YOUR NEW ODA JOURNAL!
Ten times a year...
More color...
Larger format...
Up-to-date information...
In response to growing consumer demand, DDOK has developed DeltaPatient Direct™ - our new discount referral program that allows patients to access quality dental care and pay dentists directly - at the time of treatment.

Currently, there are an estimated 1.5 million Oklahomans without access to employeesponsored dental benefits. Delta Dental of Oklahoma has developed DeltaPatient Direct™ to benefit these Oklahomans who might not otherwise be able to access quality dental treatment. Additionally, we want to help bring additional patients to our valued participating dentists.

**Here’s how it works…**

**DeltaPatient Direct™** is not an insurance product. Individuals or families pay a low annual fee to DDOK. This fee provides access to a network of participating DeltaPatient Direct™ dentists, treatment financing options through Care Credit, vision care benefits from EyeMed, educational and treatment resources (including “Ask a Dentist”), and much more.

Dental services are offered at discounted rates that you, the provider, agree to. The patient visits your office and pays you at the time of treatment, according to the DeltaPatient Direct fee schedule.

**It’s that easy!**

- No claim forms!
- No administrative costs!
- No verification of maximums and deductibles!

If you are currently a DeltaPreferred Option (DPO) dentist, or if you wish to add additional patients to your practice with no additional paperwork - we invite you to consider DeltaPatient Direct™.

Access 1.5 million patients while incurring no administrative costs, no network enrollment fees and no verification of maximums or deductibles. DeltaPatient Direct™ from one of the most trusted names in dental benefits - Delta Dental of Oklahoma.

Be sure to visit [www.PatientDirect.NET](http://www.PatientDirect.NET). Should you need an enrollment package, or if you have additional questions about our new DeltaPatient Direct™ network, please contact Kim Montgomery, with our Professional Relations Department at: 405-607-2142 (OKC metro) or 800-522-0188, ext. 142 (outside the OKC metro).

An equal opportunity employer.

Only Dental. Only Delta.
EDITOR’S MESSAGE

The new “ODA”: A colloquial term that has been passed around for the last year or so and is now the buzz word floating in the midst of our association and its membership. But indeed it is; a new vision; a new plan; and a new look. I am sure that you have noticed that this “new ODA” now extends to our publishing department providing this: a new ODA Journal.

Establishing this cooperative plan and vision for our future marks some changes that you will be seeing, starting with the very journal in your hand right now.

Previously, we published four journals per year, paralleling the seasons, winter, spring, summer, and fall. In between these publications came the newsletters, Legislative Updates, and Talkback, just to name a few.

In other words, we had multiple publications, with multiple deadlines and different goals. From the editorial board, staff, and the cost effectiveness of layout and printing, we now have the wonderful opportunity to combine all these publications into one.

“One?” you say. That’s right, one. You hold the 2004 September Journal in your hands right now. The ODA Journal will now consist of a yearly volume of ten publications. Thus, you will begin to receive a journal about every five to six weeks. Additionally, it will have a consistent layout and headings from journal to journal. Using the index tabs on each page will allow you to go directly to your particular items of interest every issue.

Additionally, the frequent issue release allows us to incorporate those other publications into this one. Hot issues, member news, association updates, messages from your officers, talkbacks, legislative issues, scientific articles, and editorial viewpoints can all be easily addressed with this frequency.

Previously, the journal had been slowed time and time again by entities unable to meet publishing deadlines. With the new frequency, the deadlines occur roughly every six weeks.

For those of you that submit on a regular basis but sometimes have difficulty making publishing deadlines, you can now submit your information for the next issue. Since the due date will occur only five weeks later – your material can be published in the next upcoming journal.

Will it all be there? Yes, and more! Our previous journals were approximately sixty to seventy pages in length. Color was dependent on advertisers and other articles selected by the editorial board to coincide with single pages of color set by the limitation of the printer and our budget.

Our new journal, as you see, is thirty-two pages in length and in full color throughout. The world you live in consists of color everywhere, cover to cover (pun intended), so to speak. Why shouldn’t your ODA Journal as well?

We truly hope that you enjoy your new ODA Journal. We will continue to strive to maintain that parallel direction of the “new ODA,” with emphasis on a member-driven and society connected association.

As always, we welcome your comments both good and not so good. Your input guides us and helps us to continually change or adjust our programs and services to meet your requests; all a part of your “new ODA Journal.”

Raymond Cohlmia
Editor 2004-2005

DON’T FORGET!

The ODA Annual Award Nomination form is due December 31st!

Nominations will be accepted for the following categories:

- Dentist of the Year
- Young Dentist of the Year
- Thomas J. Jefferson (Citizenship)
- Robert K. Wynne (Public Info.)
- Dan E. Brannin (Professionalism)
- Richard T. Oliver (Legislative)

Don’t wait until the last minute, fill out your form today.

Forms can be found on okda.org or by calling the ODA at 405-848-8873 or 800-876-8890.
On July 16, the Oklahoma Dental Association participated in Doctor’s Week with KWTV Channel 9 in Oklahoma City and KOTV Channel 6 in Tulsa.

Doctor’s Week was an event held by both stations in which each day of the week focused on a specific health issue. The health issue on Friday of Doctor’s Week was dental health.

ODA’s participation in this event included providing doctors to conduct Internet chats with the general public on issues of oral health. The Internet chats were conducted at the NewsOK offices in Oklahoma City and at the KOTV Channel 6 offices in Tulsa.

In Oklahoma City, Dr. Andrew Guthrie answered questions on when to first take a child to see a dentist and discussed the latest breakthroughs in TMJ treatment.

In Tulsa, Dr. Robert Mongrain advised participants to have their children wear mouth guards in any contact sport and explained the implications of excessive brushing.

In addition to the Internet chats, Oklahoma City and Tulsa dentists screened several hundred children for oral health problems at several local Boys & Girls Clubs in both cities as part of Doctor’s Week.

