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# JOURNAL

FALL 2003

VOLUME 94

ISSUE 2



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**MEMBER PUBLICATION  
AMERICAN ASSOCIATION OF  
DENTAL EDITORS**

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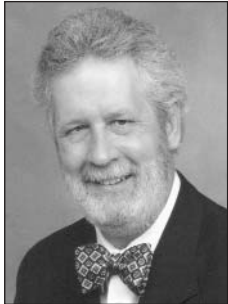
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*Early Photograph depicting a young patient being treated.*

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## Public Relations in the Twenty-first Century



By Dr. Stephen Glenn

Beginning in September of 1996, the Oklahoma Dental Association embarked on an aggressive campaign to inform the citizens of the state as to the importance of good oral health and the value of seeking dental care from

members of the Association. With the help and assistance of Jordan Associates, we produced and aired a series of television infomercials and public service announcements. That was followed, over the ensuing years, by other messages transmitted by radio, newspaper advertisements and inserts, billboards and even restaurant placemats. In fact, our partnership with Braums has been a resounding success in reaching children and their parents. Over the past seven years, the ODA has invested some serious money in telling our story to the public.

As successful as the program has been, it has not been without its critics. The yearly assessment appearing on the dues statements of members made many pause before writing the check. There was confusion among the membership as to the actual purpose of the effort. Were we trying to entice more patients into our chairs or were we really just trying to fulfill our public obligation to educate the citizens of the state about the benefits of good oral health? On several occasions I attended a meeting of the House with the premonition that the Delegates would no longer support the PR program and, on each occasion, I walked out of the House both surprised and pleased that the PR program was intact. Regardless, the program has been continually buffeted by the feeling that it had "run its course" and lacked sufficient budget to be truly effective.

The Council on Dental Education and the Subcouncil on Public Relations have proposed a bold redirection of our PR Program. Our ongoing contract with Jordan Associates will be terminated

and we will utilize their services on an "as needed" basis for specific projects. Many of the functions they have provided will be moved "in house" and a new staff position is being created to oversee our public relations efforts as well as our website development and maintenance. The Council realizes that in today's world, when individuals need information, the first place they look is on the internet. Newspapers were the best way to disseminate information in the late nineteenth and early twentieth centuries, followed by radio, billboards and television as the twentieth century progressed. But the digital age has changed all that and if the Association wants to get its message out, we must assure that message is available on the web. Trust me, those who benefit by spreading misinformation about amalgam safety or fluoride have their information available on the web. We must act!

To emphasize this new direction and focus, the Public Relations Program has been renamed the Public Information Program. Your for-profit subsidiary, ODASCO, has provided the resources to develop a truly state-of-the-art website and the Council plans to provide access for both the public and the profession. Our colleague and perennial workhorse, Raymond Cohlma, has laid a tremendous foundation for this effort, but no single volunteer can devote the energy required to bring this dream to fruition. We envision a website where the public can access a "Find a Dentist" directory or, utilizing hyperlinks, find answers to questions about their oral health and treatment options. There are already plans for interactive sections that can be utilized in classrooms across the state. On the professional side, members will be able to preview a calendar of events and agendas, register online, post announcements, and chat online. Beyond tremendous savings when compared to past PR efforts, we will now have the tools to effectively deliver our message in the twenty-first century. ●

# editor's message



By Dr. David B. Shadid

Every day dentists encounter patients who require quality care with compassion. For the most part we do a very good job of delivering this care and patients leave our offices with a

renewed confidence in the dental profession. What happens though when dentists witness restorative work they consider substandard? Too often, we use negative language that can change a patient's perception of us or their previous dentist.

What can we do to prevent this negative language from creeping into our treatment rooms? It is very simple. Think before you speak. Have you ever heard a plastic surgeon say your scar is ugly? Of course not, they always say the scar needs revision. Have you ever heard a cardiac surgeon say the prosthetic valve they placed is failing? No, they say the valve needs reevaluation. Additionally, I am sure you try to avoid the word pain in your practice by using the word discomfort. Now of course these are very generalized examples, but I'm sure you are beginning to get the idea.

Each time you think a negative thought and it is on the edge of your tongue waiting to reveal its ugly head, stop and think, "Is this something I really want to, or need to, say?" How will my statement impact the treatment I would like this patient to have? Remember, if you are critiquing someone else's work, then someone is most like-

ly critiquing yours. You should also remember that you don't know the circumstance under which the treatment was rendered. Perhaps there were underlying factors that made it difficult if not impossible to achieve a perfect result.

I believe we have a duty to the public to perform a thorough exam, explain our findings, and inform the patient of their treatment options. I don't believe we have to degrade our colleagues, or our profession, while doing so. Most of the complaints that are heard by peer review are a result of negative language because we think we are better than all the rest. Remember, no one wakes up in the morning thinking he or she will have a deleterious outcome on purpose. Things happen and it is our job to limit the number of negative outcomes while increasing the number of positives. I once heard it said, "you win some and you lose some, but in the end you hope you won more than you lost".

The next time you have a chance, let a patient know they have quality dentistry in their mouth by commending your colleagues or yourself. However, if by chance the work is not quite perfect or your own work needs some revision, remember the positive words you could use to express yourself and let the negative words get lost in your pride. Heck, if you give yourself a chance, you might even go home with a smile on your face and a spring in your step, all because you let a little positive attitude creep into your subconscious. Now go out there and make dentistry a better profession. ●

# a time to shine... in Oklahoma ODA Meeting 2003

Thanks for all of the hard work to Dr. Mark Hanstein and his committee. The Exhibit Hall was a place full of interest and activities. Thermo-guard™ nightguards, Vitallium 2000™ partials with Esthetic clasps, implants and Flud's UCLA-trained technicians for the Reliance® Captek™ restorations were some of the main topics of discussion. Education, food, drink, entertainment and camaraderie, who could ask for more? What a wonderful time to see all of the old friends and make new friends. DENPAC's annual silent auction was a big success...a lot of fun for a good cause. Thanks to everyone for supporting the Oklahoma Dental Association.

Winners of the door prizes at the Flud Dental Laboratory Booth were:

- Dr. C. H. McKee – Romeo's Italian Express  
Dinner and Dessert
- Dr. Alan McQuigg – Triad Material Kit
- Dr. Steven Strange – Linkmax Cement Kit
- Dr. Pragna Suthar – Captek Burr Kit
- Dr. Floyd Sellers – All Ceramic Prep Kit
- Dr. Ron French – All Ceramic Prep Kit
- Dr. Raymond Clock – Membership in the  
Ritz/Wolf Frequent Foto Club
- Dr. George Bussman - Frequent Foto Club
- Dr. Mike Howl – Frequent Foto Club
- Dr. Mike Shepherd – Frequent Foto Club
- Colleen McFarland – Frequent Foto Club  
(Dr. Gene McCormick's office)



**Bill Hooper, Flud Denture Manager, and Dr. Floyd Sellers ... now where are we going for that steak?**



**Bill Hooper, Mike Johnson, Flud Partial Manager, and Jay Elder, CDT, Flud Partial and Laser specialist congratulate Dr. Steve Glenn, new ODA President, as he explains all those ribbons.**



**Sammy Newcomb Wolohon, Flud Marketing/Customer Service Director and Dr. George Bussman discussing that he can't retire because Bill Hooper is still working.**

Special thanks to **Colleen Elder, CDT, Flud's Massad Denture Specialist** for her photo contributions.



**Flud Dental Laboratory  
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mission of mercy

# *You Can Make A Difference*

By Dr. Jeffrey Pierce

I was asked to volunteer my services for a few days of free dentistry by a friend and colleague, Dr. Richard Stein. Initially, I was reluctant because it sounded like more work than I was willing to do, especially since it would occur during my regular days off. However, as the time approached I became more intrigued and curious about the whole idea. After much discussion (and arm twisting) with Dr. Jeffrey Stasch, co-coordinator, I became excited with anticipation of what would lay ahead.

Not knowing exactly what to expect, I loaded a mobile cabinet with everything I could think of in order to perform "simple" dentistry. Composite gun, check; amalgam kit, check; anesthetic, check; gloves, masks, handpieces, check; and the list went on as you can imagine.

My pickup packed with supplies, I headed from Alva, OK to Garden City, KS, the site of the very first "Kansas Mission of Mercy." The first morning began for me at 5:30 a.m. as I cleared 7 inches of snow from my pickup which fell during the night. A quick breakfast, then on to the fairgrounds where check-in time was 6:00 a.m. With more snow falling, I was greeted by a line of hopeful patients at least 300 strong. I was told they began arriving at 2:00 a.m., standing outside the locked building to be assured a spot in line. A brief description of how things would hopefully take place and a quick pep talk was given by Dr. Stasch. I was shown to a M.A.S.H.-style operator, set-up, and by 7:00 a.m. the handpieces were singing and patients began flowing like a river. At 1:00 p.m. I stood up and went to lunch provided by local churches. As I left the chair, another dentist sat down. Over 60 dental units were in continual operation from 7:00 a.m. until 5:00 p.m. Over 100 dentist volunteers provided extractions, fillings, dentures, and even a few root canals,

while 75 hygiene volunteers performed cleanings and fluoride applications. In excess of 600 volunteers came together for three days in S.W. Kansas to provide dental treatment for 1,734 patients. An estimated \$300,000 worth of services were provided on an initial budget of \$75,000. These services were provided on a first come, first serve basis, with no regard to income, immigration "status", or other such factors. The line of hopeful patients had to be cut off on Saturday. For those who had a number but didn't get screened on Saturday, they returned on Sunday for treatment. Needless to say, I was one tired fellow at the end of this "KMOM." But wow, what a feeling to be able to help people without worrying about overhead, insurance coding, collections, billing, etc. I don't even remember worrying whether or not the patient sitting in front of me had signed my HIPAA compliance form. I understand most of you reading this article have had many experiences which probably dwarf mine. I would like to encourage those who have kept saying to themselves "I'll do that mission trip later in my career," to jump at your next chance. The rewards are far more than financial. I can't begin to tell you how wonderful it was to provide dental services to citizens of the United States. The heartfelt "thank you's" I received from the patients was all the reward I needed. I have heard many of you tell of your own experiences, but I could not put a measuring stick to the amount of joy in your voices until I experienced it myself. I would like to thank Dr. Jeffrey Stasch and Dr. Jon Tilton for having the vision to bring this concept to the central plains of Kansas and a special thanks to Dr. Richard Stein for the invitation. When the opportunity knocks on your door, I hope for your own sake you welcome it in. ●

your health

# Ten Commandments

for communicating with persons with disabilities

*The following information is from the Axis Center For Public Awareness of People with Disabilities.*

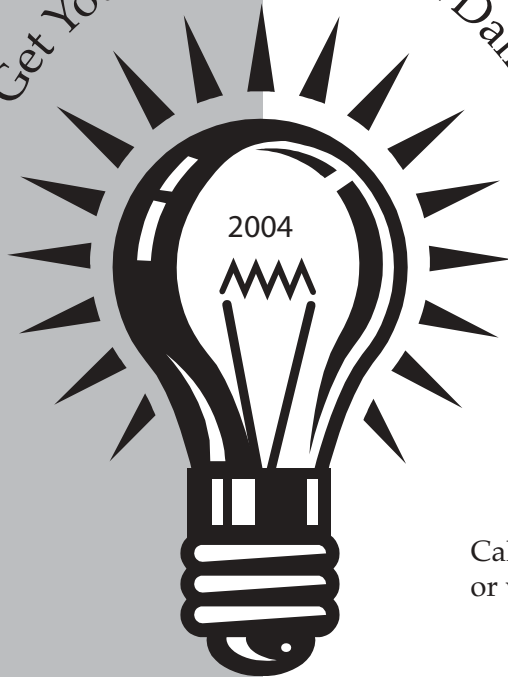
1. When talking with a person with a disability, speak directly to that person rather than through a companion or sign language interpreter who may be present.
2. When introduced to a person with a disability, it is appropriate to offer to shake hands. People with limited hand use or who wear an artificial limb can usually shake hands. (Shaking hands with the left hand is an acceptable greeting.)
3. When meeting a person with a visual impairment, always identify yourself and others who may be with you. When conversing in a group, remember to identify the person to whom you are speaking.
4. If you offer assistance, wait until the offer is accepted. Then listen to or ask for instructions.
5. Treat adults as adults. Address people who have disabilities by their first names only when extending the same familiarity to all others present. (Never patronize people who use wheelchairs by patting them on the head or shoulder.)
6. Leaning or hanging on a person's wheelchair is similar to leaning or hanging on a person and is generally considered annoying. The chair is part of the personal body space of the person who uses it.
7. Listen attentively when you're talking with a person who has difficulty speaking. Be patient and wait for the person to finish, rather than correcting or speaking for the person. If necessary, ask short questions that require short answers, a nod or a shake of the head. Never pretend to understand if you are having difficulty doing so. Instead, repeat what you have understood and allow the person to respond. The response will clue you in and guide your understanding.
8. When speaking with a person in a wheelchair or a person who uses crutches, place yourself at eye level in front of the person to facilitate the conversation.
9. To get the attention of a person who is hearing-impaired, tap the person on the shoulder or wave your hand. Look directly at the person and speak clearly, slowly and expressively to establish if the person can read your lips. Not all people with a hearing impairment can lip-read. For those who do lip-read, be sensitive to their needs by placing yourself facing the light source and keeping hands, cigarettes and food away from your mouth when speaking.
10. Relax. Don't be embarrassed if you happen to use accepted, common expressions that seem to relate to the person's disability, such as "see you later" or "did you hear about this?"

