members, and currently we have 510 members. One significant factor was the expansion of the NDA payment plan program for dues, with almost 90 members selecting that option. These indicators are bolstered by our year-to-date dues revenue exceeding that of last year at this time. If every member would talk to colleagues who have not joined or who have let their membership lapse, we could show some really significant growth! They can contact Anthony at the NDA, at 702-255-4211. We'll be happy to have them back!

Our member retention is also due to the tireless work of Drs. Richard Carraba, and Lydia Wyatt, who diligently worked to contact members who were slow to answer their renewal notices. This was a great example of committed volunteers making a difference. Thank you both!

In May we held our first Board-mandated Infection Control CE seminar for only dental hygienists. The course was attended by 105 hygienists, and the seminar received 98% rave reviews. For example: on the effectiveness of the instructor, attendees wrote, "She makes a boring subject fun to listen to," "Great speaker! Explains things very well and keeps you entertained," "The rest of the office needs to hear this…"

The SNDS has partnered with Compliance Alliance in delivering these seminars, and will be offering them periodically over the year. Our next seminar will be held August 5 at the Gold Coast. All future seminars will be geared toward dentists, hygienists, dental assistants and your entire office staff. The course will also be available for viewing on DVD at the SNDS office. We have arranged to keep the fees low enough that you can bring everyone!

We have completed the second full year of our CE Café series, and its grown to be very popular among participating members. Thanks to Nevada State Bank for providing the venue, Burkhart Dental for providing us with some clinical speakers along other support as needed, we have been able to offer this series of four, 2 CE classes, for no cost to the society and no cost to members. I've enjoyed the relaxed atmosphere, the broad range of topics and the accessibility of the presenters. I encourage members to watch for the next one.

This year Dr. Joseph Wineman has stepped down as our Peer Review Committee Chair. Peer Review is among the most important of member benefits, and Dr. Wineman did a yeoman's job of getting the committee running in a polished, professional manner. He has offered to remain on the committee in order to support Dr. Pam Caggiano, our new Chairman. We hope you wish her well, along with our colleagues who also serve on the committee. Peer Review is a tough job, but they push through and get the job done for us all. ◆

By Karen P. West, DMD; UNLV SDM Dean

Greetings from the SDM!

Student Highlights

The Class of 2011 has graduated and dispersed through the country. Five students each will be starting Oral & Maxillofacial Surgery and Orthodontic residencies; four each will be in Pediatric and Periodontic residencies; and one will begin Endodontic and Prosthodontic residencies. There are 16 students that will be starting General Practice Residencies, as well as Advanced Education in General Dentistry programs in July. For the third year in a row we have had a student accepted into a Dental Anesthesiology Residency. There are 13 students going into the military and will be representing the Army, Air Force, Navy and Army National Guard branches. The remainder of the class will be working in Nevada, Texas, Colorado, California, Arizona, Canada, Idaho, Minnesota and Washington State. We wish them the best! We also want to thank those graduates who stayed at the school a bit longer to help with laboratory teaching. They were a great help and we hope that they consider a career in full time academics someday.

The Office of Admissions and Student Affairs is nearing the end of the selection process for the Class of 2015. There were 2,287 applicants for the application cycle 2010–11. There are currently 75 students that will be matriculating this fall with 40% being female and 12% from underrepresented minority backgrounds. The entering class consists of 46 instate students and 29 out of state students. The entering cumulative GPA is 3.45 and the science GPA is 3.35. Historically, we have experienced attrition up until the week before orientation. A ranked alternate list will be used to replace the students that withdraw. Orientation week is Aug. 29–Sept. 2. Classes begin September 6. We are excited to welcome these students to the UNLV School of Dental Medicine family.

June 1 was the start of the next application cycle for the recruitment of the Class of 2016. There are currently over 1,060 applications already being processed by AADSAS. Interviews will begin in mid-September. **Dr. Connie Mobley** will be chairing the Admissions Committee next year.