These screenings were the focal point of the Doctor’s Week news story that aired on both KWTV Channel 9 and KOTV Channel 6.

The Oklahoma Dental Association also produced a Public
Service Announcement (PSA) that aired on both stations in the two weeks leading up to Doctor’s Week.

The PSA utilized the “Sip All Day, Get Decay” theme that has been popular throughout the Association.

The PSA featured Dr. Lee Beasley, Dr. Carol Blossfeld, and a host of happy, smiling children.

All video associated with Doctor’s Week—the PSA, Doctor’s Week news story, and a Doctor’s Week promotional spot featuring Dr. Andrew Guthrie—are available to view anytime on the Oklahoma Dental Association Web site www.okda.org.

### DOCTOR’S PARTICIPATING IN BOYS & GIRLS CLUB SCREENINGS*

<table>
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<tr>
<th>Oklahoma City</th>
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<td>Don Roberts</td>
<td>Robert Mongrain</td>
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<td>Trena Stewart</td>
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<td>Andrew Guthrie</td>
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*Several Assistants and Hygienists from participating Doctor’s offices also participated in these screenings.

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Have an event you would like listed on the ODA Calendar? Email details to events@okda.org
The winners of the 2004 ODA Poster Contest, Evan Pendleton and Weston Sloan, along with their families, were treated to a tour of the Braum Family Farm and Dairy Processing Plant on June 25th, 2004 in Tuttle, Okla.

The tour, given by Mr. Drew Braum, President, started with an educational video and free ice cream samples. The group rode on the official pink and black Braum Dairy Tour Bus to the processing plant where they toured the 260,000 sq. ft. facility.

The tour, approximately two hours long, covered every area of the plant from the packaging of ice cream to the processing of milk.

Mr. Braum then led the group on a non-traditional tour to one of the plant’s walk-in freezers, kept 20 degrees below zero. The group ended the day with complimentary lunch and ice cream at the Braum’s store located in Newcastle, Okla.

### Dr. John A. Miller

**Birth:** May 16, 1922  
**Death:** July 14, 2004  
**McAlester, Okla.**

Dr. Miller graduated from the University of Houston Dental School after obtaining a bachelor’s degree from Baylor University. Dr. Miller also served his country as a captain in the U.S. army. Dr. Miller practiced dentistry at Ft. Sill and in Pauls Valley and McAlester. He retired from dentistry in 1992 after practicing in McAlester for more than 35 years.

### Dr. Quentin Wesley

**Birth:** February 24, 1919  
**Death:** June 17, 2004  
**Tulsa, Okla.**

Dr. Wesley obtained his degree in dentistry in 1950 from the Kansas City Dental School. His first practice was in Tulsa, Okla. Dr. Wesley served his country during the Korean War as a Flight Surgeon for the U.S. Air Force. He later moved back to Tulsa and continued his practice until retirement in 1978.
RESOLUTION H-MS(2003-2004)-20
Be it resolved, that Dr. Daniel P. Datzell, Norman, Dr. Roger Metcalf, Bixby, Dr. Kenton E. Nesbit, Tonkawa, Dr. Gerald Lucas, Oklahoma City, and Dr. William R. Shadid, Norman, be nominated by the Board of Trustees and elected by the House of Delegates into State Life Membership of the Oklahoma Dental Association.

RESOLUTION H-MS(2003-2004)-29
Be it resolved, that the Council on Membership and Membership Services recommends to the House of Delegates that the Oklahoma Dental Association new dentist dues structure parallel the tripartite dues structure beginning in 2005.

RESOLUTION H-(2003-2004)-30
Be it resolved, that the Board of Trustees recommends that the House of Delegates nominate Dr. Ray Maddox as an honorary member of the Oklahoma Dental Association.

RESOLUTION H-(2003-2004)-31
Be it resolved, that the Board of Trustees recommends that the House of Delegates nominate Dr. Russell Stratton as an honorary member of the Oklahoma Dental Association.

Dr. Beasley introduced the following appointments to ODA leadership which were accepted by the House of Delegates:

Secretary/Treasurer: Dr. Karen Rattan
Editor: Dr. Raymond Cohlmia
Chair, Council on Annual Session: Dr. Tom McGarry
Chair, Council on Bylaws and Policy: Dr. E. Van Greer
Chair, Council on Dental Care: Dr. Debora Gill
Chair, Sub-council on Mediation Review: Dr. Krista Jones
Chair, Sub-council on OHCA and DHS: Dr. James Murtaugh
Chair, Council on Dental Education: Dr. Tim Shannon
Chair, Council on Governmental Affairs: Dr. Robert Augsburger
Chair, Council on Membership and Membership Services: Dr. Tamara Berg

RESOLUTION H-(2003-2004)-18:
Be it resolved, that the Oklahoma Dental Association establish the Centennial Membership Section for the specific purpose of collecting voluntary dues to pay for the purchase of land and the construction of an ODA office building.

RESOLUTION H-(2003-2004)-19:
Be it resolved, that the Oklahoma Dental Association will conduct a campaign to solicit Centennial Section Members.

RESOLUTION H-BP(2003-2004)-21,
Be it resolved, that the Council on Budget and Planning recommends to the House of Delegates to increase the 2005 membership dues by $55 per member to cover the new building expenditures and to maintain current operating expenses and programs.

RESOLUTION H-BP(2003-2004)-22,
Be it resolved, that the Council on Budget and Planning recommends to the House of Delegates to increase the 2005 Annual Meeting registration fees by $25 per dentist and $10 per dental assistant, dental hygienist, and lab technician.

RESOLUTION H-BP(2003-2004)-23,
Be it resolved, that the Council on Budget and Planning recommends to the House of Delegates to increase the average fee for regular ticketed events by $10 for the 2005 Annual Meeting.