For information concerning people with disabilities, call, write or fax:

AXIS Center for Public Awareness of People with Disabilities  
4550 Indianola Ave., Columbus, Ohio 43214  
614.262.8124 (V/TTY);  
800.231.2947 (V/TTY);  
614.267.4550 fax

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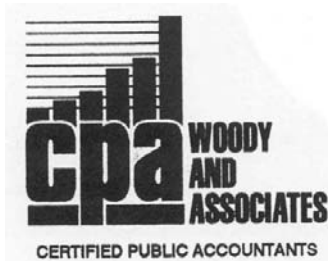
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# oda new employees

*We would like to welcome our two newest employees. Amber Begay and Kristina Awbrey have recently joined the ODA staff.*

**Amber Begay** joined us in August 2003. She recently graduated from the University of Oklahoma in Norman where she received her Bachelors degree in Political Science. Amber was born in Lawton, Oklahoma but was raised in Fort Collins, Colorado where her parents live. Being *Sooner* born and *Sooner* bred is what led her to Norman and now she has no desire to leave. In her spare time, she is actively involved in her local church and spends time painting, sewing, cooking, and reading.



From the very start, Amber has been busy helping as an integral member of the ODA team. Recently, she assisted with the ODF annual meeting and has been involved in creating the Board of Trustees and House of Delegates agenda books. She is learning the

Mediation Review process, ODA organizational structure, and serving as an assistant for Shelly Murphey, Kay Mosley, and Guillermo Gallegos.

Amber would like to thank everyone for their help in making the transition a memorable one. She has felt welcome at every event and looks forward to working with everyone.

**Kristina Awbrey** joined us in October 2003. She is a recent Oklahoma City University graduate with a Bachelors degree in mass communications and psychology. She is also a current MBA Marketing student at Oklahoma City University. Kristina is originally from Yukon, Oklahoma where her family still resides. When she is not consumed with work at the ODA, she enjoys spending time with friends, cooking, playing sports, and relaxing.



Kristina is not new to association work. She was the part-time communications assistant at the Oklahoma Bankers Association. Kristina's ODA duties include: working on the journal and maintaining contact with advertisers, annual meeting exhibits and scientific

speakers, government relations and committee work, and some of the many details that are incorporated with these areas.

Kristina would like to thank the entire ODA staff, editorial board, and journal contributors for giving such a warm welcome and continuing to be understanding through this transitional period. ●



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# New Tax Law Offers Significant Tax Savings: Section 179

The Jobs and Growth Tax Relief Reconciliation Act of 2003 ("the Act") provides federal income tax relief to almost all taxpayers. It is the third time in three years that Congress has passed a major tax cut package, and this time, the bill was passed without any offsetting tax increases. Several of the provisions should be beneficial to dental practices, including the increase in Section 179 expensing.

Section 179 of the Internal Revenue Code allows taxpayers to make an election each year to expense the cost of qualifying depreciable property used in a trade or business. The deduction is in lieu of depreciating the property over time – generally five to seven years. This election is available regardless of the legal structure of the trade or business. It is available to corporations and pass-through entities as well as sole proprietorships. However, there are several limitations regarding the election.

The first limitation addresses the dollar amount that can be expensed each year. Before the passage of the Act, the limit for property placed in service during 2003 was to be \$25,000. The Act raised the limit to \$100,000 for property placed in service during 2003.

(If an individual taxpayer has interests in multiple trades or

businesses that are conducted as sole proprietorships or pass-through entities, the \$100,000 limit is for his or her share of property placed in service during the year for all such trades or businesses.)

The second limitation addresses a further cap on the amount that can be expensed each year. The dollar amount allowed is phased out dollar-for-dollar as the taxpayer's cost of qualifying property acquired during the year exceeds a specific amount. After the Act, this limit is \$400,000 for 2003. Accordingly, a taxpayer may elect to expense the full \$100,000 if the total qualifying property placed in service during the year is less than \$400,000.

A third limitation deals with the taxable income of the taxpayer. The amount that can be expensed each year cannot exceed the taxable income derived from the active conduct of any trade or business for that year. However, to the extent that the taxpayer has elected an amount in excess of this taxable income limit, the excess is carried forward to the subsequent year.

What property qualifies for this expensing election? Generally tangible personal property such as equipment and machinery qualifies for the election. Unlike property qualifying for the newly expanded bonus

depreciation, the property can be new or used. Under the Act, off-the-shelf computer software also qualifies beginning in 2003. Much has been reported in the media about certain vehicles qualifying for the election. Vehicles used in a trade or business that weigh in excess of 6,000 pounds (large SUV's) may also qualify for the election.

One thing to keep in mind regarding the expensing election is that the election must be made on the taxpayer's original return for the year, and the qualifying property must be identified on the tax return. This is accomplished by properly completing Form 4562, "Depreciation and Amortization" and filing it with the appropriate tax return for the business. If the property is improperly identified in the tax return as "supplies", for instance, upon audit, the IRS could deny a late expensing election.

As more and more individual taxpayers are subject to Alternative Minimum Tax ("AMT"), it should also be noted that Section 179 expensing does not create any type of individual tax preference for AMT.

The above outlines the new Section 179 expensing provisions effective for 2003. This section of the new law offers significant tax savings opportunities

*Continued on Page 12*

**Section 179...** *Continued from Page 11*

for most dental practices, and we recommend that you consult your professional tax advisor to determine the applicability of these rules to your specific tax situation.

*Disclaimer: The ODA & its officers recommend you check with your qualified tax accountant or advisor before implementing any of these practices.*

By Natalie Bonney  
Certified Public Accountant/Shareholder  
Bonney, Percival and Sheets  
A Professional Corporation. ●

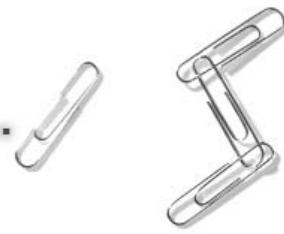
## In Memoriam

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Birth: January 6, 1923  
Death: May 18, 2003  
Tulsa

Tom Waters, DDS  
Birth: July 17, 1927  
Death: June 10, 2003  
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James Hooper, DDS  
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4322-K (3/03)

# oda news

## Membership Highlights

### DENTAL PROFESSIONAL LIABILITY INSURANCE

The malpractice insurance market has been in a state of turmoil since late 2000. When speaking of medical malpractice insurance, one does not readily think of dental, however, the insurance industry seems to place all health care in one large category. To a certain degree, deserved or not, dental is declared to be "guilty by association".

Not since the 70's have the national news media devoted so much attention to the subject of insurance. There have been featured reports in the evening news, as well as the Wall Street Journal, USA Today and most major newspapers. Major publications such as Time, Forbes, and US News & World Report have featured insurance. Physicians organized demonstrations in support of tort reform in several states.

Soaring judgments and settlements have caused significant deterioration in many carriers' results. Policies were underpriced during the competitive market of the 90's and coupled with inflationary rises in losses plus falling investment returns, malpractice insurance is the worst performing line of property/casualty insurance. In 2002 insurers paid out \$1.40 for

every \$1.00 received in medical malpractice premiums.

Dental carriers such as St. Paul, Reliance, Safeco, Gulf, Frontier, SCIPIE, TIG, Philadelphia and Kemper have withdrawn or are no longer in business. Several carriers have received ratings downgrades by A.M. Best and Standard and Poors.

Dental Professional Liability premiums are increasing but not at the level of physicians. Competition continues to keep Dental Professional Liability rates in line. You may see additional companies restrict writings particularly in traditionally unprofitable states.

However, unlike hospitals and physicians, dentists are a desirable class for a few carriers. A few years ago there were two principal markets, CNA, through Brown & Brown, and Medical Protective. Brown & Brown was the leader through selected administrators in each state. The soft market introduced new underwriting players and many Brown & Brown administrators defected to Fireman's Fund, Medical Protective, Cincinnati, Kemper and Safeco. Since the withdrawal of Safeco and Kemper, Fortress has become a major participant. The ODA endorses the Fortress program administered by Alexander & Strunk.

Nationally, we think Medical Protective is the leader in num-

ber of dentists insured with CNA second. Fireman's Fund is probably third. Fortress and its parent, OMSNIC, may be the second largest dental professional liability insurer when comparing total premiums. Nationally, OMSNIC insures the vast majority of oral surgeons. In Oklahoma, Fortress is the leader with approximately 1200 dentists insured.

The Fortress claim service is excellent, their Oklahoma premiums are among the lowest in the nation, and it offers a fine Risk Management program.

This segment of the insurance industry appears to have stabilized a great deal. However, since this business is cyclical there will continue to be changes and you will see inflationary rate increases. The fact that one carrier dominates the business in Oklahoma is a tremendous benefit to our members when negotiating rates.

Other insurances offered by the ODA:

- Business Office Protection
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- Long Term Disability
- Health Insurance
- Life Insurance
- Home & Auto
- Long Term Care ●



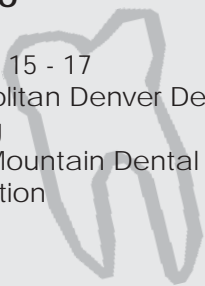
# QUARTERLY CE CALENDAR



## Arizona

November 1  
American Academy of  
Maxillofacial Prosthetics  
Annual Scientific Session  
Scottsdale

## Colorado




January 15 - 17  
Metropolitan Denver Dental  
Meeting  
Rocky Mountain Dental  
Convention  
Denver

## Hawaii

January 15 - 17  
Hawaii Dental Association  
The Hawaii Meeting  
Honolulu

## Illinois



December 3 - 7  
American Academy of Oral &  
Maxillofacial Radiology  
54th Annual Session  
Chicago

## Massachusetts

January 29 - February 1  
Massachusetts Dental Society  
Yankee Dental Congress  
Boston

## Minnesota

December 12  
Minneapolis District Dental  
Society  
Annual Mid-Winter Dental  
Meeting  
Minneapolis

## Missouri



January 16 - 17  
Missouri Dental Association  
MDA Winter Session  
Columbia


## New York

November 28 - December 3  
Greater New York Dental  
Meeting  
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## Texas

January 8 - 10  
Dallas County Dental Society  
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# Helping People Change:

## *The Magic of Motivation*

By Cathy Jameson, Ph.D.

Change is an inevitable part of a growing, progressive dental practice. But change is not always easy – and not always greeted with open arms. The following article integrates excerpts from live interviews with doctors throughout the country into my personal doctoral research on the subject of motivation, change, and communication.

Why this article? Because, almost every doctor with whom I speak asks the question, “How do I motivate my team?” And so, here is a treatise developed from research on the subject as well as recommendations from top clinicians.

### **Becoming a Change Agent**

As the leader of your organization, you are interested in the continuous improvement of your practice. You have the responsibility of leading your team to accomplish improvement goals. Therefore, you are a change agent – a helper, so to speak, for people involved with the change associated with growth and development.

### **Motivation and Communication: Their Effect on the Change Process**

One of the greatest challenges

in today’s practice is communicating effectively so that motivation is an end result of working together. Are motivation and communication connected? Does the way one communicates impact employee motivation?

Motivation has been and continues to be a challenge for organizations and their managers. The concept of motivation is defined as a “personality dimension, which occurs as an inner drive or need that leads to sustained effort toward a specific goal”. (Anderson, 1988) In most cases, the managers within an organization are held accountable for the performance of the people within their area of responsibility.

Managers believe that motivation is critical if increases in employee performance and productivity are to result. (Maynard, 1996)

In their study of employee motivation, Kay and Cristophel (1995) focused on the influence of managers’ communication on motivation. Two questions were studied by the researchers: (1) “What is the relationship between manager communication openness, manager nonverbal immediacy, and employee motivation? and (2) Is a manag-

er’s communication openness and nonverbal immediacy directly related to employee motivation, or does one or the other act as a mediating variable?”

Communication openness, for the purposes of this study, was described as “extroversion, approachability, disclosiveness, trusting, and reciprocity in interpersonal interactions”. (Rogers, 1987) Nonverbal immediacy was defined as “the degree of perceived physical and/or psychological closeness between people.” (Mehrabian, 1967)

Managers, who were more open with their communication and whose nonverbal immediacy supported their communication, provided a motivational environment for subordinates. The managers who provided openness in their communication were able to solicit more information from subordinates. The subordinates who perceived the manager as more open indicated a greater degree of motivation to solve their interpersonal conflict with the other subordinate. The data of this study, which is supported by past research, indicates that “openness is an important variable in determining constructive

organizational outcomes and, when practiced, communicative openness is a relatively stable communication behavior that will enhance positive subordinate effect.” (Kay, 1993)

In addition, positively reinforcing the person for taking steps forward on his/her path to change has been proven time and time again to be a strong and empowering motivator. Recognizing work well done and acknowledging the individual and members of the group has a profound and long-lasting impact on continuous improvement. Positive reinforcement has been and remains a strong encourager of change and of improved performance. (Walsh, 1994)

Translated to dentistry, this means team member to doctor, doctor to team member, and team member to team member. In order for people to accept change and enthusiastically approach the recommendations we provide, they must “want” to take the necessary steps. They must be motivated to change. Therefore, ability to communicate openly and effectively is a critical factor in the role as helper in the change process.

### **Overcoming Resistance to Change**

Trying to motivate your team to change may generate frustration. Resistance to change is not unusual. Most people who are change agents realize that “they can better assist other people toward effective, ‘independent

functioning’ only by helping people to help themselves.”

“Independent functioning” comes when team members are motivated to change, implement the change, and maintain their “new ways” without dropping back to the “old ways”. In order for this type of motivation to occur, the following steps must take place:

1. An environment conducive to and accepting of change and improvement is established by the helper (doctor).
2. Vision of the effects of the change is established and goals are clearly set.
3. Instruction of the new systems is given.
4. Team members are encouraged to take the necessary steps to accomplish the new goals. (Kanfer and Goldstein, 1991)

Let’s look at these four steps one at a time.