Faculty Highlights

- **Dr. Christine Ancajas** was promoted to Major in the Nevada Army National Guard. She is currently State Dental Officer for the state.
- **Dr. Gerald Fox** will be receiving Lifelong Learning and Recognition Award from the Academy of General Dentistry on July 30 in San Diego. The award recognizes completion of over 1600 documented hours of continuing education in prescribed disciplines of dentistry, including at least 500 hours completed after receiving the Mastership in the Academy of General Dentistry. Only 150 dentists countrywide have received it.
- **Dr. Cody Hughes** received the Master Clinician Scholarship from the American Association of Pediatric Dentistry. The scholarship will cover tuition for the ITL Program at the University of North Carolina and for the comprehensive review course through the AAPD.
- **Dr. Daniel Orr II** was recently selected by the AAOMS Board of Trustees and Awards Nominating Committee as the 2011 recipient of the Daniel M. Laskin Award for the specialty's Outstanding Predoctoral Educator. He will be recognized at the 93rd AAOMS Annual Meeting Awards and Opening Ceremony in Philadelphia in September.
- **Dr. McKinley Self** was a co-principal investigator for the $897,626 Faculty Loan Repayment Grant from HRSA which will aid our junior faculty as they continue in academia.
- We have also been interviewing candidates for positions as an Endodontics faculty member and Pediatric Dentistry Program Director. **Dr. Jeannie Hibler**, current Program Director, will be returning to part-time private practice in Park City, Utah.

Alumni Events

Don't forget the UNLV Dental School Alumni Association has a Facebook page that is answered by the Dr. Bill Dahkle, the president of the association. If you are a UNLV SDM alum, please let us know your current address so we can keep in touch. The Dental School Alumni Association held a very successful alumni event in May that included golf and continuing education. We hope to have another event next year.

facebook.

If you are a UNLV SDM alum, please let us know your current address so we can keep in touch.

Also, the School of Dental Medicine will host a reception at the **ADA Annual Session** in October at Mandalay Bay Resort in Las Vegas. Make sure you find us in the program and come by and say hello! ◆

UNLV Dental Class of 2011 Graduation Celebration Keynote

By Charles K. Hill, DMD

(Soft, nervous voice)

» There, there are many things, we've taught you these last four years you cannot live without as a dentist. Tonight I would like to speak about one of them. *(Removes cap)*

» I'm sorry. *(Wipes forehead)*

» Excuse me. *(Removes glasses, places on dental loupes, crumples speech paper, throws paper into crowd).*

(Normal voice)

» I remember my first year of dental school. I was in the honeymoon stage and loved every minute of it. I couldn't wait to get to second year.

» I got to second year and it got harder—pathology, pharmacology, crowns turned into bridges, I set 28 denture teeth. I couldn't wait to get out of the lab and into clinic.

» I got to the clinic and I was nervous every day—patients made me nervous, my fellow classmates made me nervous, dentistry made me nervous, but most of all… *(leans in to microphone)* my instructors made me nervous.

» I couldn't wait to get to fourth year. Everything wouldn't be so new and I would know what I was doing.

» In the fourth year, it got worse—I had to take boards, I had to do molar endo, perio surgery, work on people who didn't have any coronal tooth structure left to take their teeth out and wouldn't get numb. I thought it would never end.

» 15 years ago I sat where you all sit today *(motioning to graduates)*. 15 years ago and all I could think of was one thing… *(leans in to microphone)* I gotta get outta here and make money.

» Now even my son knows that. He's 11 years old and he told me the other day…"Dad, it's all about the cheddar."

» But I want you, the Class of 2011 to do one thing. Do it for me. Do one thing in your career in dentistry. I know you can do it. I know because I've done it for the last eight years…

» Teach.

» Teach.

» You don't have to be a full-time faculty at a dental school. You can go part-time, you can work in a hygiene program, dental assisting program, lab technician, CE credits—do anything in your community.

» Teach.

» Teach.

» And when you teach, come with a theme. I came with a theme. When I was in dental school and in practice I thought long and hard about what I wanted to be when I was a teacher…

» Cheese.

» I'm the cheese on the vegetables. Dentistry and dental school give you a lot of vegetables—and you gotta eat 'em to be a big, strong dentist. But I wanted them to taste better.

» You don't need a lot of me, you don't need a lot of me in dental school. Uh uh. Cheese is not good for you in large amounts, but you need the vegetables.

» Teach. And have a purpose.

» You could be a materials guru, clinical excellence, practice management expert. Be something.

» But teach. Somewhere, some time, to someone during your career.

» We will now have a short quiz.

» It's a single question. I will call…at random…someone in the Class of 2011.

