BULLETIN

CALIFORNIA SOCIETY OF PEDIATRIC DENTISTS

JUNE 1, 1983 VOL. IX NO. 2

President's Message

To be installed as President of the California Society of Pediatric Dentists is both an honor and challenge to me. An honor because I took office at the Seminar dedicated to Dr. Charles "Pop" Sweet—that grand, inspiring pedodontist who encouraged me to return to school and obtain a degree in pedodontics. A challenge because of what Dr. Robert Musselman (President of the American Academy of Pedodontics) told me. To summarize his comments: "The pediatric dentists in California have an outstanding organization—one which could provide excellent leadership in the Academy. It is one of the best organizations of pedodontists I have ever met." Believe me, providing leadership for this group will certainly be a challenge to me.

CSPD's new officers and committee chairmen are listed on the last page of this Bulletin. These dentists are a most dedicated group and will provide the leadership you should expect from your specialty organization. If you have any questions concerning a specific subject matter, please contact the officer or committee chairman who can answer your questions directly. Your directory which contains CSPD's Constitution and By-Laws explains the function of each committee. Our directory is being updated this year. Please contact our Executive Secretary, Bobbi Dennis, if any personal information from the 1980 directory requires correction.

Although our Public Relations objectives with Hill & Knowlton did not develop as planned, we have the know-how in our own organization to develop our own PR programs. The CSPD Practice Building and Public Relations Manual, to which 99 of you contributed ideas and which was compiled over an

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CSPD Formalizes Affiliation with AAP

CSPD is by far the largest state group of pedodontists. For many years our large number of pedodontists have not been proportionately represented by our national organization. Several times this issue has come up at our national meeting, but as is typical, change is hard to come by. This attempt to formalize our CSPD affiliation with the AAP will not solve many problems but it is certainly a step in the right direction.

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Letters to the Editor

Sweet Fund Donation Appreciated

Dear Editor:

Just a note to express my appreciation for the $500 contribution to the Charles Sweet Memorial Fund.

Dr. Sweet was in the avant-garde of pediatric dentistry and probably single-handedly did more for the specialty, from the standpoint of motivating young people to want to be pedodontists and to meaningfully influence graduate and postgraduate education in the specialty area, than any other person.

"Pop" Sweet was one of those individuals that influenced my life and primarily motivated me to become a pedodontist and ultimately an orthodontist. He was a rare giant of a person and one that comes along only once in a lifetime. His charisma was superb.

Thank you for your thoughtful contribution. Please express the sincere appreciation of the University of the Pacific to your Officers and Board of Directors.

—Arthur A. Dugoni, DDS, MSD
Dean, University of the Pacific

Practice-Related Research

Dear CSPD Members:

There have been several attempts in the past to stimulate practice-related research in our Society. Up to now, research has existed in the Pedodontic Departments of the various teaching institutions. A good part of these projects have involved graduate students. The Professional Activities Committee has been given the responsibility of extending and sharing knowledge and expertise in Pedodontics. The Committee will gladly coordinate research among Private Practitioners and help graduate students in schools with their various projects.

We will encourage research in both sectors by offering Research Grant money. As there is a limited amount of money available to graduate students and Private Practitioners, a formal proposal must be submitted to the Committee. The sponsored research must be written up so as to be acceptable for publication. It is expected that the final results will be presented at an annual meeting of the Society.

For more information and an application, please apply to the Professional Activities Committee in care of:

—Daniel Brostoff DDS
Chairman, Professional Activities
6226½ W. Manchester Avenue
Los Angeles, CA 90045
(213) 670-3677

American Academy of Pedodontics

Dear Members:

The membership of the American Academy of Pedodontics has recently elected me to the Board of Directors of the American Academy of Pedodontics for a three-year term. In order to better represent your views on the many issues facing pediatric dentistry, I urge you to communicate with me any time you feel change is needed. I promise you I will be sensitive to your needs and desires, and if I don't agree with your requests, I will respond and tell you why.