RESOLUTION H-BP(2003-2004)-26,
Be it resolved, that the Council on Budget and Planning recommends that the House policy be amended by substitution to read: Volunteer representatives approved for travel on behalf of the Oklahoma Dental Association be reimbursed for lowest advance purchased coach airfare or current government mileage rate, run of the house lodging at the designated leadership hotel, and $50 per diem effective January 1, 2006.

Be it resolved, that Article II, Section 5 F of the bylaws be amended by striking out “in writing” and inserting or by a two/thirds affirmative vote without prior notice”. If adopted, would read: “Dues may be changed by a majority vote of the House of Delegates provided that the proposal has been presented at any previous regular meeting or by a two/thirds affirmative vote without prior notice.”

Be it resolved, that Article VII, Section 5 of the bylaws be amended by adding “immediate Past-President” between “the” and “President” If adopted, would read: “Each component shall be allocated one delegate to the House of Delegates for each fifteen (15) active, life and retired members (no fraction hereof shall be considered). In addition, the immediate Past President, President, President-elect, Vice President and Secretary shall also serve as delegates.”

Be it resolved, that the Council on Dental Education recommends to the House of Delegates that the Oklahoma Dental Association participate in Doctor’s Week 2004 with Griffin Communication.

RESOLUTION H-MS(2003-2004)-27.
Be it resolved, that the Council on Membership and Membership Services recommends to the House of Delegates that component society dues adjustments be submitted to the ODA Executive Director by June 1 in order for the change to be reflected on the annual dues invoice for the following year.

Be it resolved, that the Council on Nominations and Elections recommends that the House of Delegates elect the following nominees for officers and councils of the Oklahoma Dental Association:

President: Dr. Pam Low
Vice President: Dr. Jerome Miller, ADA Delegate
Speaker of the House of Delegates: Dr. Allen Keenan, ADA Alternate Delegate
Speaker of the House of Delegates: Dr. Larson Keso
Chair, Committee on Budget: Dr. Steve Powell, Dr. Keefe Carbone
Chair, Committee on Bylaws and Policy: Dr. Bob Morford, Dr. Wes Black, Dr. Tyson Christy, Dr. Jamie Wedemeyer, Dr. E. Van Greer
Chair, Committee on Dental Care: Dr. Debora Gill, Dr. Brian Bennett, Dr. Don Smith, Dr. Janna McIntosh
Chair, Sub-council on Mediation Review: Dr. Carol Blossfeld, Dr. Carl Schreiner, Dr. Debora Gill, Dr. Billie Reeder
Chair, Sub-council on OHCA and DHS: Dr. James Murchaugh, Dr. Glenn Mead, Dr. Chris Bugg
Chair, Council on Dental Education: Dr. Tim Shannon, Dr. Mark Patrick, Dr. Thai-An Doan, Dr. Frank Miranda
Chair, Council on Governmental Affairs: Dr. Ken Rains, Dr. Kurt Gibson, Dr. Mark Hanstein, Dr. Keith Keeter
Chair, Council on Membership Services: Dr. Russell Danner, Dr. Tamara Berg.
ODA NEW HEADQUARTERS
Building Update

In August, the ODA finally received the building permit for the new ODA Headquarters. The new building site, N.E. 13th and Stiles, is currently being prepped to prepare for the construction of retaining walls. Once the retaining walls are completed, work on the foundation will begin.

The rendering of the Donor Courtyard (bottom) illustrates where Centennial donor bricks and benches will be located. These donor bricks and benches will bear the name of the ODA members who contributed funds to the Centennial Membership section to pay for the new headquarters.

In addition to the Donor Courtyard, many donors will be recognized throughout the building with Board Room Chairs or Offices that bear the donors’ names. Where will you be recognized in the new building?

Oklahoma attendees at the 18th Annual New Dentist Conference.

18TH ANNUAL NEW DENTIST CONFERENCE

The 18th Annual ADA New Dentist Conference was held on June 24 - 25, in San Diego, Calif.

Oklahoma was well represented with ADA President-Elect Dr. Richard Haught, Dr. Tamara Berg, Dr. Raymond Cohlmia, Dr. Jeff Danner and ODA Membership Director Kay Mosley in attendance. Many ADA Board of Trustees members also attended the weekend events.

The ADA Tripartite Grassroots Membership Initiative was an important aspect of the three-day conference. At the idea exchange forum, Kay Mosley, ODA Director of Membership, made a presentation regarding the ODA’s member activities and benefits.

Oklahoma currently has a 79.5% membership rate compared with the national average of 71%, according to the 2003 data. This exceptional membership retention rate is well above other state averages.

One contributing factor for the ODA’s high membership rate is the continued relationship between the ODA and the OUCOD.

The Future is Now...The New ODA Headquarters

- Help strengthen the future of dentistry in Oklahoma
- Referring this debt will save the ODA tens of thousands of dollars in interest
- All donations can be tax deducted as a business expense

For more information log on to www.okda.org or call the ODA at 405-848-8873 or 800-876-8890

Join the Centennial Membership Section Today!

- $999 – 333 Club – Medium Brick
- $1,500 – Large Brick
- $2,500 – Boardroom Chair
- $5,000 – Bench/Patio Table
- $7,500 – Office
- $10,000 or more – Customized Recognition

For more information log on to www.okda.org or call the ODA at 405-848-8873 or 800-876-8890
The summer of 1938, in Muskogee, was one of the hottest in memory. Joe Teaff, 19 years old and a recent graduate of Muskogee Junior College, had just shipped his clothes and possessions to Kansas City where he was enrolled in the freshman class at UMKC dental school.

He planned on boarding the early morning train but couldn’t tell whether it was the butterflies in his stomach that were making him feel ill or something else. It was something else – an acute case of pneumonia that landed Teaff in the hospital for six weeks.

There was no dental school that year, but a call to Kansas City brought the good news that he could enter next year’s class as long as he made up the work he had missed. So he did.