» I have chosen the person. *(Removes loupes)*

» I interviewed this individual four years ago. He's a pretty good kid. *(Puts glasses back on)* I became his mentor in clinic. I also remember a conversation we had first year about baseplate wax and Blu-Mousse. He didn't understand why he had to use wax—he argued pretty well. I like this kid.

» Jeff Roberts are you here today? *(Seeing Jeff in crowd)* Jeff, please stand, please stand.

» Jeff, this is a one question quiz—if you answer correctly for everybody, we will continue with the celebration. If you answer incorrectly, *(leans in to microphone)* I'll see you Monday, 8 am in my office for remediation.

» Here's your question. One-word answer—starts with "T"—What is the one thing you and your classmates must do during your career in dentistry? You have ten seconds…go!

» *(Jeff Roberts speaking)* "Teach."

» *(Hill speaking)* That is correct, Jeff, you may sit down.

(Places cap back on)

» In closing, I'd like to thank everybody here.

» To the friends and families, thank you for all the support you've given these graduates before, during, and after dental school. *(Leans in to microphone)* Yes, they're gonna need more support after school.

» Thank you to everyone I've worked with—everyone at UNLV for the past eight years. I hope it's been evident that I've enjoyed coming to work every single day.

» And thank you, finally, to the Class of 2011, I hope you get everything you want out of dentistry. Achieve everything that you set a goal for, and then some.

» Thank you. You were a great class. I will miss you.

Editor's Note: The written version of Dr. Hill's sage advice does not do the presentation justice. There are two YouTube versions available: www.youtube.com/watch?v=-JEEmv3y4ag&feature=youtube_gdata_player *or* www.youtube.com/watch?v=702jAlpt94E

Dr. Charles Hill was an Asst. Professor of Clinical Sciences at UNLV SDM during the Class of 2011 convocation and will begin training in the UNLV SDM Orthodontic Residency in July 2011.

NNDS Executive Director's Message

Lori Benvin

What does it mean to volunteer? To provide care pro-bono? Who is giving back to our community? These are questions that *many* of our dentists are answering. Many licensed dentists in Nevada are providing needed pro-bono dental care—even when some offices have been facing up to a 40% reduction in production since 2009.

This year the Northern Nevada Dental Health Program has been faced with a reduction in the number of providers willing to treat children in their offices and some have been forced to reduce the number of children they treat pro-bono. However, we know the reasons could be they are also providing pro-bono care to other patients in our community from programs that serve children and/or adults. We also are aware that some of you may not participate with NNDHP but give back by helping patients who walk into your practices on a daily basis. We applaud all of you and we certainly want to capture any donated dollars collectively and report that generosity to our state legislators. Our administrative merger with Saint Mary's allows NNDHP to collect that data, report it to the NDA, boast about your generosity to state Legislators, and give you volunteer CE credits toward your licensing renewal.

When the NDA sends membership renewal packets, they ask for your annual donated dental figures. I will collect that data if you are not a NNDHP provider and give those amounts to our legislative committee. Simply email *nnds@nndental.org* or fax 775-337-0298 with your amounts.

One program that has taken flight in northern Nevada is the Adopt a Vet Dental Program. It is bridging a huge gap for our veterans who desperately need dental care and are unable to receive care from the VA. Many of our veterans do not meet the government criteria to receive care at the VA Dental Clinic and cannot afford to pay for the dental treatment. I thank those dentists who are providing pro-bono care to our veterans.

Recently the Joel F. Glover Memorial Foundation held their 1st annual scholarship fundraiser—the Joel Bowl. This foundation was created when Sparks High School informed Joel F. Glover, DDS, that he was to be inducted into the Hall of Fame. Joel and his son Joel T. discussed the creation of a perpetual scholarship—the goal of which is to enable Sparks High School students to fulfill their potential through higher education and, ultimately, through *community involvement*. Students receive scholarships to pursue a career in the health care field and in turn, they will give back to their community.

On behalf of the Northern Nevada Dental Society we **thank all of our members** who help our community of patients by providing pro-bono dental care to those less fortunate. Whatever program you chose to participate in, or giving back to someone you know is really all we can ask.

All of the NNDS Executive Board members, all Committee Chairs, Committee members, NNDHP Board Members, and your Delegates who spend their time and generously give to your association. These colleagues are all volunteers; representing and safeguarding the dental profession. I make special mention of someone who has been the President of the Northern Nevada Dental Health Program for countless years and publicly thanks everyone else who participates in NNDHP or who gives of their time. We owe a huge debt of gratitude and congratulations to Dr. Greg Pisani. He truly is the champion for this program and gives back every day.