I would also like you, the membership, to understand that I am going to make requests of you. My first request is to have each of you belong to the American Academy of Pedodontics. It is only with the total support of *all* Pediatric Dentists that the Academy can truly be *the* voice of Pedodontics. And my second request is for each of you to volunteer to serve on committees of the Academy, and to become active in promoting pediatric dentistry.

—David L. Good, DDS

Witch-Doctor Dentist Crackdown

Here is an interesting quote from *The Church Around The World*, Volume 12, No. 4: "The Tanzanian government has moved to crack down on local witch doctors' practice of extracting teeth from little children to ward off evil spirits. At least 40 children have died from excessive bleeding and several hundred have been left with severe gum and jaw infections."

This could be a left-handed warning to the stateside humanitarian who occasionally goes on a weekend village missionary exodontic spree across the border only to fold up his or her tent and steal away back to the aseptic-sterile office and home leaving the village patients, mostly children, to fend for themselves without benefit of post-operative care, treatment, or supervision. I have done this sort of thing in Alaska, Canada, and Mexico. Solutions to the problems are evasive. Think about it!

—J.D. Bamrud, DDS

Public Relations Program

Dear Member:

At the 1982 Annual CSPD. Meeting, the membership voted to initiate a Public Relations Program by means of an assessment of $100.00.

At our recent Board of Directors meeting in San Francisco on January 15, 1983, the Ad Hoc Public Relations Committee of John Groper, Warren Brandli, Kent Payne, and Roland Hansen presented a review of their past negotiations with the P.R. firm of Hill and Knowlton and a current evaluation of these proceedings. The findings showed the firm

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Immediate Past President's Message

I am calling this my S.O.S. message—"The State of Society Message"—as I leave the office of President of CSPD.

On June 26, 1982, at my first Board of Directors meeting where I presided, I read the goals that I wanted to seek in my tenure as your elected president. I can't say that I have batted 100% on these goals, but my enthusiasm to do the best in the interest of this group who represent the majority of pediatric dentists in California has remained at 100%.

Even though it may not be evident to the Board and the membership, only one who has served as President can really know how almost everyday something will come across your desk that directly or indirectly involves the welfare of the specialty of pediatric dentistry in California. I honestly try to resolve these matters with haste (in several instances, I made decisions that did not always meet the satisfaction of one or more of the Board of Directors). But isn't this what a president is supposed to do? Just ask Jerry Brown, George Deukmejian, and Ronald Reagan.

I have had the interest, privilege and enthusiasm to be associated with a group such as this when I first sent out a call for the uniting of the pediatric dentists in California in 1969, and then when Weylon Lum sent out a successful call for organizing in 1974 (when we were to be either the California Academy of Pedodontics or the California Society of Pedodontics). The greatest honor came with being chosen your president in 1982. Please do know that I assumed this position with great sincerity and regard and wanted to do all I could to further CSPD's aims, even though my "process" was not by the rule book of Sturgis or Roberts. What I felt was important, was to accomplish that which was necessary for the aims of the business of CSPD, even though some matters were not in sequence at a Board Meeting.

During the past year, we have faced and come to grips with the problems of public relations, particularly with the Hill and Knowlton Company. For the resolution of this matter, we will have to thank the many efforts and time spent by Drs. Roland Hansen, Jonn Groper, Warren Brandli, Bob Weis, and Kent Payne. I regarded that matter as the number-one problem we had in the 1982-83 year. I am sorry it could not have been resolved more favorably, as public relations for pediatric dentistry in California still remains a matter of concern and something I still feel we need for our private practices.

On the favorable side, we should recognize Mike McCartney for his many hours of work compiling professional and laity information used in our offices. In the beginning of our talks pertaining to public relations, many thought we could do it ourselves with member dedications; Mike showed us how to do it.

I think the next serious matter had to do with the accusation given to the State Board of Dentistry about child abuse in pedodontic offices. By our official representation at a State Board meeting, this matter was quickly nipped in the bud and resolved. My appreciation is given to David Good, Wilfred Nation of Loma Linda, Paul Barkin of UCSF, Larry Luke and Steve Blain of UCLA and President-Elect Rolf Spamer for their support by being in Sacramento with me.