Teaff and his classmates graduated in January, 1943 – the first expedited class at UMKC due to the pressing demands of the military and WWII. Each graduate received a DDS degree and, as a bonus, a commission as a junior officer in the US Army or Navy.

Teaff chose the Navy and was stationed in Charleston, S.C. as chief of prosthetics at the dental clinic. Teaff then served a stint at Long Island Naval station before returning to Muskogee in 1946.

A beginning dental practice (Teaff bought out a retiring dentist for $15,000) was soon interrupted by another call from Uncle Sam, as Teaff did an additional two years with the Navy on a destroyer tender stationed in the Philippines.

Final discharge in 1950 brought Teaff back to Muskogee to continue a private practice that spanned 61 years with his retirement in September 2004.

Teaff was always active in organized dentistry, having served as President of his local and district dental societies, as chair of numerous state committees, Speaker of the ODA House of Delegates and President of the ODA, 1960-61.

Teaff also served on the Muskogee City Council for eight years and as a Deacon and Elder in the First Presbyterian Church.

Teaff has been a leader and mentor for the current generation of Muskogee dentists, and leaves a legacy of dental excellence.

Joe Teaff took time to discuss his career in dentistry with the ODA Journal.

ODA: What was dental practice like when you first started?

JT: Most patients sought care only when they had a toothache. Amalgam restorations were $0.50 and a gold inlay went for $12.00. I always did my own lab work and I felt I could do a better job than a dental lab, and continued doing my own work until the 1980’s.

ODA: During your career, what were the three biggest changes in the dental practice?

JT: From my perspective, sit-down dentistry is number one – we were taught to stand and bend over. The air-driven, high-speed handpiece, carbide burs and diamonds are a close second. We used belt-driven 3,000 RPM handpieces, and even the Page-Shays handpiece only turned 50,000. The third would be the tremendous improvement in dental materials and techniques.

ODA: What were the biggest issues facing the ODA while you were President?

JT: There were two important issues in 1960-61. First, a dues increase was sorely needed and provoked considerable discussion, but it was finally passed – all $15 of it. Secondly, the ODA had been renting office space near downtown Oklahoma City and needed to expand. The construction of our own building began with an offer of donated land near the new Baptist hospital. Fundraising started and pledges for almost all of the construction costs were obtained, but the concept was eventually tabled. Finally after three years, the current ODA building construction began on the present site.

ODA: What do you like most/least about practicing dentistry?

JT: The most rewarding thing is the relationship you build with your patients and their families and the trust that is maintained over the years. I least liked the commercialization of dentistry, although I realize now what I perceived as bad was actually sound business practices. Advertising was frowned on. I remember once the State Board actually made a dentist remove a small neon “dental office” sign from his window.

ODA: What advice would you give to a new dental graduate?

JT: I would encourage them to avoid initial start-up debt as much as possible and live and save within your means – although I realize that the cost of providing adequate care to your patients is almost prohibitive today as opposed to the 1940’s. Careful planning and postponing personal gratification initially will produce the rewards you seek. Also, begin accumulating CE hours immediately by becoming an Academy of General Dentistry member and working towards Fellowship and Masters Levels. It is a terrific way to start a life-long pursuit of knowledge and competence.

Dennis Weibel, DDS
ESTHETICS WITHOUT COMPROMISE

King of
CAPTEK

FEATURING
AGREAT UNIT FEE OF $125.00

FROM HEUMANN & ASSOCIATES PRESENTING A CAPTEK PRODUCTION/CAPTEK WITH IPS.D.SIGN® PORCELAIN PRODUCED WITH: SUPERIOR BIOCOMPATIBILITY, EXTREME BOND STRENGTH, NO SPECIAL CHAIR-SIDE REQUIREMENTS, THE ULTIMATE FIT. NOT STARRING: GREY MARGINS.
Scott Adkins is the ODA’s contract lobbyist. Adkins joined the ODA in 2003 and has already proved valuable by successfully handling several bills of interest to ODA members during the 2004 legislative session.

Scott Adkins grew up in Poteau, OK, a small community located in the southeastern part of the state. After high school, Adkins attended The University of the Ozarks in Clarksville, Arkansas, working his way through college and eventually receiving a B.S. in business.

After graduation, Adkins continued his education by attending Southern Methodist University where he received a Masters in Business Administration.

Adkins is currently the President of his own firm, Scott Adkins Consulting, which specializes in lobbying, government, and public relations.

Part of Adkins’ success in lobbying is the result of his previous political experience—he served six years in the legislature as a member of the Oklahoma House of Representatives.

Adkins recently sat down with the ODA Journal to discuss lobbying, legislation, and why it is essential to have a personal relationship with your legislators.

ODA: What do you feel is the biggest legislative issue facing Oklahoma dentists today?
SA: Scope of practice issues are a daily struggle at the Capitol. It seems that every year a group or outside interest attempts to weaken our ability or authority to manage the dental health of our patients.

ODA: What role do you serve as the contract lobbyist for the ODA?
SA: As the contract lobbyist for the ODA, I’m like the quarterback of our legislative football team. The Board of Trustees can be seen as the owners of the team, with Dana Davis, ODA’s Executive Director, acting as the head coach. My role is to advise the Association in formulating policy and the legislative agenda. Once these matters are decided, I direct the action at the Capitol to implement the game plan put forth by the coach and owners.

ODA: Locally, what can dentists do to help with important issues at the Capitol?
SA: Every dentist should have an appreciation of the influence the legislature can have on our profession, both positive and negative. The House and the Senate write or approve the laws under which we practice. They have the ability to allow us to manage the dental health of patients or write us out of business.

ODA: If legislators are that powerful, then it is probably a good idea for every dentist in the state to know their Senators and Representatives.
SA: Absolutely. The most important thing any dentist can do is have a personal relationship with their legislators. One of the goals that I have for the ODA is to put a local face on our issues at the Capitol. A Senator or Representative should immediately think of their dentists back home when facing a dental health issue before the legislature.