#### **(1) An Environment Conducive to Change**

As a change agent, the following insights will be helpful.

(I) Many behaviors are not observable. Some of your team members’ intimate feelings, apprehensions, embarrassments, and fears are deeply hidden. Only when confident and effective communication occurs between team member and helper/doctor can progress begin.

(II) Changing present behavior or changing a present “way of doing things” is difficult and oftentimes perceived to be unpleasant. The seeking of pleasure or the elimination of pain motivates behavior, and certain-

ly change. Many team members are motivated by the vision of positive change, growth, development, and the pleasure that comes from these changes. Others are motivated by the hope of relieved pain.

(III) Some team members want relief from discomfort or conflict, but they want this result without having to alter their own behavior. This, of course, cannot happen. In an environment/relationship with this type of “expectation gap”, failure or disappointment is inevitable. (McNerney, 1996)

The process of any change whether that be a clinical/technique change or a managerial change must be clearly outlined. In addition, the benefit of the change and of new goals is mandatory. Only when the team members and doctor are working cooperatively toward the same goals can success be realized. Obviously, an environment conducive to change is critical.

Dr. Steven Hutt, of Wycoff, NJ says: “Change is a must. Changes in technology, treatment modalities, materials, management, etc. are changing the entire face of dentistry – rapidly! If a doctor expects everyone on his/her team to have the same goal and be working toward that goal, then everyone must know what’s going on. Education within the practice sets the tone for continuous change and development.”

Dr. Chuck Puntillo of Burlington, Wisconsin understands the value of helping his team members accept change.

"Our practice is constantly in a dynamic state. It is a challenge that we accept. I've tried to create an environment where change is not only accepted, but where people are excited by it rather than afraid of it. Even if there is great apprehension, if we believe the change will be beneficial, we go for it. Then, we celebrate the success. That success motivates us to search for new and better ways of doing things."

"Change is absolutely inevitable whether we want to admit it or not," reflects Dr. Bill Griffiths of Beaverton, Oregon. "If we are not willing to change, everything will pass us by. We may feel that we are on the 'cutting edge' but if we become complacent and think that we have 'arrived', that thought process becomes detrimental. Commitment to change and progress has to be burning within the dentist before team members enthusiastically embrace change. If the doctor is wishy-washy about change, that sends mixed signals to the staff that say remaining status quo is OK.

When you, as the leader of the dental team, have to make decisions, get committed to those decisions and don't falter. The team will stand behind firm decisions that are backed up with reason and validation."

When asked what motivates her team members, Dr. Julie Stelly of Plano, Texas, a thriving community north of Dallas, responds as follows: "We have moved to being more progres-

sive in our practice – in both the clinical and the management aspects of the practice. We are offering a complete package of dentistry to patients – more comprehensive diagnosis, treatment planning, and presentation. We involve every team member from beginning to end with the flow of patient treatment.

Everyone can see the total picture about how a patient is going to be treated. Everyone sees his or her importance in the patient's experience and in treatment acceptance. We're not interested in how many patients we can see in a given day, but rather how much quality dentistry we can do in a given day – how we can better serve our patients.

This is so motivational to our team members. Each person knows his/her role and knows how important it is. We need every person to best treat our patients. We empower team members to make each patient visit the very best experience possible. From this, they feel a sense of pride in themselves and in the practice."

Dr. Stelly goes on to say, "The day of the dentist being placed on a pedestal and the team members cowering to the dentist are over! Thank goodness. Team members feel better about what they are doing and better about themselves. As a doctor, I love this empowerment of responsibility. Delegation becomes a relief to me. It lets me, as the doctor, focus on the clinical aspect of dentistry. I

don't have to micromanage everything. "

## (2) Vision is Established and Goals are Clearly Set

One of the characteristics of an outstanding leader is to know the goals of the members of the organization and to help those team members accomplish their goals. In an environment where people know that their own goals are valuable and where they feel supported in accomplishing their goals, energy and enthusiasm thrives. People who feel thus supported will be more likely to support the goals of the team and the goals of the practice.

Says Dr. Mark Bilello of Houma, Louisiana, "I have tried to help my team visualize the benefits of the changes we have implemented. First, I had to figure out what I wanted. I had to develop a clear vision and be committed to the goal of realizing that vision.

I always make sure that the team members know what's in this for them. We work hard on establishing a specific vision of the benefits. I know that behavior is driven by 'what's in this for me?' So, I try to help people see that the change is not only good for the patients and for the practice – but, ultimately good for them, too."

"The first step in motivating team members to accept change is to establish the vision and to present it to the team so CLEARLY that all team members are definite about the path you are taking. This is the

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essential first step – even if that takes a while. Model that vision with your standard of care. Then have the team work together to establish goals so that everyone knows how you will go about reaching that vision,” according to Dr. Griffiths.

Each of the areas of your practice needs to have goals and the ability to track the goals, evaluating on a regular basis through meetings and reviews. These meetings, along with performance reviews, lets you know if you are on path. Then you can reward yourselves with pats on the back when things go well and alter things when necessary. And, certainly, rewards can be given—rewards for the work well done.

The achievement of excellence far exceeds all other motivators. Empower team members to be leaders within their own area. Nurture their sense of responsibility and the self-esteem that comes from being trusted to carry out tasks. Clarity of expectations and being rewarded for excellent performance develops a sense of co-ownership and pride in the practice.

Dr. Puntillo agrees that the first step of progress in practice development is clarity of goals and expectations. “In my practice, we write down our goals – all things we would like to get done. Then we prioritize those goals. Even goals about equipment purchases; what do we want; what pieces of equipment

are of highest priority; how will we make the equipment pay for itself, and so on. This is done as a team.

We find that goal setting is one of the most motivational things that we do as a team. Every year we sit down with our consultant and review last year’s goals and set new ones for the upcoming year. Throughout the year, we evaluate our progress. Are we on course? Are we off course? If we are off course, we do what is necessary to get back on course.

We are always motivated to see that we are able to accomplish goals. This gives team members a sense of accomplishment and pride.”

“Including team members in the decision making process and including them in setting goals for the practice is the best way to help people accept change and to motivate them to be enthusiastic about building the practice,” says Dr. Bilello. “This makes the team members feel a part of the practice.”

When asked how his team goes about the goal setting process, Dr. Bilello provides the following description:

“Each team member establishes individual goals – personal goals that they would like to achieve in the practice, as well as team goals. We review the goals together. We become aware of what each person wants to accomplish in his/her career in dentistry, as well as what they want to accomplish in our practice. Then, we compile the team goals and develop

a strategic business plan of how we intend to accomplish those goals.

Dr. Bilello goes on to say that “Goal setting helps with communication. It really helps to know what motivates the individual members of the team. Then, other team members can help make those goals really happen. It eliminates a lot of the guessing. Being clear about expectation eliminates a lot of inaccurate assumption.”

Dr. Stelly believes that “The team has to know the goals. Then and only then can you celebrate the victories. Then and only then can you know if you are on or off course. We want our team to know the numbers of the practice. We have taken the shroud of secrecy off our practice. That has been detrimental in the past. If the team members don’t know the facts, they imagine things. But if they know the facts, they are more willing and able to stay on track.

We want to financially reward our team. Everyone knows that we have to work together to be able to do that. We have to share the numbers before we can move forward. This helps everyone keep a finger on the pulse of the practice. The team members feel more respected because we share the numbers. Energy and vitality have been a result of that sharing.”

### (3) Teaching of the Necessary Materials and Systems

Once goals have been determined and a specific plan of action has been put into place,

instruction and education must take place. Provide continuing education through courses or through in-office instruction.

All of the doctors interviewed attend continuing education courses together and individually each year. They say that continuing education builds not only the technical skills involved with task performance, but that they also nurture the "people skills" that are so critical to dental practice success.

All of the doctors interviewed engage or have engaged the services of a private practice management firm who comes to the office to work directly with the doctor, his/her team, and his/her practice.

Dr. Bilello comments, "It took someone coming into the practice to help us get the systems organized and integrated – really working in our practice. We had heard a lot of things in CE courses – but we needed a coach to come into our practice to help us make things happen."

"Staff meetings must be organized so that ongoing training and education are an ongoing part of sharing information," says Dr. Hutt. "The key to learning is repetition, repetition, and repetition. For example, everyone on the team from the clinical team to the management team must understand the benefits of treatment so that they can deal with patients' questions – and even their objections."

(4) Team Members are Encouraged to Take the Necessary Steps to Implement the Desired/Necessary Changes

Now, you have worked on and developed a clear vision of your ideal practice. You have done the following:

(1) Developed a definite vision of each patient's experience with you,

(2) Visualized the way team members will interact with each other, and

(3) Spent educational time on how the clinical and business systems will flow.

Once this vision has been clearly defined, once you have written specific goals, and once you have organized your practice so that each person on the team sees clearly where you are, then self-management and self-regulation becomes the path of power and progress.

As a leader and as the owner of the business, encourage your team members to become self-starters/self managers – people motivated to put the new learning into action. Self-management becomes time and cost effective – plus it reduces frustration and stress.

Examples of self management methodology are:

(1) modeling;  
(2) learning to analyze problems; and

(3) developing problem solving methodology.

These methods help individuals move toward more effective cognitive and interpersonal actions. (Kanfer, 1977) As a person becomes more independent, the role of the helper becomes one of support rather than one of dependence.

Self-management techniques have three main goals:

(1) to assist the person/team member to acquire more effective interpersonal, cognitive, and emotional behaviors;

(2) to alter the person's perceptions and evaluative attitudes of problematic situations; and

(3) to change a stress-inducing or hostile environment or to learn to cope with it by accepting that it is inevitable.

(Rothbaum, Weisz, and Snyder, 1982)

In order to understand the concept of self-management, consideration of the psychological processes that occur in self-regulation is relevant. Social learning theory is founded on the concept that many everyday occurring behaviors consist of a sequence of responses that have become automatic over time – one response occurring automatically as a result of a particular stimulus. Thus, stimulus-response. These automatic responses do not require serious contemplation or decision making. These responses are deeply seeded and are difficult to change. This classic, "I have always done it this way!" premise can get in the way of change.

When a doctor and team member determine that a change of behavior is in the best interest of the individual or practice, a "qualitatively different mode of cognitive functioning" called controlled processing initiates the self-regulation modality. Controlled processing requires focused attention on the necessary change of behavior or performance, continuous

decision making, or thinking through each step to make sure that the right choice is being made, and the unlearning of protocols that may have worked historically but no longer are effective.

"It is so easy to continue to be free-flowing in our habits and repeat old actions or thoughts even after we have consciously learned something new. 'Intellectual' learning has to filter down to automatic response through either repetition or emotional significance." (Grupe, 1993)

There are three distinct phases or stages within the self-regulation process: (1) Self-monitoring: deliberately attending to one's own behavior. In other words, monitoring and tracking what one is presently doing. (2) Self-evaluation: comparing these monitored behaviors to the desired goal or the desired outcome. In other words, what is one really doing in comparison to what one ought to be doing or what one wants to be doing. (3) Self-reinforcement: a person's cognitive and emotional reaction to the results of the self-evaluation. Self-reinforcement affects both the feedback – what are the strengths or weaknesses of past performance, and the feedforward – how will this evaluation affect or influence future performance?

The self-regulation model of self-management can be motivational for the individual when the present state of affairs is clearly defined; oftentimes they begin to seek a more desirable state. The motivation from this

evaluation comes from within the person and is more of a driving force than outside recommendations. The individual can begin imagining the result of altered behaviors and improved performance. This imagery can produce the vision that becomes the guiding force and the motivation necessary to access change. The imaged happenings are remembered in the mind as if the events had actually happened, and this can enhance a person's ability and willingness to actually carry out the actual behaviors. (Booth, 1997)

Training in self-management requires strong early support by the helper/consultant with the team member gradually relying more and more on the newly learned skills and on him/herself. The team member's new skills will include: (1) self monitoring – continuing to monitor predetermined goals and objectives, (2) establishment of specific modes of performance by establishing contracts with him/herself and with other members of the team, (3) accessing support from the team members, (4) self-regulation, as previously defined, and (5) developing significant reinforcement for excellent performance and for accomplishing goals.

How do doctors work toward the development of these self-management techniques?

### **Three Self Regulation Stages**

There are three self-regulation stages in moving team members and the practice to the next level.

(1) Self-monitoring: Have each

team member monitor his/her own position and performance. Monitor it, also.

(2) Self-evaluation: Determine where the practice and the individual team members are at the present time and where they would like to be.

(3) Self-reinforcement: Learn from the past performance. What has been working? What hasn't been working? What could be better, and how can you make that happen?

Once these three phases have been completed, a clear path of change and development can take place. Internal motivation becomes the driving force. Internal motivation is critical for constructive progress to be made. Motivation is unique and individual. "You can motivate some people – but others cannot be motivated," says Dr. Hutt. "Finding that motivated person can be difficult." Dr. Hutt's practice focuses on comprehensive restorative and enhanced aesthetics, and he understands how critical motivated team members are to his progressive practice.

When asked how he motivates team members, he refers to one of the three most effective self-management methodologies: modeling. "Modeling may be the most important factor in motivation. People model others. If people see and hear the same method repetitively and consistently, they become used to the new change. They begin to see the benefits of the change and the successes relat-

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ed to it. When people buy into the new and better way, they go to another level of personal management. With this elevation comes the ability to accept more."