Also, in my opinion, the Peer Review Committee is one of our most needed and active committees in our interests. The Committee is in good hands with Paul Reggiardo as Chairman. I am also pleased at the way Mark Lisagor has become so active as Chairman of the Dental Care Committee. This is a committee I see from letters that require many hours of correspondence, and from being invited to attend many meetings on this subject. I would like to see the issue of compensation for sealants and preventive dental resin restorations (of the Simonsen categories) be a financed fact by the CDS and dental insurance companies. With Mark as Committee Chairman, I am sure we will see a favorable outcome on this issue. Speaking of financing, I would like to make a recommendation to the Board and the membership that we look into the excessive rise in the cost of hospitalization for dentistry in conjunction with general anesthesia. Mark my warning, that unless we become interested in this matter, indicated patients will not receive this type of treatment in a hospital setting, and we will be forced to engage in dangerous practices of outpatient heavy oral, I.M. and I.V. sedation. I also want to acknowledge the fine work of Lonnie Lovingier as Editor of the Newsletter. As one who has had this job, I can appreciate his efforts and think we now have the best State Pedodontic newsletter in the country.

For a future project, I would like to see the CSPD involved in a discussion with the schools who have advanced pedo programs concerning the need for pedodontic manpower in California. We shouldn't try to dictate, but have input and hear what the schools' thoughts are on this subject.

We have recently had correspondence from the American Academy of Pedodontics in calling for various state pedodontic groups to apply for component organization status. I would like the next president and the Board to take this matter up and decide at this time whether we should "join up." One of their conditions is to have our respective constitutions in close harmony with each other. There may or may not be an issue here. Will it really provide for representation at a national level? Many of us do not feel that we have had any input into the

selection of national officers. I call on Dr. Robert Musselman, the current president of the AAP, who is here with us this weekend to discuss the issues involved. Also, we should be keeping an eye on Assembly Bill 214, which provides for mandatory children's dental examinations prior to entering school. I have already sent a letter of support to Dr. Shirley Bailey of the State Board, who has helped author this bill.

We also need to get some new guidelines on the yellow-page advertising of our members, even though new rulings by the State Board may define these guidelines for us.

I would like now to thank the membership for the privilege and honor of being your President for this 1982-83 year. It has been a matter of prestige and pride for me to be your President, and "I gave it my best shot." Also, no President can go without a sincere thanks to Bobbi Dennis, our Executive Secretary, for her never ending support and work on behalf of this group.

Thanks, too, to the committee chairmen and their members for their efforts in always having a report at the board meetings when their committees have been active.

—Hugh M. Kopel, DDS, MS
President, CSPD, 1982-83

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The AAP formed a committee to develop a type of component status for state groups. After developing some guidelines they submitted them to us for our application for component status. The terminology "component status" does not really match the loose ties we're establishing. We will be more or less affiliated at an "arm's length" with no major commitments such as financial on either part. However, though there seem to be no drawbacks of any magnitude, the benefits could prove to be extremely important later in terms of communication alone.

The following are the guidelines we received:

1. A proposed component organization shall be a duly incorporated, nonprofit entity with a stated purpose.
2. The constitution and bylaws of a component organization must not be in conflict with the constitution and bylaws of the American Academy of Pedodontics. The Component Organizations Committee shall review the constitution and bylaws of the organization applying for component status for possible conflicts and will make recommendations to the Board of Directors regarding areas of potential conflicting statements.
3. Voting members of a proposed component organization must be eligible for membership in the American Academy of Pedodontics, but a member need not be a member of the American Academy of Pedodontics. All members of component organizations shall be encouraged to join the American Academy of Pedodontics.
4. All component organizations shall hold annual meetings and shall elect officers.
5. There shall be no financial obligations between the American Academy of Pedodontics and the component organization.
6. General policy statements affecting pedodontics shall emanate from the American Academy of Pedodontics.
7. The final determination of component status shall be by a majority vote of the Board of Directors of the American Academy of Pedodontics upon the recommendation of the Component Organization Committee of the American Academy of Pedodontics. The proposed component organization shall be notified of their decision within twelve months from the time the application is received by the American Academy of Pedodontics central office.
8. All requests for applications and information for component organization status shall be directed to the central office of the American Academy of Pedodontics in writing.