ODA: Legislatively speaking, what future goals do you have in mind for the ODA?
SA: My primary objective is to raise the legislative profile of the ODA around the state and, in doing so, increase our influence at the Capitol. We have members in all 77 counties. Our dentists are some of the most respected professionals in their communities. Those are tremendous resources that we need to organize. Legislators, first and foremost, listen to their folks back home. My goal is for every dentist in Oklahoma to see themselves as the LOCAL lobbyist for the ODA. ●
ANTIBIOTICS FOR YOUR COMPUTER?

It happened again. I received a call from a colleague and heard the scream and cry over the phone, “Help! My computer’s not working right!” After a long talk, he informed me that he had been surfing the Internet and reading his e-mail.

While reading his e-mail, he opened an e-mail from an unknown source…and then it happened. The machine began to do strange things and delete files.

He didn’t understand the confusion so he went to another machine in his network. It too, was demonstrating the same response. He rapidly and frantically moved from one unit to another to no avail.

Just then, his receptionist came back and said, “Doctor, I can’t access any of the accounts, insurance, or schedules; my machine is locked up.” His heart sank. He thought, what happened?

After speaking with him and checking out his computers and hardware, I surmised that his machine had been infected by one of the computer viruses floating around.

I referred him to a local company that was able to resolve his issue after a multitude of hours. Luckily, he had a recent backup, less than a week old, that was used to restore most of the data and information prior to the infection.

The question that I ended up answering for him was what a computer virus is and how he caught it. Most importantly, he wanted to know how he could keep it from happening.

I informed him that he needed to get the most protection as possible when things get back online. Yes, I said the most protection. Please remember that it is virtually impossible to have 100% protection. Read on, I’ll explain.

First, in order to understand what a virus is we must understand how a computer operates day-to-day. A computer is nothing more than a glorified calculator or typewriter that performs its operations by instruction.

These instructions are written in a programming code that tells the computer what you want it to do. Programming code is written one line after another and can be very complex.

For example, let’s say that you have a group of numbers that you wish to sort into three groups. One group colored orange for those less than 50; a second group that consists of numbers with values more than 51 but less than 100 colored green; and the last group consisting of numbers more than the value of 101 and they would be colored red. Your code would look something like this:

- Line 1; if “x” [the number] is less than 50 place into column 1.
- Line 2 would be if “x” is more than 51 or less than 100 place into column 2.
- Line 3 would be if “x” is more than 101 place the number in column 3.
- Line 4 would be that after sorting the numbers, make column 1 orange.
- Line 5; make column 2 green
- Line 6; make column 3 red.
- Line 7; if there are remaining numbers to sort go to Line 1; if not, end the sequence and display “done.”

What you see is a basic program that separates numbers for you. The computer starts with each number and runs it from line one to six and then starts back over again at the top. When there are no other numbers to sort, the sequence stops and the computer signals the operator it is done.

Now for the virus. There are people out there that just want to disrupt every computer for kicks. I won’t get into that, we just know they are there and their game plan is to inflict havoc on as many systems as possible.

So here is what happens. The virus-maker makes a little program that interferes with your program by inserting a line say after line five that says “Go back to line one.”

If this occurs it would put your program and computer into a loop where it never ends trying to complete the task. It would start at the top, go down to the line the hacker put in, and it would start over at the top again, with no end in sight.

Now you have the computer-locked-up thing happening to you. The machine is now useless because it is busy trying to finish the sorting program, which now has no terminating line to tell it to stop.

This type of example of a virus is very small and somewhat insignificant. However, others can cause your computer to act strange and unresponsive and even worse, some could erase your hard drive by hitting certain keystrokes or by executing a certain program.

The virus that my friend “caught” in the above story was a type of virus that corrupts the basic operating parameters of a computer system and network. It affected his entire network at his office and put his system down for over three days.

The moral of this story has several learning points. First, it is imperative to have up-to-date antivirus software to help protect you from the literally thousands of viruses out there.

Early on, I remarked that it is impossible to have 100% protection. The reason this is true is by the nature of antivirus software and services in itself.

They operate on the principle that when a virus is released, they learn about it through their operatives and develop the “antivirus program” to combat against it.

Once the antivirus program is made and distributed, that particular virus becomes non-threatening to those computers.
with that particular antivirus program. The antivirus companies work on the after-the-fact basis of working on combating these viruses once they are made and distributed.

If you happen to be the one computer that gets the new virus before the antivirus program is released, then your machine will get the virus.

The percentage of getting a new virus with all the computers out there is extremely remote, but nonetheless does exist. This is why even with the most up-to-date antivirus programs, it is impossible to have 100% protection.

Some names of companies are McAfee, Norton, and Panda. These are live services, meaning that they are constantly being upgraded, and would be constantly downloading the new antivirus programs into your computer to protect you from all of the known viruses out there.

They also include "scripting software," which is a type of program that tends to look for strange activity on your computer and alert you to the possibility of a virus or other potentially harmful items. Never open any e-mail files from people that you don’t know.

The second moral of the story is to have a “firewall” program. These programs, available from many of the same antivirus software companies, do just what they imply. Protect you from fire on the other side of the wall.

The other side of the wall, in this case, is the Internet and all the computers that you are linked to when you log on to the World Wide Web.

When you surf, you are receiving information from other computers and services. However, your machine, in order to view these pages of information, sends information back to that particular computer to complete the system link. The site you are viewing may use programs to gain inside information about you and your personal data or even attempt to deliver a virus to your machine.

If the doctor had up-to-date antivirus software on his system he probably would have never caught the virus in the first place.

He did not have any protection and as a result lost data, money, and time. This all stemmed from the fact that he recently hooked up one of his network computers to the Internet and e-mail.

Have frequent and accurate backups for your data. This will save you countless numbers of hours entering in information. Check to make sure that your computer is making correct, operational, and accurate backups by testing them occasionally.