Dr. Hutt also refers to another powerful self-management methodology, positive reinforcement. "Positive reinforcement, when done repetitively and with sincerity becomes a motivator. Sometimes you have to think about this consciously before it comes as second nature.

But, when you give that type of reinforcement, people begin to see what kinds of performance you are seeking. This becomes a part of who they are and then, the motivation can come from within.

Each person is motivated in a different way. You may not know a person's 'trigger button', so try different avenues. Motivation has to come from within. Some people have it; some people don't have it. But you still have to work on it. You've got to find the personal motivator for each individual. You must work on understanding the person. Understand the motivator, and play to that direction. Motivation must be individualized: One on one."

All doctors spoke of the importance of appreciation. Dr. Griffiths says: "I try to follow Dr. Ken Blanchard's model: 'Catch someone doing something right, instead of only catching people doing some-

thing wrong.'

I try every day to express my appreciation to my team members. I try to do something to show them that I appreciate them. It isn't a technique. It's a genuine response to exceptional performance. That seems to spur my team on to do other exemplary things that are above and beyond expectation."

It's true. Positive reinforcement goes a lot further than negative reinforcement. Dr. Griffiths continues by speaking of the positive effect of delegation of responsibility. "We make sure that the team members have responsibility and that they feel validated to make decisions. They must understand the philosophy of the practice and of the treatment we provide. Then, they can go forward with us. We like the theory of 'individualized instruction' taught by our management consulting team. They teach us a proven concept, and then individualize it to work effectively for us. I have found that to be very motivating to my team. They can use their skills and intelligence to accomplish the tasks.

We have learned to delegate responsibility whenever and wherever we can in our state. This responsibility is accompanied by trust. There is great motivation when someone is given a responsibility, the appropriate training, and then is entrusted to do it."

The doctors are correct. Responsibility is a motivator. When delegating responsibility,

proceed in the following manner and success will be yours:

(1) Identify things that can be delegated.

(2) Train/educate.

(3) Entrust your own skill to the student with careful instruction, including what you want them to do, how you want them to do it, and why this task is critical in the whole scheme of things.

(4) Guide them as they are in the training mode.

(5) Validate them in front of the patients. Build their self-esteem.

(6) Then, delegate. Turn the task over. Trust.

#### **What are the benefits to you and your practice?**

(1) Doctor's time is better managed.

(2) Numerous responsibilities can be delegated and lifted from the doctor's repertoire.

(3) Patients love the interaction with team members.

(4) Increased productivity and improved bottom line for the practice.

How do doctors motivate people to stay in dentistry and to continue to excel in their own area of expertise?

"A person's job must bring them satisfaction," says Dr. Griffiths. "The days of running people ragged, having them leave and replacing them with people waiting in the wings is over. Today's dental auxiliary must be treated with respect. These are professional men and women who want to be treated

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as professionals.

The schedule has to be manageable, and it has to be doable. They have to have a stake in the outcome so they can at the end of the procedure say: 'We did a great job' not 'Dr. Griffiths did a great job'. We did a great job."

All doctors interviewed agreed that team members need to be compensated appropriately: equitable salaries, benefit packages, incentive bonus programs, and continuing education.

One particular benefit espoused by these doctors was providing quality dental care to team members. Dr. Griffiths comments "If we want our team members to support quality, comprehensive, aesthetic dentistry, we must provide that kind of care for them. It's really demoralizing for an assistant to help turn out beautiful state-of-the-art dentistry and to know that 'Gee, I will never be able to have that in my own mouth. I will never be able to afford that kind of dental care.' That's one of the ways we can motivate them to stay interested in dentistry. My staff continually shows people the dentistry that is in their own mouths. They are proud of their own dentistry, the type of care we provide, and are proud to be in the profession."

These doctors wanted to make sure that their team members have a safe and secure environment and that they would reap

the rewards of work well done so they wouldn't have to leave to seek those benefits in another position/job.

Dr. Stelly comments on the

of change because they are afraid of making mistakes. The doctor has to be empathetic. She has to let people know that it's OK to make mistakes. No one is

### **Cathy Jameson, Ph.D.**

Cathy Jameson is president and CEO of Jameson Management, Inc., an international dental lecture and consulting firm with offices in Davis, Oklahoma, Oklahoma City, Oklahoma and New York City, New York. An accomplished speaker, writer, and workshop leader, Cathy earned a Ph.D. in organizational psychology after focusing her studies on effective, stress-controlled management. As a Certified Effectiveness Trainer, Cathy integrates her academic background and her knowledge of communication into the management of dental teams and practices. After 26 years of "hands-on" experience in her husband's practice and more than 15 years of lecturing and consulting, her strategies have proven workable and effective for hundreds of thousands of doctors, team members and practices worldwide.

Cathy has not only been a featured speaker for major dental meetings throughout

the world, but is also an adjunct faculty member of the Oklahoma University College



of Dentistry and New York University College of Dentistry. Cathy's books, *Great Communication = Great Production* and *Collect What You Produce*, are top sellers in the dental arena. While her passion for and success in speaking and consulting require much travel, Cathy maintains a balance in her life including some time with family, friends and clients at home - a ranch in southern Oklahoma.

challenges of change as it relates to self-management. "Change is difficult. Some people are afraid

perfect. If people are willing to learn from those mistakes, everyone will be better. If the

team doesn't realize that mistakes are accepted and inevitable, no one will even try.

She must let the team know that she is committed to the change and understands how difficult that change may be."

Every member has to be on the same page. Constant communication is imperative. The doctor has to be a good example and a good role model. If the doctor slides back to old ways, this isn't a good example for the team. You have to be consistent. If the doctor can be consistent, other team members see that they can be consistent with their efforts, too.

Dr. Stelly says that she tries to give people positive reinforcement for trying. "This will give them the encouragement to step out of their comfort zone. If they stay in the comfort zone, they aren't going to grow. If they make mistakes but learn from those mistakes, success is on the other side."

When asked what she does to prevent slipping back into old behavior patterns, she replied: "Sometimes you need to draw on outside sources. You may be trying to motivate your team members, but sometimes suggestions and recommendations come across better from a third party – an outside consultant who has a third party set of eyes; a coach who looks at things from an unbiased point of view; a coach who encourages you to stretch and grow and not slip

back to the old ways because they know that progress is in your best interest."

Dr. Bilello feels that three major factors have helped his team members implement change, and do so enthusiastically:

(1) Involvement: Team participation. Setting and working toward common goals.

(2) Sharing the numbers of the practice with team members and having regular staff meetings for constant evaluation, refinement, and positive reinforcement. "Being more aware of the business aspects of the practice makes the team member more willing to reach in and help make the practice more profitable." Then,

(3) Share the good fortune—rewards for work well done, such as an incentive bonus.

He continues by saying, "I used to be afraid to share business data, but in reality, the staff knows how much is coming in, they just don't know how much is going out. The team is more willing to work toward increased productivity and is more interested in conserving costs when they understand the dollars going out as well as they understand the dollars coming in."

Dr. Bilello feels that modeling is the best way to motivate his people to be self-managers and to not fall back into previous patterns. "I set a standard ethically and morally in the dentistry that I do. If someone compromises ethics and staff witnesses that kind of thing, that

becomes a demotivator. If someone challenges our standards and ethics, I stick to the ethics. My people see that as the role model, and do the same thing.

At some time you have to take a stand and say this is the way we are going. This is the vision of the practice. Sometimes you have to put your foot down. When team members see your commitment, they will either get on board or leave."

### **In Summary**

The consensus of the data and of the interviewed doctors was that the five most profound motivators of people in the workplace today are as follows:

- (1) Achievement of work well done;
- (2) Personal pride and satisfaction in being a part of quality treatment and excellent care of patients;
- (3) Continuing education;
- (4) Equitable compensation;
- (5) Respect, responsibility, and appreciation.

When asked how important motivation is to the productivity of her practice, Dr. Stelly closes by saying, "Motivation is the most critical factor in productivity. Motivation is the key. If everyone is on the same page and if the doctor and key team members can continue to motivate and encourage others, then the sky is the limit. The key is to keep everyone goal-oriented, unified, and excited about the possibilities.

Then you are going to have a team of consistent, long-term employees, you don't have

turnover and with that kind of consistency, you are going to have increased productivity.”

This pre-published article was submitted by Jameson Management, Inc.

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# oral pathology



*Case provided by Glen D. Houston, DDS  
Chair, Department of Oral and Maxillofacial Pathology*

## Case History

This 43 year old male is referred by his physician for examination. The patient's chief complaint is a "swelling" involving the palatal mucosa. The physician's provisional diagnosis is to rule out dental infection. The area has been present for "many years" according to the patient and is asymptomatic.

## Questions:

1. Your working differential diagnosis for a mass involving the palatal mucosa might include (multiple answers):

- neurofibroma
- malignant lymphoma
- salivary gland neoplasm
- palatal abscess
- antral carcinoma

2. Which of the following adjunctive techniques may be useful in obtaining a definitive

diagnosis? (multiple answers)

- biopsy
- radiographic survey
- fine needle aspiration of the lesion
- vitality testing of the teeth in the region
- bone marrow aspiration

3. Radiographs of the area reveal a well-circumscribed radiolucency involving the maxilla adjacent to the mass. A fine needle aspiration was inconclusive. The pathology report describes sheets of cuboidal cells forming ductlike structures, loose myxoid material, and cartilaginous tissue. The correct diagnosis is:

- antral carcinoma
- pleomorphic adenoma
- ameloblastoma
- adenoid cystic carcinoma

## Answers:

1. Your differential diagnosis

should include all of the entities listed, because they can all present as a palatal mass. The neurofibroma (a) is a peripheral nerve neoplasm that is composed of a mixture of Schwann cells and perineural fibroblasts. This neoplasm is typically observed in the young adult and presents as a slow growing, soft, painless lesion that presents as a circumscribed nodule. The skin is the most common location for the neurofibroma, but lesions of the oral cavity are not uncommon. Malignant lymphoma (b) is a malignancy of lymphoreticular histogenesis. This malignancy may develop in the oral soft tissue or centrally within the jaws. The soft tissue lesion appears as a non-tender, diffuse swelling that most commonly affects the palatal mucosa, gingiva, and buccal vestibule. Because of the numerous lobules of minor salivary gland tissue involving the palatal mucosa, both benign and malignant salivary gland neoplasms (c) can also be observed arising from the palatal mucosa. Benign salivary gland neoplasms such as pleomorphic adenoma and monomorphic adenoma would be included in the differential diagnosis. Malignant salivary

gland neoplasms such as mucoepidermoid carcinoma and adenoid cystic carcinoma must also be considered. The palatal abscess (d) may also present as a mass. The source of the abscess is typically a nonvital tooth in the area or a periodontal defect. The antral carcinoma (e) is typically a disease of the elderly individual with a slight predilection for males. Affected patients typically notice an ulceration or mass involving the hard palate or the alveolar bone.

2. The appropriate adjunctive techniques useful in obtaining a definitive diagnosis include the following:

- (a) biopsy
- (b) radiographic survey
- (c) fine needle aspiration
- (d) vitality testing of teeth in the region

The vitality testing of the teeth in the region and a radiographic survey in conjunction with the clinical examination are indicated in order to complete a comprehensive oral examination. A fine needle aspiration or incisional biopsy is indicated in order to render a definitive diagnosis concerning the observed palatal mass. The bone marrow aspiration (e) is not indicated this early in the patient evaluation.

3. The correct diagnosis is (b) pleomorphic adenoma - see "Discussion" section.

The other possibilities are not considered here because (a) antral carcinoma is typically a squamous cell carcinoma but occasionally may be an adenocarcinoma. The various cytolog-

ic and morphologic features of malignancy observed with this condition are not observed in the present case. The ameloblastoma (c) is composed of numerous islands, cords, and sheets of odontogenic epithelium dispersed throughout a mature fibrous connective tissue stroma. The epithelial proliferation consists of a core of loosely arranged cells resembling stellate reticulum of the enamel organ. This central core is surrounded by a single layer of tall columnar ameloblast-like cells. The adenoid cystic carcinoma (d) is composed of a mixture of ductal cells and myoepithelial cells that can have a varied arrangement consisting of three major patterns which are cribriform, tubular, and solid variants. These patterns are not observed in the present case.

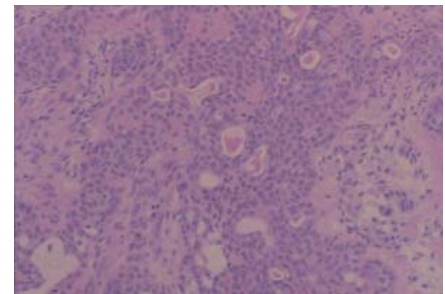
### Discussion

This particular tumor of salivary gland origin has masqueraded under a variety of names throughout the years, but the term "pleomorphic adenoma" most accurately characterizes the unique microscopic pattern of this lesion.

The pleomorphic adenoma is the most common of all salivary gland neoplasms. It represents over 50% of all cases of salivary gland neoplasms of both major and minor salivary gland origin and 90% of all the benign salivary gland neoplasms. Of the major salivary glands, the parotid gland is the most common site for the pleomorphic adenoma. It may occur, however, in any of the major glands or in any of the widely distributed

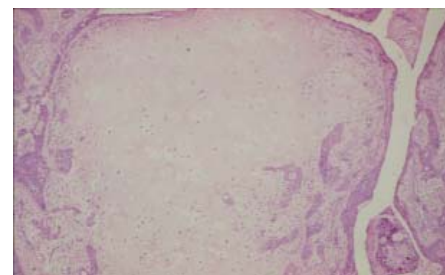
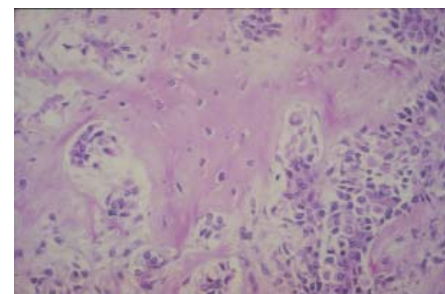
intraoral accessory salivary glands. This lesion occurs somewhat more frequently in women than in men and is usually observed in patients in the fourth to sixth decades of life.