The CSPD board received the guidelines and presented them to the members who voted unanimously to submit our application and constitution and bylaws to the AAP. There seemed to be only some minor differences in our bylaws and Dr. Good, an AAP board member on their committee to review this, did not feel it would be a major issue. So now we must wait to hear back from AAP.

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18-month period by Dr. Mike McCartney, is a manual which we all should be using. The manual received numerous positive comments at the Quail Lodge Seminar.

Dr. Warren Brandli is initiating a project which should make membership in CSPD advantageous to every pediatric dentist in California. The project should also open the channels of communication between the California Chapter of the American Academy of Pediatricians and CSPD.

CSPD is applying for component status in the American Academy of Pedodontics. This affiliation will open the channels of communication between the Academy and CSPD, allow pedodontics to present a united front when speaking to issues, and lead to a change in the means for selecting members of the governing body of the American Academy of Pedodontics on a geographic basis.

On behalf of all the members of CSPD, I would like to welcome Dr. Stephen Wei to California. Dr. Wei became Professor and Chairman of the Department of Pedodontics at the University of California on June 1.

—Rolf Spamer, DDS, MSD
President, CSPD

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was not able to provide the services that were originally presented to the Board at the agreed-upon figures. To make the project worthwhile to the membership (wherever they are located), many more dollars were required. The Board felt that it would be in the best interests of CSPD not to accept this particular proposal and method of public relations. However, CSPD will continue to pursue various other methods for public recognition of pediatric dentists and their work in the State of California. We appreciate the members' encouragement and financial support in this endeavor, and we are returning to you the $100.00 assessment.

May I personally acknowledge and thank the Ad Hoc Committee for the many hours they spent in their efforts on behalf of the welfare of the membership of CSPD.

—Hugh M. Kopel, DDS
Past President, CSPD

Treasurer's Note

At the end of year 1982, expenses exceeded income by approximately $1,000. As we become more active and involved, the projection for 1983 looks like expenses will exceed income by about $2,000. A dues increase from $50 to $65 was voted unanimously by the membership present, to take care of the shortfall. A detailed Treasurer's Report will be published in an upcoming newsletter.

This is the first dues increase in eight years. NOT BAD!!!

—Kent W. Payne, DDS
Treasurer, CSPD

Peer Review Committee Report

The purpose of the peer review system is to resolve disputes that may arise in the delivery of dental care between the dentist and the patient (or parent). Since 1981, we, as specialists, have had the right to conduct our own peer review proceedings through the CDA peer review mechanism. Prior to this time, cases involving pediatric dentists or other specialists were heard at the local dental society level. As we begin the third year of our own peer review, it is appropriate to reflect that CSPD is doing an *excellent* job of peer review. Since January of 1981, we have completed 30 peer review cases and in no case has either party requested an appeal—an indication that our decisions are accepted as fair and impartial (and I hope wise) by both the dentist and parent.

How do we "stack up" with our colleagues? In 1982, more than 1,200 peer review cases were initiated statewide. Of these, only 12 involved pediatric dentists! Overall, CDA reports that approximately 50 percent of all peer review cases that continue through the system to resolution are in favor of the dentist, and 50 percent favor the patient. Of our 30 cases during the last two years (an admittedly small sample), 65 percent have been resolved in favor of the dentist and 35 percent in favor of the patient.

Like our generalist colleagues and specialists in other fields, the overwhelming majority of cases—85 to 90 percent—are initiated by a dissatisfied patient (or parent). When the parent feels he or she does not have the ability to obtain a satisfactory solution to a real or imagined (or misunderstood) problem in the office where the problem occurred, the case becomes a candidate for the peer review process.