Go get your antibiotics, fire protection, and backup systems installed now. If you already have them, make sure they are up-to-date and operating properly!

Until next time, happy (and disease free) computing!

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The 2004 legislative session adjourned on May 28. Several bills of interest to the Oklahoma dental community were introduced during this Legislative session. The following is a recap of that legislation:

**HB2415 – Dental Hygiene Advisory Committee**

The most controversial bill of 2004 was HB2415, authored by Rep. Fred Stanley (D-Madill), the Chairman of the House Public Health Committee, and sponsored by the Oklahoma Dental Hygiene Association.

HB2415 would have created (thus mandating by law) a Dental Hygiene Advisory Committee to the Oklahoma Board of Dentistry.

The ODA opposed this legislation and its attempt to circumvent the State Board. The proposal disregarded agreements reached months earlier between dentists and hygienists that would have let agency rule process take its course.

With help from ODA members around the state, this bill was defeated on the floor of the House of Representatives. As a result of our efforts to defeat HB2415, legislation sponsored by the ODA got caught in the crossfire. The ODA had to sacrifice HB2670, which would have put in place a dental loan repayment program for up to five new dentists a year who agree to provide dental care to underserved areas of Oklahoma.

HB2670 was pulled from the house calendar and did not receive a final hearing.

**Cigarette Tax and Tort Reform**

The Oklahoma Dental Association joined the entire health care industry in lending support to the efforts to pass cigarette tax and tort reform initiatives.

HB2660 was successful and will be put to a vote of the people. This bill would create an additional $.55 per pack cigarette tax. Combined with federal matching money, this initiative will provide close to $500 million in additional health care funding to the state.

HB 2661 was the controversial tort reform measure that passed the legislature. Opponents from the business community said that the bill didn't go far enough because provisions for product liability were omitted.

Health care providers stood in support because of the expanded liability cap, loser pays provisions, modifications to joint liability, and enhanced definition of frivolous lawsuits.

**OSEEGIB**

The ODA was also active on two other bills of interest to dentists. The ODA supported the passage of HB1571 by Rep. Harrison / Sen. Rabon, which will open up the state employees insurance group (OSEEGIB) to competition and additional insurance plans to provide reimbursement for dental services.

This legislation has now become law. The ODA opposed language in SB1280 by Rep. Hilliard / Sen. Robinson that would have expanded the authority of many health care providers to legally use the term “doctor” in their title.

With the help of the medical, osteopathic, and optometric associations we were successful in getting that language removed from the bill.

**Moving Forward**

Overall, the 2004 legislative session was a successful one for the Oklahoma dentist. The most significant development in 2004 was the new level of legislative organization and teamwork that is being established within...
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The legislative goal for the ODA in 2005 and beyond is to increase the political influence of the Association. To do this, our Association must have the support and help of EVERY DENTIST in Oklahoma.

On September 17th, the ODA will hold a grassroots political seminar in Oklahoma City. This important effort will be conducted in conjunction with the Oklahoma Dental Foundation meeting.

During this meeting you will learn how to motivate Legislators and policy makers and discover why it’s CRITICAL to our profession that we make our voices heard in the political process.

Essentially, you will learn how to HELP YOUR ASSOCIATION HELP YOU!

I’m excited to be a part of the ODA. Through updates in the ODA Journal and on the ODA Web site, I will continually keep you updated about the legislative activities that are of interest to Oklahoma dentists.

I look forward to meeting each of you on September 17th at our grassroots political seminar.

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As a member of organized dentistry, you have access to benefits offered in eight distinct areas: government relations, insurance, publications, education, public relations, individual assistance, career counseling, and research/evaluation of products, business services and educational entities.

Unfortunately, most benefits are intangible items, so they are not so readily apparent. Membership, for example, offers you free access to the advice of experts in every area of dental practice, such as contract law, practice management, and dental benefits.

Some of this advice is available nowhere else and some expertise would be excessively expensive anywhere else. Your membership also allows you to effectively combat groups that would like a piece of Dentistry at your expense. The collective influence exerted by a united voice far exceeds what you as an individual or a splinter group could ever apply.

However, your dental association is more than a mere special interest group. It is your best hope for making the practice of dentistry better not only for yourself, but for your patients as well.

The association was originally created for this sole purpose. Conscientious practitioners started the ADA in 1859 to eradicate the rampant quackery that plagued the public for centuries and gave Dentistry a bad name.

They obtained protective legislation and raised the average level of practice through education. Association members maintain higher standards by agreeing to live by a code of ethics.

As a member you demonstrate that you are more than an opportunistic merchant of dental services. You are a doctor who cares – first and foremost – about the welfare of human beings.

Your professional organization cannot succeed without grassroots participation. Thwarting of imposed government regulations and ambitious public relations efforts do not happen by chance.

Your dental association is the source of the miracles and it is run entirely by volunteers – your colleagues. They determine through the democratic process what Dentistry’s unified policies will be, what approach the profession will take to solve complex issues, what the dues will be, how benefits and services will be funded, and what actions the staff will take. To be maximally effective, your volunteer colleagues must have access to a steady supply of dynamic ideas and new talent. They need what you have to offer.

What’s in it for you? As a volunteer, you will have a unique opportunity to personally shape your own future, to steer the profession on the right path, and to have a say about what is happening.

What’s more, the leadership skills involved in running a committee – delegating, budgeting, communication, public speaking, writing, working with computers – are the very same ones you need to make the most of your dental practice!

There is no question that whatever you give to your profession returns to you ten-fold. But there is more. Volunteerism is a special opportunity for learning, for personal growth and for creating lifelong relationships with individuals far beyond the isolated sphere of a dental office whom you would otherwise never meet.

Volunteers develop a unique camaraderie because they know that collectively their efforts – however small – really do make a difference in solving problems and helping others. In fact, they make all the difference!