The typical history described by the patient is usually that of a small, painless nodule which slowly increases in size. Pain is not a common symptom of this lesion. It usually does not demonstrate fixation either to the underlying structures or overlying mucosa and is seldom



ulcerated.

The diverse microscopic pattern of this lesion is one of its most characteristic features. Islands of cuboidal cells arranged in ductlike structures is a common finding.



Loose myxoid stroma, hyalinized connective tissue, cartilage, and even osseous tissue are observed. This neoplasm is typically encapsulated, although tumor islands may be found within the fibrous capsule.

The treatment of choice for this tumor is excision. In this particular case, surgical excision with removal of a margin of normal tissue and the overlying mucosa would be sufficient to prevent recurrence. The use of radiation therapy or multiagent chemotherapy is of little benefit and is therefore contraindicated in the treatment of the pleomorphic adenoma.

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# Special Smiles!

Special Smiles, a Special Olympics / Healthy Athletes initiative, was on the road to Stillwater for the second time, Thursday, May 15. Primarily developed as an outreach oral health program for Special Olympics athletes, Special Smiles also seeks to gather information regarding the health needs of this often neglected population. Data that is collected is forwarded to Special Olympics headquarters and then to the Surgeon General of the United States.

Approximately 375 athletes were screened this year! Though this number was lower than last year's 425 athletes, changes in the location of the athletic events are probably responsible. Construction on the Oklahoma State University campus necessitated our move to a different location, which may have impacted our access to the athletes. Ever resourceful, next year we will try to have two sites available to us!



"This is tremendously rewarding work, and the volunteers are to be commended for their time," says Dr. Kevin Haney, Special Smiles Clinic

Coordinator for the state. "A large portion of the first-year dental hygiene class from OUCOD and Bartlesville helped out, and this was after their summer vacation had started." Special thanks also goes to the third-year dental students and faculty who volunteered their time with the event. "We need almost 40 volunteers to host a successful Special Smiles event during the Oklahoma State Summer Games, and it never seems to be a problem getting students and faculty to volunteer! And, we could never do this without sponsorship from the many dental companies that donate supplies for our program, particularly Patterson Dental Supply and Colgate Oral Pharmaceuticals." A special thank-you goes to the University of Oklahoma and to the College of Dentistry who continue to make outreach programs such as Special Smiles a major theme in their service to the state and people of Oklahoma.



This year also marked the introduction of two other Healthy Athletes initiatives to the Oklahoma State Summer

Games - Opening Eyes and FUNFitness. Opening Eyes, sponsored primarily by the Lions Club of America, evaluates the athletes for proper vision. Glasses, if needed, can be made on-site for the athlete. FUNFitness, a physical therapy initiative, provides the athletes with exercise regimens and skills to enhance their overall health and athletic performance. Says Dr. Haney, "The addition of these two programs at this year's games was a major undertaking and a significant success for the Healthy Athletes initiatives. And, we look forward to adding Healthy Hearing (audiology) and Health Promotion (healthy diets) in the near future. With the addition of the last two programs, conceivably the athlete could enjoy the competition of the games as well as become more aware of the overall state of their own health."



If you are interested in volunteering for next year's Special Smiles event, please call Dr. Kevin Haney at the University of Oklahoma College of Dentistry. ●

# WHAT'S EATING YOU?

By J. Michael Steffen, DDS, MS

If you want a tough sell, try telling your patients they are not allowed to have soft drinks during the time they wear braces. Soft drinks have become icons in today's society of fast-paced adolescent lifestyles. In fact, the soft drink industry has done such a masterful job of indoctrination that kids today don't think they can survive without drinking two or more cans per day. Many have this "liquid candy" for breakfast, lunch, dinner, and any time in between.

Years ago, I noticed the relationship between cola consumption and decalcification in my patients. What heartache to remove braces, only to find white marks on all the front teeth. Permanent scars, some that even require restorative care, will forever mar an otherwise beautiful result. As an orthodontist, I fight decalcification on a daily basis.

## The pH Factor

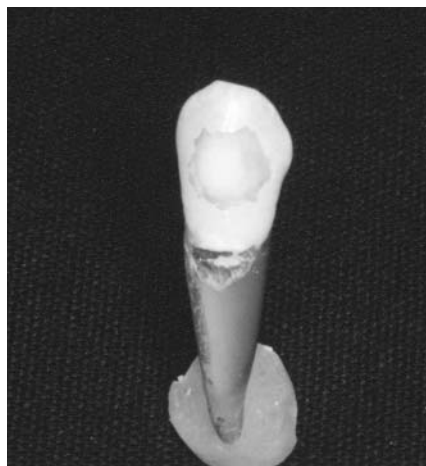
In 1995, I did an in-vitro study to test the idea that the contents of soft drinks could decalcify teeth. I took 27 extracted teeth and waxed out the crown of each tooth, except for a buccal window where a bracket would normally be placed, and soaked them in nine different soft drinks for 72 hours. I then removed the wax coating, sectioned the teeth longitudinally, and had them analyzed under an electron microscope. The



*Figure 1. Waxed out crown with exposed labial surface after 72-hour exposure to test solution.*

destruction to the enamel that took place in 72 hours was amazing.

Sugar in these drinks made



*Figure 2. Following removal of the wax, the area of enamel dissolution is clearly visible.*

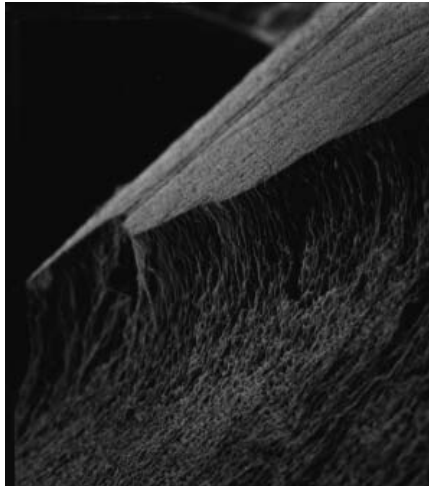
absolutely no difference. Why? Because there was no plaque present. The trashed enamel

came exclusively from the acidity of the solution. The pH of cola drinks ranges from 2.3 to 2.9 – extremely acidic. The acid, either phosphoric or citric, simply pulled calcium ions from the structure of the enamel.

Carbonic acid is also used in the process of making carbonation. In vivo, in the presence of plaque, colas are double whammies because the plaque allows diffusion of the acid and sugar into the plaque, where it simply "rots" the tooth. (I have had many patients do my study for their science projects but without the electron microscope. Each of them has won.)

When there are no braces present, you can etch a tooth, and within 2 days, the calcium and phosphorus salts in the mouth will remineralize the surface of the tooth. When patients who do not have braces drink colas, their teeth still become etched, but the acid can be cleaned from the teeth by the lips, cheeks, and tongue, and the body goes about its business of renewing the enamel surface. When braces are present, however, the teeth are no longer self-cleansing because the lips, cheeks, and tongue cannot easily touch the surfaces of the teeth. Hence, the acid stays in contact with the teeth for much longer periods of time, and the body's renewal mechanism cannot keep up with the etching process. The result is

decalcification. This is especially true for patients who have soft enamel (less mineral content). Some enamel is so dense that you could pour battery acid on



*Figure 3. Regular Coke, in which the surface has been etched prior to submersion. 300x magnification*

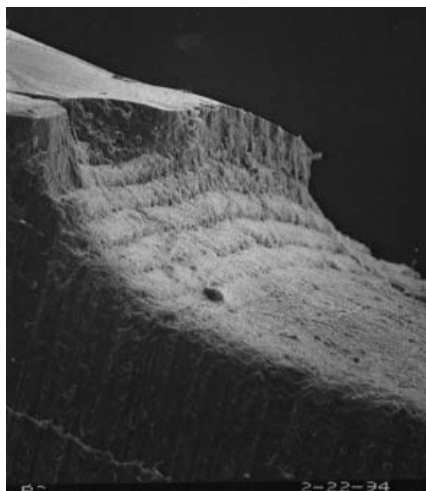
it without a scratch. But whenever you examine a patient and there are existing restorations, that should run up a red flag. This patient is decalcification waiting to happen.

#### **The Break Down**

In 1942, the annual consumption of soft drinks in America was 60 12-oz servings per person per year<sup>1</sup>. Today, according to the National Soft Drink Association, the average American drinks 53 gallons of soft drinks per year<sup>2</sup>. Does that make you dizzy? And since I don't consume any, some unnamed persons are drinking way more than 53 gallons. A can of soda contains 10 teaspoons of sugar, so the average teenager is getting 15 to 25 teaspoons a day of added sugar from soft drinks alone. If a person drinks three

soft drinks per day, 365 days a year, that is 164, 250 additional calories over and above the calories we ingest from the food we eat. And we wonder why obesity is prevalent in America!

Bess Dawson-Hughes, MD, a bone-disease expert at the Jean Mayer USDA Human Nutrition Research Center on Aging at Tufts University in Boston, once said, "I'm particularly concerned about teenage girls. Most girls have inadequate calcium intakes, which make them candidates for osteoporosis when



*Figure 4. RC Cola with no etchant or sealant prior to submersion. 300x magnification.*

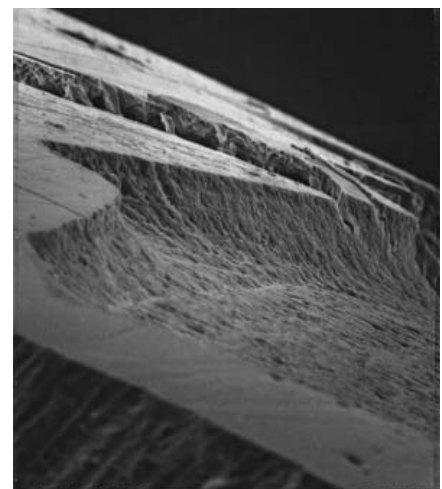
they're older and may increase their risk from broken bones today. High soda consumption is a concern because it may displace milk from the diet in this vulnerable population"<sup>3</sup>.

Although Dawson-Hughes is only commenting on the replacement of calcium in milk with soft drinks, consider this: We know for certain that the acid in soft drinks pulls calcium



*Figure 5. Regular Coke on a surface which had been etched and sealed with a light-cured sealant prior to submersion. 300x magnification.*

from the teeth. Since teeth and bones are molecularly similar, it is not a big leap to see that the body uses the calcium from bones systemically to neutralize the acid from the drinks. So, if we understand that a child builds his bone mass from birth to around age 21, and from there he or she only loses bone mass, think what effect this is going to



*Figure 6. Diet Pepsi with no etchant or sealant prior to submersion. 300x magnification.*

have later in life.

Sugar-free soda varieties are no better for you. Not accounting for the acid content of those drinks, which is the same as the sugared varieties, according to Christine Lydon, MD, of the Yale University School of Medicine, there have been more than 100 independent studies conducted on aspartame, and more than 90% have demonstrated significant health risks<sup>4</sup>. These risks include significant correlations between aspartame consumption and vision impairment, hypertension, brain tumors, and arthritis. There has been increasing pressure on the US Food and Drug Administration to review classification of aspartame as "generally considered safe" in light of these studies.

Heavy soft drink consumption can interfere with your body's metabolism of iron and diminish nerve-impulse transmission. Sodas may contain – but are not required to disclose – such ingredients as ethyl alcohol, sodium alginate (possibly hazardous to pregnant women), brominated vegetable oil (found harmful to vital organs of animals), and caffeine. Caffeine is a member of the same alkaloid group of chemicals as morphine, nicotine, cocaine, purine, and strychnine. All of these compounds have one thing in common: They are addictive. A good example is that when children ages 6 - 12 stop consuming caffeine, they suffer withdrawal symptoms that impair their attention span and performance (Journal of the American

Academy of Child and Adolescent Psychiatry, Vol 37, 1998). It is no wonder we never get tired of drinking soft drinks. Caffeine can also cause nervousness, irritability, sleeplessness, and rapid heart beat.

#### **The Last Straw**

What do we do about this bad news for our patients? First, we must educate parents about the dangers of soft drinks for their entire families. The big problem is that the two major producers of soft drinks worldwide are in a bidding war to become the purveyors of soft drinks in our school systems. The Edmond, Okla, school district 4 years ago received \$3.39 million for 10-year "pouring rights" from the winner of this bidding war. That means that each middle and high school has vending machines, for which the school gets a cut of each drink sold, and kids have the option of drinking as many as they can obtain or afford. We need to approach school districts with this information and make it available to parent-teacher associations and civic groups. Nothing will change unless we make the effort.

Secondly, the only technique I have found that prevents decalcification is placing a thick coat of sealant over the front surface of the teeth on which braces are placed. If the coat is too thin, it will abrade away with tooth brushing. But a thick coat will remain throughout treatment and can be removed with various polishing techniques once the braces have been removed.

If patients are motivated to drink colas, there is not much we can do to stop them. But we can be careful in how we bond the teeth and protect the enamel. Because after all, a smile is forever, and so are self-induced decalcification scars.

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Reprinted with permission. Steffen JM. What's eating you? Orthodontic Products, April/May 2003; 10:48-49. ●

## WE WANT TO HEAR FROM YOU!

Take a few minutes to let us know what your district members and their families are doing.