In fact, I suspect most of us are very good at solving just the type of problems that bring parents to peer review. We probably do it every day. The extra explanation. The correction of treatment that doesn't meet our standards or doesn't go well. Taking the time to listen to a parent's complaint and then addressing ourselves to that complaint. We, as pediatric dentists, probably do this very well on a daily basis.

When, however, our best efforts and our best explanations fail to satisfy and a dispute cannot be solved between the dentist and patient, then peer review offers an unbiased resolution to the problem and a fair answer to all questions raised by the patient or parent. We distinguish ourselves as professionals and keep our obligation of service to the public by the peer review system.

—Paul Reggiardo
Chairman, Peer Review

Dental Care Committee Update

1. The **CDA Annual Conference on Insurance** held at LAX in January was attended by the Dental Care Chairman representing CSPD. The major concern was the impact of the new legislation affecting medicine and dentistry July 1. The formation of more "Preferred Provider Organizations" (PPO's) will definitely affect dentistry. These are groups of providers who may contract directly with third-party groups. We may see much activity in this area as a cost-containing alternative to conventional fee-for-service. The role of Pedodontics here is definitely in question. We should watch this carefully.
2. **Sealants**
   Academy guidelines regarding sealants will be presented in Atlanta in May. We should encour-

age more third-party underwriting in view of current concerns regarding lack of guidelines and potential for overutilization. It is suggested that dentists always submit for payment to make carriers aware of usage pattern and *consumer demand*.

3. **The "Dentical" Blues**
   Those of us who continue to treat patients covered by Dentical continue to express our unhappiness with the newest "rules" being imposed regarding payment for restoration of teeth where caries are not radiographically evident (or where no X-ray was taken). The implication suddenly is that in the absence of a written narrative describing the clinical presence of caries, the restoration must have been placed where none was needed! These sorts of rules are an obvious attempt at forcing more dentists to discontinue seeing these patients in their practices. What is the ultimate outcome? Perhaps making it easier for the state to contract for care of these patients with specific providers only. *If you see Dentical patients, you must document in writing any pathology not visible on radiographs. We should continue to make our complaints heard both directly andthrough CDA.
4. **Hospital Dentistry**
   Several members have expressed difficulties with some Medical insurance providers denying payment for hospital admissions for dental restoration in the absence of a handicap or other medical justification (typically, the very young, unmanageable child). Before the Dental Care Committee proceeds, it would be helpful for us to know the extent of this problem. Members are encouraged to contact Dr. Mark Lisagor, 3901 Las Posan Road, Camarillo 93010, (805) 484-2705 or (805) 484-3928 evenings. Examples of rejected claims might pinpoint either specific types of cases or *specific carriers* where this is a problem. The committee would also appreciate any special "insights" CSPD members may have regarding minimizing this problem in their practices.

—Mark Lisagor
Dental Care Committee

Interdisciplinary Affairs

The Interdisciplinary Affairs Committee of the California Dental Association met at the CDA Building in Los Angeles, Friday, February 11, 1983.

As Chairman of our committee, I was asked to attend. The meeting was very informative and there was a good exchange of ideas between the various specialty groups present in California. Of particular importance to the California Society of Pediatric Dentists was: (1) The California Dental Association is developing a software program and we (CSPD) will be called upon for input into their program. (2) The Dentist Company, a newly formed company as part of the California Dental Association, is a printing company. I have compared prices and they are about 40% cheaper on printing than any other sources I have seen. This service is available now for all CDA members. You can send for a quotation of price. (3) CDA's marketing campaign (Radio-TV) at latest report has only brought about a 1% increase in those CDA members' offices who were surveyed.

Although no future meeting date was set, I would appreciate hearing from our membership about any problems as they relate to other specialty groups.

—John N. Groper, DDS
Interdisciplinary Affairs Committee

Pacific Telephone Yellow Pages

Pacific Telephone announced: "Now you can inform new patients of your area of practice. Starting with the next edition of your Yellow Pages Directory, the display advertising and general listings section for *Dentists* will be followed by a special new section called the *Dentist Guide*, which will list practices by field (with explanations for consumers).