By Edward Feinberg, DMD
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The Second Career of Dr. Gary Gardner

By his own admission, Dr. Gary Gardner had an incredibly rewarding career in dentistry. He operated a successful practice in Lawton, Okla. for 41 years, served as Oklahoma Dental Association President in 1976-77, and, perhaps most importantly, established a career that allowed him plenty of time to pursue his love of golf.

So it comes as a bit of a surprise, even to him, that only one year after his retirement from dentistry he seems to be embarking on a new career…as a sculptor.

Where did Dr. Gardner get the motivation to pursue sculpting? From another Oklahoma dentist naturally.

“Dr. Grant Ritchey, a dentist in Norman, was teaching a sculpting class at the Firehouse Art Center,” Dr. Gardner recalls. “He knew I was an art lover, and he tried to get me to come up and take a class, and finally I did. That was eight years ago.”

Since that first class, Dr. Gardner has continued to study sculpting at renowned sculpting programs such as the Scottsdale Artist School in Arizona and Loveland Academy in Colorado. He initially attended these classes as a hobbyist; he simply enjoyed sculpting and wanted to learn more about the process. However, as Dr. Gardner continued his education and his sculpting skills improved, he began to consider ways that he could produce work that would be displayed in the public sphere. He, like all artists, hoped his artistic expression could somehow contribute to a social understanding of the subjects and themes his work embraced.

In hopes of achieving the goal of creating a public piece, Dr. Gardner submitted his work to a competition held in Lawton to have the city namesake, General Henry Ware Lawton, sculpted in conjunction with Lawton’s centennial celebration. Numerous entries were considered by a selection committee, and at the end of the process Dr. Gardner was commissioned to create the sculpture of General Lawton. In just eight years Dr. Gardner had gone from taking his first sculpting class to being selected to create perhaps the most important sculpture in the city of Lawton.

“I believe every dentist is a sculptor,” Dr. Gardner said in explaining his ability to quickly transition from doctor to artist. “We are always working with our fingers and hands. Plus, I’ve found sculpting faces comes naturally, and I think it’s because I’ve been looking at faces for over 40 years. I know the face, intimately.”


(continued on pg. 23)
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As many investors have learned the hard way in recent years, building wealth while preserving principal is not about riding the hot sectors or even picking the “best” investments. It’s about investing regularly over the long term with a diversified portfolio.

Your portfolio’s asset allocation – the mix of investments you choose – is key to achieving diversity, maximizing returns and managing risk, even more than your choice of actual investments.

Whether you dream of retiring in style, sending your children to the university of their choice or starting your own business, how you allocate your assets will be critical to achieving your goals.

Finding the right asset allocation for you

A diversified portfolio begins with three main asset classes: stocks, bonds and cash. Each of these performs differently in different situations. They also offer different levels of risk and potential returns. The tricky part is deciding what mix of investments is right for you.

When it comes to building your own portfolio, your investments should reflect your age, your individual needs and goals, and the overall economy. But since these factors are fluid, allocating your assets is truly an ongoing process.

Stocks

Stocks represent shares of ownership in the companies that issue them. These are your best shot at long-term growth (rather than short-term income) and may represent the majority of your portfolio, depending on your time horizon.

Though more risky than bonds or cash, stocks have produced higher average annual returns over time and offer the best long-term potential hedge against inflation.

According to Ibbotson Associates, a respected financial services consulting firm, there has been no 15-year or longer period where stocks, as represented by the S&P 500 index, didn’t see a gain. Fifty-four of the past 76 years have seen the stock market gain money.

It’s also important to diversify your stock holdings. Growth and value stocks should be well-represented in your portfolio, with exposure to large-, mid- and small-caps, as well as international and sector funds, depending on your risk factor.

A financial advisor can help you select stocks based on indicators such as projected earnings per share, growth, price-earnings ratio, etc.

Bonds

Bonds are certificates of debt issued by corporations and governments when they borrow money. In repayment for the loan, bond issuers promise to pay interest to the bondholder for the life of the bond.

These interest payments provide current income to the bondholder. At maturity, the bond is retired and the principal amount repaid.

A rise in interest rates generally results in a decline in the value of a bond, and vice versa. Bond prices tend to fluctuate less than stock prices, and some bonds provide income-tax-free interest payments.

Cash

Not only the green stuff that lines your pocket, “cash” also includes taxable and tax-free money market funds, CDs and treasury bills.

These are among the lowest-risk investments, but they also provide lower potential returns compared to stocks and bonds, with CDs and treasury bills fluctuating less than money markets.

Get assistance and review your portfolio regularly

You can access general online asset allocation tools through investment Web sites, but you might also wish to seek the advice of a financial advisor to fine-tune your specific financial goals.
He or she can help you create a sound asset allocation plan based on your unique needs and risk tolerance. But simply creating an asset allocation strategy is not enough. Together with your financial advisor, you should examine your portfolio frequently to ensure that your asset allocation is not shifting significantly because of movements in the market or changes in your own personal situation.

This article does not constitute tax or legal advice. Consult your tax or legal advisor before making any tax- or legally related investment decisions. This article is published for general informational purposes only and is not an offer or solicitation to sell or buy any securities or commodities. Any particular investment should be analyzed based on its terms and risks as they relate to your individual circumstances and objectives.

(continued from pg. 20)

Now that the General Lawton sculpture is complete, Dr. Gardner is considering other public projects. He wants to put some of his work in galleries in Oklahoma City and, one day, Santa Fe, N.M., hoping to finally have the time to play a few rounds of golf, and continue to sculpt. His current projects include personal work, such as a sculpture of his grandson, and he is also currently sculpting Quanah Parker, the last Chief of the Comanche.

“Sculpting is ultimately a hobby for me. That’s what I began it as, and that’s what it still is,” Dr. Gardner said. “If it becomes more than that, if I get some pieces in galleries and sell them, or undertake other public projects, well, then that’s just extra.”

“It’s like this,” Dr. Gardner says reflecting on his new career. “At this point in my life, I find sculpting as rewarding as I found dentistry to be when I was a young man.”