### **Tulsa County Dental Society**

Dr. Jeff Parker  
2525 S. Harvard Ave. #501  
Tulsa, OK 74114

### **Northwest District Dental Society**

Dr. Larry Kiner  
2414 A. Heritage Trail  
Enid, OK 73703

### **South Central District Dental Society**

Dr. Michael Jackson  
309 N. Sheridan Rd.  
Lawton, OK 73505

### **Oklahoma County Dental Society**

Dr. Tamara Berg  
2650 N. Mustang Rd.  
Yukon, OK 73099

### **Eastern District Dental Society**

Dr. Sid Nicholson  
730 Callahan  
Muskogee, OK 74403

### **Northern District Dental Society**

Dr. Jandra Mayer-Ward  
P.O. Box 868  
Vinita, OK 74301

### **Central District Dental Society**

Dr. Fred Benenati  
707 SW 24th Ave., Suite 201  
Norman, OK 73069

### **Southwest District Dental Society**

Dr. Dustin Lively  
114 S. Louis Tittle  
Mangum, OK 73554

# district reports

## **Central District News**

By Dr. Fred Benenati

The Central District Dental Society will hold its Fall meeting at the Holiday Inn, Norman, on Oct. 22, 2003. The guest speakers will be **Dr. Krista Jones**, speaking on mediation review, and a representative from Alexander Strunk insurance agents speaking on malpractice insurance.

**Bobby Carmen** has joined **Bill Blum** in practice in Norman. Bobby completed his tour of duty with the US Navy after graduating from the OU College of Dentistry. **Bill Shadid** has retired from dental practice in Norman after a career that has spanned forty years in Purcell and Norman. We all wish Bill many happy years in his retirement.

## **Northwest District News**

By Dr. Larry Kiner

Northwest District Dental Society members are gearing up to begin a new season of county Dental meetings. Garfield County will begin September 9 with a program given by Centerpulse at the Oakwood Country Club. President **Erin Roberts** is the contact person at

580.237.0694.

**Trent Yadon** is the contact for Woodward County meetings. They also meet on the second Tuesday of September. Their meeting place and program are yet to be announced. Trent's office number is 580.256.8668. **Wes Lucas** has a new dentist in his office.

**Scott Hubbard** is from Mooreland and after graduation and boards began his practice with Wes. Scott spent some of his time between boards and practice going to Mexico on a mission trip with a church group from Stevenville, Texas. Scott is single and glad to be back in Northwest Oklahoma even though he cannot find a racquetball court.

**Jim Highfill** and the other Kay County dentists are also meeting on the second Tuesday of September. Their first meeting is at the Daily Grind, a restaurant in Ponca City. Their program is scheduled to be **William Reeves** covering nonsurgical perio and implants. They are scheduled through May with programs thanks to **Nancy Tyndall**, who has been very instrumental in finding speakers. Jim is also the contact person for Kay County and his number is 580.762.5335.

**Quint Whitefield** and **Vic**

**Andrews** have a new dentist in their office. **Todd Gentling** is also a recent graduate of the University of Oklahoma College of Dentistry. He grew up in Edmond, graduated from UCO and then attended dental school after spending several years as an x-ray technician. He is married to wife Kellie and they are the proud parents of Paige, 6 years, and Claire, who is 4 months old. Todd is an avid hunter/fisherman and has looked forward to living in the Ponca City area for quite some time. Congratulations to Todd and his colleagues there in Ponca City.

**Ed Braly**, an oral surgeon in Enid, has offered a mini-residency in implants to area dentists. This course has been taking place at the Autry Technology Center in Enid. The course is designed to give an overview of the many phases of implant usage. Those participating in the course will present a patient of theirs for treatment planning, implant placement, and restoration to complete the case. Those participating are **Trent Yadon, Kurt Grieshober, Erin Roberts, Jana Oister, Larry Smith, Susan Davis, Shelby Jones, Lisa Grimes, and Larry Kiner.**

So that's the news from Northwest Oklahoma. By the time we read this it will hopefully be much cooler.

## Oklahoma County News

By Dr. Tamara Berg

November 14th we welcome **Dr. Jaimee Morgan**, cosponsored by Ultradent, for our continuing education course. Plan to attend "Putting Pizzazz in your Cosmetic Dentistry with Direct Bonding". Contact **Sue Hill** at 946-2279 for additional information.



*Dr. Tamara Berg, Oklahoma County President, examines a patient during the Boys and Girls Club of America screening.*

A big thank-you to the dentists and staff members participating in the Boys & Girls Club of America screening process. Blue Cross & Blue Shield and Crest Healthy Smiles led the efforts in screening over 130 children on Friday, July 25th. **Drs. Lillian Barnes, Tamara Berg, Carol Blossfeld**, (and her assistants **Erica** and **Shawna**), **Larson Keso**, and **Jeff Danner** worked at the morning screenings held at Memorial Park. The afternoon screenings at McKinley Park included **Drs. Ray Cohlmi Sr.** (and his assis-



*Dr. Ray Cohlmi and his assistant Kim perform a screening.*

tant **Kim**), **Tamara Berg**, and **Mark Felton**, and **Ms. Jaylynn Stimmie**, an assistant from **Dr. Ken Miller's** office. We met a lot of wonderful children while giving back to Oklahoma Dentistry.

During the summer, many of our members take advantage of a break from the council meetings and spend time with their families relaxing. Here is a sampling of what kept them



*Dr. Mark Felton screens a patient.*



*Volunteers and patients take time to pose for a picture.*

busy: **John Archer** spent Memorial weekend in Indianapolis at the Indy 500. **Betsy Brackett** took a trip to Santa Fe, New Mexico. **Pat Woods** and family enjoyed a baseball trip to Bosman, Montana and Yellowstone National Park. **Krista Jones** has been busy working on a new home being completed in Edmond. **Brian Amy** has also been working with his home construction. **Tom McGarry** purchased a new building and will be moving his practice. **David Birdwell** got wet when his boat capsized while white water rafting in Missouri. **Jeff Cohlmia** spent weekends at the lake. **Scott Searcey** visited Hawaii. **Michael Kierl** spent time at beautiful Lake Tahoe with his family. **Larson Keso** traveled to Asheville, North Carolina. **Ray Plant** has been working on his condo association preventing a take over. **Vann Greer** attended the AAO meeting in Hawaii, taking time to visit 3 islands. She also spent time in Taos, New

Mexico. **Les Hardy** went trout fishing at Vermejo Park in New Mexico. **Denny Leseberg** went to Carmen, Mexico. **Thai-An Doan** broke her back in a car wreck in May. She has also been going back and forth to Dallas (long distance relationship). **Grady Lembke** visited his brother in Birmingham, Alabama. **Carol Blossfeld** has had morning sickness. She is expecting her first child in February and has been adjusting to the pregnancy. Congrats also to **David Shadid** and wife, expecting this winter. I have spent most of my summer getting ready for an outstanding year in OCDS (and collecting the above information)!

### **Tulsa County News**

By Dr. Jeff Parker

A great time was had by all 120 who attended our Dental Arena Football Night with the Tulsa Talons in July!

We're very excited about the

excellent speakers and their informative programs we have scheduled for our 2003-2004 TCDS all day and evening meetings:

- Tuesday, September 9, 2003 Evening Meeting featuring **Dr. Daniel Tylka** on "TMJ: The Evidence-Based Care"
- Tuesday, October 14, 2003 Evening Meeting featuring **Dr. Jim Kessler** on "A Review of Indications for All Ceramic and Metal Ceramic Restorations"
- Tuesday, November 11, 2003 Evening Meeting featuring **Dr. Donald Mitchell** on "Implant Update"
- Friday, November 14, 2003 All Day Meeting featuring **Dr. Jeffrey Okeson** on "The Clinical Management of Temporomandibular Disorders"
- Thursday, December 4, 2003 Holiday Party at the Oklahoma Aquarium
- Tuesday, January 27, 2004 Evening Meeting featuring Table Clinics & Elections
- Friday, January 30, 2004 All Day Meeting featuring **Dr. William Robbins** on "Comprehensive Esthetic Diagnosis - Putting the Pieces Together"
- Tuesday, March 9, 2004 Awards Banquet & Installation of Officers
- Friday, March 26, 2004 All Day Meeting featuring **Dr. John Burgess** on

"Restorative Dentistry Today"

We would like to welcome our new TCDS members: **Drs. Chasity Carper, Kenneth Garner, Alvaro Felipe Gonzalez** and **John Mose, III.**

Congratulations to the following "proud" dads and moms on their new arrivals:

**Dr. Aliakber** and **Farida Akberali** - baby girl Insia - born May 16th.

**Dr. Alvaro** and **Adriana Gonzalez** - baby boy Diego - born August 1st.

The Oklahoma dental community is with you all the way, **Dr. Richard Haught**, for a successful campaign for ADA President-Elect! Everyone attending the ADA Annual Session October 23rd - 26th in San Francisco, California, is encouraged to stay for the Monday evening October 27th "Meet the Candidates" Reception - lets all give Richard our support! ●

# Dentist Day at the Capital



**Wednesday  
February 11, 2004**



# dental organizations

## **D-DENT**

Ms. Shirley Harris  
Executive Director  
222 N.E. 27<sup>th</sup> Street  
Oklahoma City, OK 73105  
(405) 424-8092

## **Oklahoma Board of Dentistry**

Ms. Linda Campbell  
Executive Director  
201 N.E. 38<sup>th</sup> Terrace, Ste. 2  
Oklahoma City, OK 73105  
(405) 524-9037

## **ODA Alliance**

Judy Keenan  
2743 S. Utica  
Tulsa, OK 74114  
(918) 743-6907

## **Oklahoma Dental Foundation**

Dr. Stephen Mayer  
244 S. Scraper  
Box 868  
Vinita, OK 74301  
(918) 256-6441

## **Baylor College of Dentistry**

Ms. Elizabeth J. Fulce  
3302 Gaston Ave.  
Dallas, TX 75246  
(214) 828-8358

## **Tulsa Junior College**

Director of Dental Hygiene  
909 S. Boston, MP458  
Tulsa, OK 74119  
(918) 595-7023

## **Oklahoma State Department of Health**

Dr. Michael Morgan  
Chief of Dental Services  
1000 N.E. 10<sup>th</sup> Street  
Oklahoma City, OK 73117-1299  
(405) 271-5502

## **Oklahoma Association of Women Dentists**

Dr. Dana Martin  
1600 Airline Rd.  
Pauls Valley, OK 73075  
(405) 238-5181

## **UMKC Dental School**

Mr. Barry Daneman  
Director of Advancement  
650 East 25<sup>th</sup> Street, Rm. 411  
Kansas City, MO 64108  
(816) 235-2100

## **Retired Dentists Group**

Dr. Sunshine Sullivan-Myers  
7307 Waverly Ave.  
Oklahoma City, OK 73120  
(405) 842-3988

## **American College of Dentists**

Dr. Krista M. Jones  
2000 S. E. 15<sup>th</sup>, Bldg. #200  
Edmond, OK 73013  
(405) 341-0203

## **Rose State College**

Ms. Janet Turley, RDH  
Director of Dental Programs  
6420 S. E. 15<sup>th</sup> Street  
Midwest City, OK 73110  
(405) 733-7336

## **Oklahoma Academy of General Dentistry**

Dr. Mark Duncan, Editor  
13913 N. May Ave.  
Oklahoma City, OK 73134  
(405) 775-0033

## **O.U. College of Dentistry**

Dr. Frank J. Miranda,  
Senior Associate Dean  
P.O. Box 26901  
Oklahoma City, OK 73190  
(405) 271-5988

## **Oklahoma Dental Assistants Association**

Ms. Linda Bilby, CDA  
9131 W. 71st  
Tulsa, OK 74131  
(918) 224-5531

## **International College of Dentists**

Dr. Allen Keenan  
3808 E. 51st  
Tulsa, OK 74135  
(918) 749-5033

## **Pierre Fauchard Academy**

Dr. William Goodman  
P.O. Box 233  
Fairland, OK 74343

## **ODA ALLIANCE**

Judy Keenan, President

Recently our treasurer, **Melinda Danner**, wrote a check to the Oklahoma University Foundation, Inc. in the amount of \$1,500.00. This will fund the first of two annual scholarships to be awarded by our Alliance to a fourth-year dental student and a second-year dental hygiene student. We are very proud to be initiating this new project, knowing that it is only possible because of our increased membership. We will also be expanding our dental health activities to area shelters and be continuing our day at the state legislature on its first day of session which occurs during National Children's Dental Health Month.

We hope all of our current members will renew their membership by sending in their dues, notice of which came with the ODA dues statements. We welcome new members as well. We also have a new opportunity, Friends of the Alliance, for ODA dentists, spouses or friends who would not ordinarily be members of the Alliance but would like to support our dental health and scholarship projects. Their names will appear in our yearbook. Dues can be paid by writing a \$35.00 check made payable to the

Alliance to the Oklahoma Dental Association and mailing it to the ODA office in Oklahoma City. We want you to include your home address and your membership designation.

The first board meeting was held in conjunction with the Oklahoma Dental Foundation Meeting at the Renaissance in Tulsa-Broken Arrow. After the meeting, other attending spouses were invited to join the board members for lunch at the Cafe Royale in Windsor Market where we had shopping and browsing opportunities. It was great fun.

We are hoping that a good showing of Oklahomans will attend the Thelma J. Neff luncheon at the American Alliance meeting during the ADA meeting in San Francisco. **Sherry Beasley** will receive the Thelma J. Neff award for her outstanding service as past president of the AODA, for her significant contribution to the record fundraising of the Oklahoma Dental Association's Political Action Committee's Silent Auction during the 2003 ODA Meeting and for help in establishing our new scholarship program. The following day our AODA will receive an award for membership retention. **Mella Glenn**, President-elect, and I are delegates.