1. Endodontics (Root Canal)
2. General Dentistry
3. Oral & Maxillofacial Surgery (Surgery of Face & Jaw)
4. Orthodontics (Straightening—Braces)
5. Pedodontics (Children)
6. Periodontics (Diseases of the Gums)
7. Prosthodontics (Crowns, Bridges, Dentures)

The Dentist Guide will be similar to those Guides already in the Yellow Pages for Physicians and Surgeons and for Attorneys. Professionals prefer this type of listing because it sets their practices apart from the hundreds of thousands of others in the general listings, and it helps new patients find the appropriate specialists."

The CSPD board of directors has reviewed this subject and recommends for our members to use this listing. We *highly urge* everyone to include "member of California Society of Pediatric Dentists." If you are already using the CSPD logo as a group in your area, you may continue if you wish.

1984 Annual Meeting

The 1984 Annual Meeting of the California Society of Pediatric Dentists will be held from March 29 to April 1 at La Quinta Hotel near Palm Desert. Mark your calendar.

—Melvin L. Rowan, DDS

Pediatric Dentistry: Perceptions of Change

Pedodontics is changing. A conversation with anyone who treats children will verify that perception. Both the general practitioner and the specialist are witnessing this change. A decade ago, the typical children's dental practice had few caries-free children. Seventy-five percent of the caries observed were interproximal. Few children were involved in an effective home oral hygiene plan. Rampant caries patterns were a frequent finding in the initial examinations of children. Today, even in non-fluoridated areas, a very different pattern of oral disease exists in the mouths of children in the United States.

The recently published National Dental Caries Prevalence Survey for 1979-80, which was developed as part of the National Caries Program, provides clear data to illustrate this change in patterns. The Survey, which had a wide national sampling, demonstrates that 54% of all caries in the mouths of children aged 5 to 17 involved occlusal surfaces. Additionally, 37% of all children are estimated to be completely caries-free. In those children with active caries, 17% of DMF surfaces were classified as decayed and unrestored, whereas 76% of decayed surfaces had been restored by dental treatment. Finally, only 7% of permanent tooth "surfaces" had been extracted because of caries. These findings indicate phenomenal improvements in children's dental disease patterns.

The dentist who works with children today finds his efforts primarily expended in preventive care, in treating young children with nursing bottle syndrome, in trauma care, or in interceptive or preventive orthodontics. Certainly restorative dentistry remains an important component of most practices, but it is frequently not the major activity.

The Caries Survey data raises a number of questions. In particular, since over 50% of all carious lesions now occur on occlusal surfaces, what is the cause of that change? The major implication is that proximal surface caries activity has been greatly decreased by fluoride. Fluoridation of the water, topical application of fluoride by the dentist, the use of fluoride toothpaste, and the present availability of fluoride rinses without prescription have all contributed to increased systemic and topical fluoride exposure for growing children. Further, the American diet has improved in many respects; less sucrose is being ingested by the average American. These nutritional changes have had clear benefits on the oral health of children.

Another question raised by the 54% occlusal caries rate is why the unquestionably effective use of sealants is not in more widespread practice. Of those 54% "diagnosed" occlusal lesions, what percentage were "prophylactically" treated with restorations; when, in fact, active caries was not present and a sealant could have been used in lieu of the restoration? A tremendous body of research and clinical data now supports the effectiveness of sealants in preventing pit and fissure caries. Much of the remaining resistance to the use of sealants derives from the lack of third party coverage for this preventive measure, and secondarily, from the clinician's reluctance to explain the procedure to the parent and to establish an appropriate fee. It remains for us to make clear to third parties and our colleagues the necessity for the use of sealants.