“And that’s really saying something.”

Dr. Gardner sitting beside a smaller version of his “General Lawton” piece.

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CASE HISTORY: A 16-year-old female presents to your office with a chief complaint of a “bump on my tongue.” During the examination, a dome-shaped nodule with a broad sessile base is observed. The area is asymptomatic and has been present for two years.

Question:
1. An appropriate clinical differential diagnosis for the lesion includes (multiple answers):
   a. Neurofibroma
   b. Squamous cell carcinoma
   c. Fibroma
   d. Granular cell tumor (myoblastoma)
   e. Gumma of tertiary syphilis

   Your differential diagnosis should include:
   a. Neurofibroma
   c. Fibroma
   d. Granular cell tumor (myoblastoma)

   All three of these lesions can present intraorally as an isolated tongue mass.

   The neurofibroma (a) is the most common type of peripheral nerve sheath neoplasm. This tumor is typically observed in young adults and presents as a slow-growing, soft, painless lesion. Although this tumor is most commonly observed on the skin, it can be observed intraorally with the tongue and buccal mucosa being the most common intraoral sites.

   The fibroma (c) is the most commonly observed tumor within the oral cavity. The buccal mucosa, labial mucosa, tongue, and gingiva are all common intraoral sites. It usually presents as a firm, smooth-surfaced, pink nodule. This fibrous mass is usually not ulcerated and is asymptomatic.

   The granular cell tumor (myoblastoma (d) is a benign soft tissue lesion that exhibits a predilection for the oral cavity. The tongue is actually the most common anatomic location for this entity. It typically presents as an asymptomatic, sessile nodule that is usually less than two cm. in size and can be observed at any age.

   Although squamous cell carcinoma (b) may occur on the tongue, it would not be included in the differential diagnosis here because it is usually observed involving the posterior lateral or ventral surfaces of the tongue in older male patients. Additionally, the gumma of tertiary syphilis (e) may also present intraorally, typically as an indurated, nodular, or ulcerated lesion. Although it also has been associated with the tongue, the gumma is usually observed in an older patient population.

Question:
2. The following adjunctive techniques may be useful in obtaining a definitive diagnosis:
   a. Fine needle aspiration
   b. Biopsy
   c. Radiographic evaluation
   d. Follow the patient closely for 10-14 days to evaluate any changes or resolution of the area
   e. Stain the lesion with toluidine blue

   The following technique may be useful in obtaining a definitive diagnosis:
   (b) biopsy of the lesion

   An isolated, asymptomatic mass involving the tongue is best managed by a biopsy (b).

   There is little to be gained by:
   (a) fine needle aspiration of the lesion
   (c) radiographic evaluation
   (d) following the patient closely for 10-14 days to evaluate any changes or resolution of the area
   (e) staining the lesion with toluidine blue (this stain may be helpful in evaluating areas of erythroplakia; but not a submucosal nodule of the tongue).
Question:
3. A biopsy specimen is submitted to the oral histopathology center for histologic examination. The pathology report describes a remarkable area of epithelial hyperplasia in the overlying epithelium with a network of cells in the submucosa featuring a very granular, eosinophilic cytoplasm. The correct diagnosis of this lesion is:
   a. Lingual thyroid
   b. Squamous cell carcinoma
   c. Granular cell tumor (myoblastoma)
   d. Histoplasmosis

Answer:
The correct diagnosis is (c) granular cell tumor (myoblastoma). See “Discussion” section.

The other possibilities are not considered here because:
The lingual thyroid (a) is composed of remnants of normal thyroid tissue and may represent the patient’s only functioning thyroid tissue.

Squamous cell carcinoma (b) arises from dysplastic surface epithelium and is composed microscopically of invasive islands and cords of malignant epithelial cells. This pattern is not observed in the present case.

Histoplasmosis (d) is composed of collections of macrophages organized into granulomas. Multinucleated giant cells are usually present and special stains are usually required to demonstrate the presence of the 1-2 YY of yeasts of Histoplasma capsulatum. Additionally, this pattern is not observed in the present case.

Discussion:
The granular cell tumor was first reported under the term granular cell myoblastoma in 1926 by Abrikossoff. Since this time, there have been over 700 cases reported in the literature. Numerous theories on the histogenesis of this lesion have been advanced and, until recently, the origin of the granular cell tumor was still unknown. Many investigators felt that it was of muscle origin, while other theories centered around histiocytic, stem cell, and neural origins. Recent studies have demonstrated support for a nerve sheath cell (neural) origin. The term granular cell “myoblastoma,” which implies muscle origin should, therefore, be discouraged.

The lesion has been observed in many sites including the pituitary gland, vocal cords, skin, breast, buccal mucosa, and the lip. The most common location for the granular cell tumor is the tongue, representing over 50% of all reported cases. This entity appears to occur at any age with no definite predilection for any one decade. There appears to be no difference in the incidence of occurrence between females and males. It typically presents as an asymptomatic, slow-growing, firm nodule which is usually covered by normal appearing mucosa.

Microscopically, this lesion is an ill-defined mass located in the superficial fibrous connective tissue subjacent to the surface epithelium (arrows). Granular cells (GCS) are characteristically arranged in strands and fascicles divided by fibrous connective tissue septae. It is particularly common for the surface epithelium to exhibit a remarkable pseudoeipitheliomatous hyperplasia (PEH) which can be confused with squamous cell carcinoma in a superficial biopsy specimen. The single most important fact to remember concerning the granular cell tumor is its potential to be misdiagnosed microscopically as squamous cell carcinoma. This is particularly true of lesions of the oral mucosa in which there has been minimal removal of diagnostic tissue during the biopsy procedure. To prevent this error, the clinician must be familiar with the clinical and microscopic features of this lesion in order to ensure that the patient is properly treated.

The treatment of the granular cell tumor is simple surgical excision. Recurrence is not to be expected.

References:
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