I'd also like to thank the NNDS Executive Board—Past President Dr. Scott Jarrett, our Immediate Past President Dr. Mark Handelin, President Dr. Quincy Gibbs, Vice President Dr. Jason Ferguson, Secretary/Treasurer Dr. Frank Beglin, Member at Large Dr. Brandi Dupont, and our outgoing Member at Large and the Recruitment & Retention cochair, Dr. Bill Van Patten.

Thank you also to our ADA Delegates—Drs. Jade Miller, Dwyte Brooks and Michael Banks; Peer Review Chair Dr. Paul Brosy and the entire Peer Review Committee; Drs. Kai Funke, George Henderson, Bo Tripp, Ken Vaughn, Rosalyn Wright, Ken Stewart, Brad Munninger, David Jarrett, Brady Neugebauer, Eric Escobar, and James Smerdon.

Welcome to our new additions to the NNDS Executive Committee—

Dr. Perry Francis, *Member at Large*

Dr. Maggie Heinen, *CE Speaker Chair*

Dr. Rick Dragon, *Membership Recruitment & Retention Chair*

We look forward to a great year! ◆

WELCOME NEW NNDS MEMBERS

Derek Johnson, DMD – General
John C. Shepphird, DMD – General
Kristian Sievert, DMD – General
John Vu, DDS – General (renewed)
Trung Vu, DDS – General
Kathryn Wallace, DDS – General

NNDS President's Message

Quincy L. Gibbs, DDS

Change is inevitable. We can't help it. You can turn on the television and see on the 24-hour news channels how it is constantly in flux. Our environment is different every day, our government turns over every four years, the smartphone I just bought is obsolete, and our children seem to become teenagers and adults in the blink of an eye. We see change happening in dentistry all of the time as well. The barrage of product magazines and journals that always find their way to our desks will tell you that. It can be daunting keeping up with the latest and the greatest.

We have a few choices when met with change: stick our head in the sand and hope it goes away or grow with the change. Change is inevitable, growth is optional. In our office, that is what we tell our dental team whenever we make a change. They tend to roll their eyes and say "what now?", but more often than not the change is beneficial to our patients and to us.

I know that I am preaching to the choir on this one—if you are reading this column, then you are at least a bit interested in what is happening in our profession and are a member of our tripartite associations. When I talk to people both in and outside of dentistry the conversations are always interesting. Usually someone is telling me a story of a toothache or a visit to the dentist that they never forgot. Often they are pointing to something in their mouth while trying to finish the story. They all have been touched by what we do everyday.

In the next few years, dentistry will be challenged by those that want to change it, for what they deem is "for the better." Often these interests come from people outside of dentistry. Who knows better what is good for dentistry than dentists? We have a long history of outstanding care, safe practice techniques, generosity, and self-governance. As we face the challenges to how and why we practice, it will fall to all of us to stand up and show why our profession is great, why we have been so successful and why we work so well. We need to educate our patients not only about home care and dental disease, but also about how they and we are threatened by midlevel providers, capping of non-covered services, and over regulation. If you are not aware of these issues, please take it upon yourselves to contact our district trustee or any one of your local executive board members and delegates. If you are at odds with the current direction of the ADA or the NDA, your opinions are great, and we would love to hear from you and have you get involved. It is easy to sit and be an armchair quarterback, more difficult when you are in the game and see what is around you. You are more effective when you are in the game than on the sidelines, that is why membership is so powerful.

This summer we will have our annual meeting where our NDA leaders will plan a strategy for growth. In the fall and winter, we will have our monthly NNDS meetings; these are great resources for keeping up with our profession and seeing new and old friends. If you haven't attended for a while, take this as a personal invitation to come; we would love to have you. I know your executive board, delegates, and Lori Benvin have been working hard to make this a fantastic year.

As they say information is power, and the more you know and the more your patients know how you are taking care of them, the better off we all are. Our profession will continue to change, make sure you have a hand in helping it grow in the direction you want it to. ◆

NNDS 2011 Save the Date

All of our events are updated on our website at www.nndental.org.

August 4: NNDS Open House BBQ, *Bartley Ranch Park, Reno.* Bring your families!