**Kathy Trammell**, Immediate past president and our DEN-

PAC representative, is looking for silent auction items.

**Margaret Hosier** and **Jonni Segnar** are planning a wonderful luncheon at the 2004 meeting. **Gretchen Landers**, vice-president, will be contacting you about membership. **Susie Taylor** is serving as secretary. **Becky Baggett** and **Tina King** are enthusiastic about our dental health plans.

Wishing you well...

## D-DENT

By Shirley Harris

We are very happy to report that **Dr. James Limestall**, our wonderful Board of Director's President, is feeling and looking so much better these days! He and wife Beverly are back on the road traveling all over again – he seems to be making up for lost time.

D-DENT is also glad to inform the dental community of its highly successful FUNDRAISER this year that many of you had to miss due to another dental meeting on the same night. We added a "Special Event" to our already well-known, winning, annual Charity Golf Tournament. Since this year was our fifth golf fundraiser, we decided to go "Big-League" and pulled in as many Oklahoma celebrities as possible. We re-named it the "D-

DENT Celebrity Golf Classic" and added the first annual "All-American Sports Dinner and Silent Auction" the night before.

This event was truly "ALL-STAR" and we want everyone to know what a fabulous first-time turnout we had so you can all make plans to attend next year! The Dinner and Auction were held Thursday, June 19, 2003, at the marvelous Will Rogers Theater Center on Western and 43rd (the old movie theater for those who remember back that far!). The evening was very patriotic with Red, White, and Blue everywhere, and the red Geranium Centerpieces (compliments of McCauley Nursery) were gorgeous. Delicious "down-home" cookin' was the night's fare with fried chicken and roast beef plus all the fixin's – no one left hungry.

Host for this special two-day fundraiser was **Mickey Tettleton**, two-time Major League All-Star Catcher formerly with the Texas Rangers, who graciously signed baseballs for all the children and young adults (and even some parents too!) Thursday night. Many families did bring their kids of all ages, so it was a fun "family affair" – what better way to spend the evening than quality family time. Mickey was also generous in donating a Baseball Bat & Ball signed by



*Don Demeter, Mickey Tettleton, Sean O'Grady, Uwe Von Schamann, Patty Zimmer, Tom Bakes, Paul Blair, and Cale Gundy were some celebrity golfers attending the D-Dent Golf Tournament.*

him along with his baseball collection cards to the silent auction.

Over forty fantastic items were sold in the auction, with the most heated battle waged over the "\$500 full retail" Gift Certificate donated by Samuel Gordon Jewelers, proving that diamonds ARE indeed a girl's best friend. D-DENT was very proud this year to feature two Certified, Titled, Limited Edition, Bronze Sculptures by world-renowned artist and sculptor, Lorenzo Ghiglieri from Italy. Patriotism running high, Oklahoma Bondsman Association Executive Director, **Robert "Bob" Rollins**, "flew" home with the Flying Colors sculpture of a proud American Eagle in flight above the American Flag (red, white, & blue) – a truly beautiful sight.

Among the most popular auction items up for bid were: sev-

eral University of Oklahoma Collector Footballs signed by former Sooner Head Coach, **Barry Switzer** (1973-1989); Sooner #36 **Steve Owens** ('69 Heisman Trophy, 1991 Football



*Mickey Tettleton, and son, Matt McBee and Darrin Higgins made the 1st place team at the golf tournament.*

Hall of Fame, NFL Detroit Lions); Sooner #11 **Tinker Owens** (Big 8 Conf.'72-'75, Nat'l Champs '74-'75, NFL New Orleans Saints); Twins

Sooner #74 & #73 **Phil and Paul Tabor** (NFL NY Giants/NFL Chicago Bears, plus Big 8 Track Champs 2 yrs in shot put/discus); and Legendary Super "Uber" Kicker Sooner #10 **Uwe Von Schamann** (NFL Miami Dolphins & a devoted supporter of the developmentally disabled). Uwe also donated two terrific signed Photo Prints: one of his famous WINNING "kick heard around the world", during the last 10 seconds of the 1974 OU vs. Ohio State Football game, and one of former Sooner Linebacker #57 **Cedric Jones** (All-American/ NFL St. Louis Rams & NY Giants). Steve Owens further donated an adorable Print of a little toddler boy in his underwear (imprinted with #36) and

a too-large red OU Football helmet – signed by Steve.

Also "all the rage" were magnificently decorated large baskets containing goodies and

Gift Certificates for: a BOX OF STEAKS from Schwab Meat Co.; "Weekend Getaway" at the OKC Embassy Suites Hotel; 1-Night weekend stay & Breakfast for Two at the OKC Renaissance Convention Center Hotel; 1-Night weekday stay plus 2 Rounds of Golf at the Grand Casino Tunica Hotel in Mississippi; a 3-day/2-night 'mini-vacation' in a Deluxe Room at the Horseshoe Casino & Hotel in Mississippi; and a BIG D Road Trip for 1-Night at La Quinta Conference Center in Arlington, TX with Six Flags over Texas tickets.

That adorable new pet store, Paws Around Town ([www.pawsaroundtown.com](http://www.pawsaroundtown.com)) located in NorthPark Mall & The Market at Quail Springs, donated several cute items, including an authentic jacquard hand-woven Tapestry from the North Carolina mountains. The Will Rogers Theater Center was not only so accommodating to work with, but also donated two Gift Certificates for "Dinner for Two" at Sushi Neko and Musashi's Japanese Steak House.

Last, but certainly not least, were those who donated Entertainment to the Dinner/Auction. D-DENT is genuinely grateful to **James N. Jarvis, M.D.** (yes, the Dentists let a Medical Doctor participate!) and his Band, St. James & the Infirm, for stepping in at

the last minute to provide a delightful array of memorable songs. The Band is comprised of all professional businessmen (in other words, they give up sleep & family time to pursue



*Oklahoma Bondsman Association's Bob Rollins' bronze sculpture "Flying Colors" made by Lorenzo Ghiglieri.*

their passion). Also, many thanks go to **Bill Phillips**, Choctaw resident, long-time D-DENT supporter, and another good ol' Capitol Hill boy, for his brilliant renditions of golden oldies such as Frank Sinatra and Nat King Cole tunes. In a nutshell, it was a STELLAR evening and superb "kick-off" for the Golf Tournament!

The competition is always high on the golf course, but with all the "Celebrity Golfers" this year, it was really soaring. In fact, the celebrities almost outnumbered the players! Those big-hearted donors who

gave their time so freely included (in alphabetical order): **Tom Bakes**, former #85 OU Sooner Football Defensive Tackle & San Diego Chargers; **Rev. Paul Blair**, OSU Football Star, & Major League with the Chicago Bears; **Rev. Don Demeter**, OKC Capitol Hill Baseball player & member of the "53 Dream Team" who played 14 years in the Majors with the Dodgers, Phillies, & Tigers; **Cale Gundy**, Midwest City Footballer, OU Sooner ('90-'93) career "passing" leader, and now Sooner Football Coach with Bob Stoops; **Sean O'Grady**, McGuinness High School Boxer, turning Professional Boxing Champ in 1975 at 15 yrs. with 8 yr. Career & winning US Boxing Assoc. Lightweight Champ in 1980; **Mickey Tettleton**, event host (previously highlighted in article); **Uwe Von Schamann**, Football Legend (also previously honored in article); and **Patty Zimmer**, former OSU Golfer winning the Big 8 Women's Conference Title and playing the pro circuit for a time.

One final note on the Golf Tournament, the First Place Team winning the large bronze trophies was Mickey Tettleton's group – anyone surprised?!

Finally – PLEASE support your United Ways of OKC Metro, Tulsa Area, and Claremore – they help support

D-DENT! Don't forget to look us up on our Website: [www.d-dentok.org](http://www.d-dentok.org). We know not many of you have visited there because you haven't called our office to get the "password" for the special Dentist link; so, "try it, you'll like it".

### **OKLAHOMA DENTAL ASSISTANTS ASSOCIATION**

By Linda Bilby, CDA

The American Dental Assistants Association recently held their 2003 Annual Meeting in Nashville, Tennessee in conjunction with the Academy of General Dentistry. Several Oklahoma members attended this meeting and two delegates from Oklahoma were present. Delegates attending were: **Linda Bilby, CDA**, President ODAA and **Rebecca Streeter CDA, Sec/Tres.** ODAA.

Other members attending were: **Grace Holden, CDA** COMSA, **Joy Carter, CDA**, **Jean Mueller, CDA**, **Denice Elwell, CDA**, **Carol Focht, CDA**, and **Kathy Kent, CDA**.

The ODAA would like to welcome our new ADAA President: **Kay Mosley** from Oklahoma. We are very proud of Kay and her accomplishments and support her year as President of The American Dental Assistants Association. The ODAA hosted a party after

the Gala and installation. We presented Kay with several Oklahoma "gag" gifts and stories of her past hunting trips and gave her some advice for the upcoming year as President.

In addition to great educational meetings and business activities, we were able to enjoy some southern hospitality by touring the great state of Tennessee. We stopped overnight in Memphis and toured Graceland and enjoyed the nightlife on Beale Street. In Nashville, we toured the Jack Daniels Distillery, Grand Ole Opry, and many other sights.

The first Board meeting for the ODAA is fast approaching and we will be planning events for the year including continuing education, Dental Assistant Recognition Week, membership recruitments and finally our state meeting. We would like to extend an invitation to you by becoming active in your local association and inputting on these events. If you don't have a local association, I will be happy to assist you in organizing your local.

In closing, I would like to share a few words from our new National President, Kay Mosley. These words were taken from her inaugural speech entitled: The Keys to Success.

"The keys to success that I have learned in my 25 years of dental assisting that made me

a successful assistant are the same characteristics that I believe all great leaders possess. These characteristics include caring, loyalty, trust, integrity and productivity.

I recently read that the definition of a good leader is being an enthusiast, a coach, a facilitator, a team builder and a nurturer of future leaders. A GREAT leader is one who not only exhibits those traits, but also has passion, sensitivity, consistency and attention to the bottom line."

CONGRATULATIONS KAY

### **UNIVERSITY OF OKLAHOMA COLLEGE OF DENTISTRY**

By Frank J. Miranda  
Senior Associate Dean

#### *CLASS OF 2007*

The Class of 2007, our newest group of 59 freshman students, began dental school last July with a summer course in Gross Anatomy and are now busy tackling the first-year curriculum. The class was selected from a pool of 301 applicants, and is composed of 42 males and 17 females with a mean GPA of 3.45 and a DAT average of 17.8. There are 52 Oklahoma residents and seven non-residents (Arizona, Hawaii, Idaho, Texas, and Utah [3]). With ten Native American students, we once again have a strong contingent representing this important population group.

Nineteen students enter with already strong family ties to the profession. Six are children of Oklahoma dentists and/or OUCOD alumni: **Gabriel Bird** (Drs. **Wally Ruiz** and **Mayra Bird**); **Nathan Brown** (Dr. **Kelly Brown** [DDS'76]); **Damon Johnson** (Dr. **Richard Johnson**); **Brett Leemaster**, (Dr. **Larry Leemaster** [DDS'87]); **Chris Tricinella** (Dr. **Ken Tricinella** [DDS'80]); and **Vincent Willcox** (Dr. **Vernon Willcox** [DDS'85]). Eleven others are related to current dental students or alumni: **Robert Baird**, brother of **Michael Baird** [Class of '04], cousin of **Dan Baird** [Class of '04], and cousin of **Dr. Stan Baird** [DDS'99]; **Jeffery Barrett**, brother-in-law of **Dr. Jon Thomas** [DDS'96]; **Hanh Dang**, sister-in-law of **Khanhlan Phan** [Class of '05]; **Barrett Hall**, cousin of **Jason Hall** [Class of '05]; **Drew Holloman**, brother of **Matt Holloman** [Class of '06]; **Brandon Jensen**, son of **Dr. Alan Jensen** [DDS'86] and cousin of **Dr. Todd Hoggan** [DDS'00]; **Stephen Meacham**, brother-in-law of **Chris Reeves** [Class of '06]; **Daniel Messer**, nephew of **Dr. Randy German** [DDS'81]; **Celeste Riggs**, wife of **Mike Riggs** [Class of '04]; **Spencer Sautter**, cousin of **Dr. Kevin Miller** [DDS'01]; and **Travis Turney**, brother of **Dr. Lewis Turney** [DDS'01]. Finally, **Nathan Talley** is the

nephew of **Dr. Robert Talley**.

We look for the Class of 2007 to have little trouble upholding the tradition of excellence we've come to expect of all our students.

#### *NEW FACULTY/STAFF*

We would like to officially welcome several faculty and staff who have joined our ranks since the first of the 2003 year. New faculty include Dental Hygiene: **Patrick Strohkirch**; Fixed Prosthodontics: **Rick Safi** [DDS'02]; Oral Implantology: **Bryce Dorrough** [DDS'79]; Oral & Maxillofacial Surgery: **Thomas Dudley** and **Zeneida Vasquez**; Pediatric Dentistry: **Don Cheatham** [DDS'81], **Gene Litteken**, [DDS'82], **Ron Winder**, and **Tamara Worthen** [DDS'95]; and Periodontics: **Janice Kramer** and **Vanna Shaw**.

New staff include AEGD: **Lizeth Rios-Jimenez**; Clinic Operations: **Gail Andrews**, **Erica Austin**, **Joe Engel Jr.**, **Amanda Polk**, **Kevin Reynolds**, and **Meredith Rice**; Oral & Maxillofacial Surgery: **Kaishia Linzy** and **Hillary McCoy**; University Dental Faculty Group: **Sandra (Owens) Farmer**, **Jane Haley**, and **Lisa Rieger** (RDH'01).