August 27: Jason Eberle 3rd Annual Memorial BBQ & Concert, *Bartley Ranch Amphitheater, Reno*. A benefit concert for the Northern Nevada Dental Health Program (NNDHP).

September 1: NNDS Annual Spouses/Guest Night, *Reno Aces Baseball Club, Reno*. Theme "Take me out to the Ballgame."

September 23: 9th Annual NNDHP/Joel F. Glover Charity Golf Tournament, *Somersett Golf & Country Club, Reno.*

NORTHERN NEVADA
DENTAL HEALTH PROGRAM

NINTH ANNUAL JOEL F. GLOVER, DDS

CHARITY GOLF TOURNEY

PLACE:
SOMERSETT GOLF & COUNTRY CLUB

DATE:
FRIDAY, SEPTEMBER 23, 2011

BBQ LUNCH:
10:30 A.M. TO 12:00 P.M.

TEE TIME:
12:00 P.M. SHOTGUN START

FORMAT:
SCRAMBLE, MULLIGANS AVAILABLE
(NO DENIM, COLLARED SHIRTS, PLEASE.)

FEES INCLUDE:
LUNCH, HOSTED BEVERAGE BAR, DINNER*, RANGE BALLS AND GOLFER'S GIFTS

*NON-GOLFERS THAT WISH TO JOIN A FAVORITE GOLFER FOR COCKTAILS AND DINNER MAY PURCHASE A DINNER TICKET FOR $40 PER PERSON.

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Calendar of Events

AUGUST–NOVEMBER 2011

August 2011

Thu. 4	NNDS Open House BBQ	5:00 PM	Bartley Ranch Park, Reno
Fri. 5	*SNDS presents:* CE Seminar—Infection Control	9:00 AM	Gold Coast Hotel, Las Vegas
Tue. 9	NNDS Executive Committee meeting	5:30 PM	161 Country Estates Cir, #1B, Reno
Wed. 10	SNDS Health and Wellness Committee meeting	*Contact SNDS office at 702-733-8700 for time & location*	
Wed. 17	SNDS Peer Review Committee meeting	*Contact SNDS office at 702-733-8700 for time & location*	
Tue. 23	SNDS Executive Committee meeting	6:00 PM	SNDS office, 8863 W Flamingo Rd Ste 101, Las Vegas
Sat. 27	3rd Annual Jason Eberle DDS Memorial Concert & BBQ	5:00 PM	Bartley Ranch Amphitheater, Reno

September 2011

Thu. 1	NNDS Annual Spouses/Guest Night Dinner	6:00 PM	Reno Aces Ballpark
Tue. 6	NNDS Executive Committee meeting	5:30 PM	161 Country Estates Cir, #1B, Reno
Tues. 13	SNDS Community Night!	5:30 PM	Gold Coast Hotel, Las Vegas
Wed. 14	SNDS Health and Wellness Committee meeting	*Contact SNDS office at 702-733-8700 for time & location*	
Wed. 21	SNDS Peer Review Committee	*Contact SNDS office at 702-733-8700 for time & location*	
Fri. 23	NNDHP/Joel F. Glover Annual Charity Golf Tournament	12 NOON	Somersett Country Club, Reno

October 2011

Tue. 4	NNDS Executive Committee meeting	5:30 PM	161 Country Estates Cir, #1B, Reno
Thu. 6	NNDS General Membership Dinner meeting	6:00 PM	The Grove at SouthCreek, Reno
Mon. 10 *through* **Thur. 13**	ADA Annual Conference	Mandalay Bay, Las Vegas	
Wed. 21	SNDS Peer Review Committee meeting	*Contact SNDS office at 702-733-8700 for time & location*	

November 2011

Tues. 8	SNDS Member Dinner meeting	5:30 PM	Gold Coast Hotel, Las Vegas
Tue. 8	NNDS Executive Committee meeting	5:30 PM	161 Country Estates Cir, #1B, Reno
Wed. 9	SNDS Health and Wellness Committee meeting	*Contact SNDS office at 702-733-8700 for time & location*	
Thu. 10	NNDS General Membership Dinner meeting	6:00 PM	The Grove Event Center at South Creek, Reno
Wed. 16	SNDS Peer Review Committee meeting	*Contact SNDS office at 702-733-8700 for time & location*	
Fri. 18	*SNDS presents:* CE Seminar—Dr. Paul Homoly	9:00 AM	Gold Coast Hotel, Las Vegas

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