#### *GRADUATE PROGRAM RESIDENTS*

We also extend a warm welcome to the new 2003-04 residents in our four postgraduate

programs. The Advanced Education in General Dentistry (AEGD) program welcomes **Amy Fillman**, **Maria Martinez**, **Kyle Rush**, **Lance Schmidt**, and **Coy Tucker**. They join **Joy Hasebe**, who is completing a second year in the program.

New Graduate Periodontics residents are **Joey Heinze** and **Ethan Moulton**. Ethan must be a glutton for punishment; he just completed two years in the AEGD program before joining grad perio! Joey and Ethan join second-year residents **Reinaldo Rosas** and **Edwin Sutherland**, and third-year residents **Grady O'Neill** and **Nikola Vasilic**.

New residents in Oral & Maxillofacial Surgery are **Gerard Bruno**, **Shawn Davis**, and **Jovito Sabal**. Other OMS residents include **Justin Bley**, **Robert Bryan**, and **Rocky Cullens** (2nd year), **Daniel Henrichsen** and **Mark Newey** (3rd year), and "senior" **Curtis Bowman**.

Incoming Graduate Orthodontics residents **Matt Heim**, **Edward Jahn**, **Hema Patel**, **Justin Power**, and **Geoff Sparks** join "veteran" 2nd-year residents **Robie Herman**, **Jason Landers**, **Srishti Mehta**, **Silvia Menendez**, **Jeremy Watson**, and **David Weller**.

Congratulations to the "lucky dozen" who completed their residencies this past summer: **Mark Burye** (Oral Surgery),

**Andrew Colgan** (Oral Surgery), **Gordon Cooper** (Ortho), **Matt Daggett** (AEGD), **John Johnson** (AEGD), **Todd Jorgenson** (Perio), **Al Junquera** (Perio), **Lori Logan** (AEGD), **Ethan Moulton** (AEGD), **Kristen Netsel** (Ortho), **Ryan Nowlin** (Ortho), and **Andy Traxler** (AEGD).

#### *2003 WREB RESULTS*

We are pleased to report that the Class of 2003 did very well on last June's WREB licensing examination. Of the 51 who took the exam, 49 had passing scores for a pass rate of 96.1%, our second highest score in the last eight years. The remaining three members of the class took other licensing examinations; as of this writing, results had not been received on their performance.

#### *CAREER DAY*

Our annual Career Day was held Friday, August 8 at the College of Dentistry. Forty dentists and dental hygienists from across the state each sponsored a prospective student to this recruitment/CE event. Career Day, a cooperative effort among OUCOD's Office of Student Affairs, Department of Dental Hygiene and Department of Continuing Education, introduces prospective students to the professions of dentistry and dental hygiene, and provides a contin-

uing education program for their sponsors.

After welcoming remarks by **Stephen Young** (Dean), the sponsoring dentists and dental hygienists enjoyed a presentation given by two of our dental hygiene faculty members, **Jane Bowers** and **Jane Wilson**, on their department's recent experiences with distance learning. The morning program concluded with an update on fixed prosthodontics by **Herbert Shillingburg** (Professor Emeritus, Fixed Prosthodontics).

The prospective students were treated to a presentation by **Patricia Nunn** (Chair, Dental Hygiene) entitled "The Dental Team - Who's Who?", followed by a panel discussion addressing the many positive aspects and opportunities associated with careers in dentistry or dental hygiene with panelists **Donna Sheppard** (RDH'99) and **Robert Schick** (DDS'98). **Mrs. Nunn** and **Robert Miller** (Associate Dean, Student Affairs) completed the session with an update on the admissions process for their respective programs.

After a barbecue lunch, the students and their sponsors were escorted on tours of the dental building and the HSC campus. Thank you to second-year dental students **Chase Dighton**, **Leslie Genoff**, **Kesa McConnell** and **Jayson Voto**

who returned early from their summer vacations to assist as tour guides.

Sincere thanks also to **Vicki Coury** (Dental Hygiene), director of the College's CE department, and to staff members **Debbie Black**, **Sally Gilley**, **Kristy Jurko**, **Susan Martin**, **Janet Powell** and **Diana Stone** for all their hard work in planning, organizing and coordinating all the activities that made Career Day 2003 possible.

#### *STUDENT SUMMER RESEARCH*

This past summer, 26 dental and dental hygiene students (including two DH students in the Bartlesville program) participated in student/faculty research — an increase of seven over last year's group. All twenty projects were funded by the J. Dean Robertson Society. The summer research program provides an opportunity for students to [1] conduct actual research under the auspices of faculty mentors, [2] gain knowledge about research protocols and the materials/methods being studied, and [3] develop stronger faculty/student relationships outside of the classroom. Congratulations to all our student researchers (and their 13 faculty sponsors): Class of 2006 **Leslie Genoff**, **Kimberly Greenlee**, **Erin Heathcock**,

**Doug Huber, Jeremy Johnson, Tim Kirby, Marti Lane, Chris Reeves and Yu Jun Xu;** Class of 2005 **Deborah Butler and Scott Renfrow;** Class of 2004 **Pete Moore, Adam Pitts, Mike Toole, Sarah Vannatta and Gayla Winters;** and DH Class of 2004 **Stephanie Bills, Lacey Cermak** (Bartlesville), **Leah (Bonham) Dobbs, Jena Hankins, Lacey Howe, Jessica Lingle, Elizabeth Mandraccia, Keri Robinson** (Bartlesville), **Jennifer Warren** and **Tiffany Williams.** These projects will be presented as table clinics during our annual Scientific Day next Spring. Look for them!

#### *GOOD SHEPHERD MISSION*

**Frank Lipsinic** (Fixed Prosthodontics), faculty coordinator of the Good Shepherd Mission Dental Clinic, provided the following update on the mission: "Thanks to the generosity of our new partners, the Delta Dental Plan of Oklahoma Foundation and the Mercy Health Systems Kids Plus Program, we completed the first year of expanded services with both the Monday evening free extraction clinic and our new Tuesday evening free children's clinic (under the leadership of **Dr. Teresa Davis** [DDS'00]). The children's clinic, staffed by dental students and volunteers from the private practice community, treated

over 180 children in its first year. Through the generous grants of our new partners, we are making further facility improvements that should be completed and ready for showcasing at our scheduled Open House on Tuesday, September 2."

A new list of volunteer dentists willing to donate an evening per month to work with dental and dental hygiene students at the Mission is being developed. If you are interested in helping, please contact Dr. Lipsinic at 271-5346. New 2003-04 Mission Dental Clinic student coordinators for the Monday evening extraction clinic will be seniors **Pete Moore, Adam Pitts** and **Mike Riggs.**

#### *HONOR ROLL STUDENTS*

We use two honor roll designations to recognize outstanding academic performance during each grading period. The College of Dentistry Honor Roll recognizes those with grade point averages of 3.00 to 3.49. GPAs of 3.50 and above is awarded with membership on the Dean's Honor Roll. For the Spring 2003 semester, the honor rolls included 45 freshmen and 28 sophomores; honor roll status for 21 junior students was based on combined performance during the spring semester and summer session. Congratulations to all 94 honor roll students and spe-

cial kudos to the following 43 Dean's Honor Roll recipients: (Class of 2006) **Jamie Ariana, Felipe Avery-Miranda, Lauren Avery-Miranda, Neil Ayers, Seth Evetts, Anna Ferrell, Cord Fitzgerald, Kimberly Greenlee, Brad Hall, Erin Heathcock, Matt Holloman, Colin Holman, Doug Huber, Mark Kelly, Jason Knapp, Jennifer Matousek-Ronck, Shane Ragan, Chris Reeves, Miranda Ruleford, Amanda Sengel, Kyle Serfoss** and **Jason Voto;** (Class of 2005) **Brooke Bottom, Aaron Bulleigh, Carrie Chastain, Lori Holden, Brandon James, Eric Kyrk, Jake Mendenhall, Scott Renfrow, Darek Ridpath, Will Robinson, Tommy Rogers, and Amy Rowland;** (Class of 2004) **Jacob Hager, Kelly Joice, David Miller, Abbey Onan, Adam Pitts, Greg Segraves, Lindsay Smith, Sarah Vannatta** and **Brian Ward.**

#### *OTHER STUDENT NEWS*

At the ADHA Annual Session in New York last June, **Amy Roberts** (DH'03) received third-place recognition for her research poster "Academic Dishonesty in Bachelor's of Dental Hygiene Schools", based on a research project she completed during her senior year in the dental hygiene program. Amy won a cash prize and a matching grant for OUCOD.

## FACULTY NEWS

**Mary Martin** has stepped down as Associate Dean of Clinics effective July 31 after five years in the position. Replacing Dr. Martin is **Ed Wilson** (Chair, Occlusion) who had served as Assistant Director of Clinics for the past four years. Taking Dr. Wilson's place as the new Assistant Dean of Clinics is **Leon Bragg** (Operative Dentistry). Both appointments were effective as of August 1.

Effective August 2, **Paul Mullasseril** (Removable Prosthodontics) was appointed Interim Chair and **Kenneth Coy** (Dental Services Administration) Interim Vice Chair of the University Dental Faculty Group, the College's intramural faculty practice. They replace **Stephen Reagan** (Director, AEGD) who is stepping down after five years as UDFG Chair.

**Tammie Vargo** (Dental Hygiene) received the inaugural American Dental Hygienists' Association Future Leader Award. Selected from a list of nominees from across the United States, Tammie (RDH'00) was presented with the award during the ADHA Annual Session in New York City last June.

Last February, **Kevin Smith** (Director, Graduate Oral & Maxillofacial Surgery) was elected President of the

Oklahoma Society of Oral and Maxillofacial Surgeons. In August, he was also appointed to the Continuing Education Committee of the American Association of Oral and Maxillofacial Surgeons.

When we announced faculty promotions in the last issue we inadvertently omitted **Cheryl Church** (Oral Diagnosis) who was promoted from Clinical Instructor to Clinical Assistant Professor effective as of July 1. Cheryl (DDS'94) has been a full-time or part-time faculty member at the College since completing a general practice residency in 1995.

## RETIRED DENTISTS – ORGANIZATIONAL NEWS

By Albert Staples, DDS

The September meeting of the Oklahoma Retired Dentists was held Monday, September 15, 2003 at the Oklahoma Dental Association office.

Following lunch, **Dr. Steve Young**, Dean, OU College of Dentistry, presented an interesting program covering the past, present and future of the Dental College. Included in the program was material covering recent landscaping of North East 13th Street facing the dental building. Only pedestrian traffic will be allowed on this portion of 13th. The results will enhance the appearance of the college and facilitate access to

the Medical Center library across the street.

The next meeting of the Retired Dentists will be held at the Oklahoma Dental Association office on October 20, 2003. For information call (800) 876-8890 or (405) 848-8873.

## OKLAHOMA STATE DEPARTMENT OF HEALTH

By Michael L. Morgan, DDS, MPA  
Chief, Dental Health Service

On September 1, 2003, the new Oklahoma Smoking in Public Places and Indoor Workplaces Act took effect.

Most indoor places are smokefree. The new Oklahoma laws apply to

- Indoor places used by or open to the public
  - Indoor workplaces
  - Public transportation
- Smoking is prohibited in these places, except for certain exempt places specified in the laws.

How are restaurants affected? The new laws have a slightly different timetable for restaurants, which will have an additional 30 months (until March 1, 2006) to be either all smokefree or – if they elect to permit smoking in some areas – to provide enclosed and separately ventilated smoking rooms that meet the law's

requirements for protecting nonsmoking areas.

Unlike other public places and workplaces, restaurants will be able to continue designated smoking and nonsmoking areas without separate smoking rooms until March 1, 2006. Restaurants will be permitted to serve food and beverage in their smoking rooms, and the new laws consider all sizes of restaurants the same, regardless of seating capacity. The laws also specify that smoking may be permitted in outdoor dining areas of restaurants, but not within 15 feet of any exterior public doorway or air intake.

The Dental Program at the State Health Department has had a very busy summer. In addition to our regular programs, we have provided some in-service training for nursing home personnel, conducted dental educational programs in senior citizen nutrition centers, and provided dental educational programs in daycare centers, as well as in scheduled health department clinics.

The Oklahoma State Department of Health 2003 reportable disease statistics for the reporting period ending August 30, 2003 are published for your information.

AIDS .....	139
Gonorrhea .....	2,691
Hepatitis A .....	10
Hepatitis B .....	31
Hepatitis C .....	2
Syphilis .....	34
TB.....	90

## INTERNATIONAL COLLEGE OF DENTISTS

By Dr. Allen Keenan

Twenty-six attended the annual Summer Educational Retreat of the International College of Dentists (Oklahoma Chapter) in Ruidoso, New Mexico, June 13-15, 2003. **Dr. Ray Cohlmi**a gave the educational seminar. Everyone enjoyed the meeting and voted to repeat the event next year. Many thanks to **Drs. Scott** and **Maggie Russell** for organizing the weekend. •



Direct Reimbursement is a self-funded program that reimburses an individual based on a percentage of dollars spent for dental care, not on the type of treatment provided; it also allows patients to seek treatment from the dentists of their choice.

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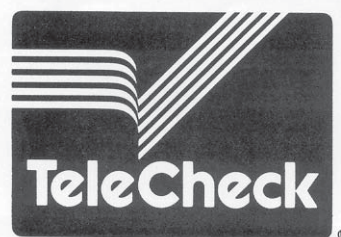
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