Another interesting fact from the Caries Prevalence Survey is that for younger children (aged 5 through 11) the caries-free rate approximates 60%. In addition to validating the effects of fluoride, home care programs, and appropriate diet, this finding also raises concerns regarding the frequency of radiographs with the primary purpose of caries detection. A recent special issue of *Pediatric Dentistry* discussing the proceedings of the conference on "Radiation Exposure in Pediatric Dentistry" of April 22, 1981, discusses the growing conservatism in the use of radiographs for children. Our profession is now mindful of the dichotomy between the need for exacting diagnostic information and the concern for potential problems caused by ionizing radiation. The finding that so large a percentage of children are caries-free and further, that so much caries occurs on occlusal surfaces, delivers a clear message to the health professional. For every child an individual determination of need for number and frequency of radiographs is mandatory. Generalized radiographic "screening" series as a routine procedure are inappropriate in any practice setting.

The new patterns of oral disease in children are clearly affecting the specific services which are provided for children. These diminished disease patterns, however, are not the only agents of change in children's dental care. The delivery systems of children's care are also being modified. During the 1970's, the supply of dentists in the United States increased approximately 25% as a direct result of federal policy. We are now witnessing a retrenchment of such policy in dental schools across the nation. As one reflection of the higher dentist-to-population ratio and related attitudinal changes produced by the policies of the 1970's, the actual care delivery systems themselves have changed dramatically.

The ADA recently released a document from the Special Committee on the Future of Dentistry. The committee attempted to identify specific trends within the profession. Chief among the findings of the Special Committee was that the private sector remains and probably will continue to be the main mode of delivery of care. Nonetheless, the increase in HMO's, in retail and franchise centers, and in corporate centers is substantial. Children's dentistry, like all other aspects of oral health care, is being de-

livered in these new settings and is experiencing the same mix of assets and liabilities.

Present national economic conditions also are affecting children's dentistry. The Special Committee's report reveals that the public continues to perceive the cost of dental care as too high. Advertising is also expected to continue to influence the public's perception of dentistry. The report predicts that the general practitioner will expand his or her activities to include more procedures previously performed by specialists. Specialty practices resultantly will be confined increasingly to more advanced procedures. For Pedodontics the implications are clear. Emphasis is shifting to more complex areas such as the child with an extensive protocol of restorative needs or with a serious behavioral or medical problem. Within the specialty, an increased emphasis is being placed on preventing and intercepting growth and development problems. The Dental School undergraduate curriculum is changing to offer the student more information on these advanced pedodontic issues. Previously such issues were considered exclusive to the realm of the Pediatric dental specialist.

Another factor affecting change in children's oral health care is the present political climate. Federal policy changes may alter the availability of dentistry to children, and particular groups of children may be affected. The *ADA News* of September 27, 1982, stated that twelve states reduced Medicaid benefit coverage last year alone. Again, referring to the National Caries Survey, the fact that 76% of decayed surfaces were classified as 'treated' may be misleading. An assumption might be made based on this data that all children in the United States are receiving nearly optimal dental care. This would not be an accurate assumption. When further analyzed for ethnic and socio-economic status, the data illustrates that the white population has a restored rate of 80%, while the non-white rate is only 50%. This more detailed analysis indicates that certain segments of the population are better served than others by dentistry. With the possibility of major change in the Medicaid funding, including not only the elimination of coverage for certain income groups, but also a change in the structure of what services are covered, the resultant implications for individuals dependent on Medicaid are of serious concern.

The political climate is also changing with respect to fluoridation. In the May 1982 bulletin of the Greater St. Louis Dental Society, Dr. Ralph Rosen, in an editorial, commented on the recent defluoridation of Alton, Illinois: "How could this have happened right in the AMA and ADA's backyard? Where were Chicago's research authorities, hospitals, and universities? . . . Where were our legal talents? . . . How many years has Illinois regressed by this action?" The continual undercurrent opposed to fluoridation may be growing in strength. The progress we have made in combating caries in children could be threatened by this regressive change. Additionally, the potential fluoride shortage, as a result of decreased phosphate mining, is beginning to affect fluoridation. Unless alternative sources for fluoride are identified, this problem may be a dramatic one in the near future.

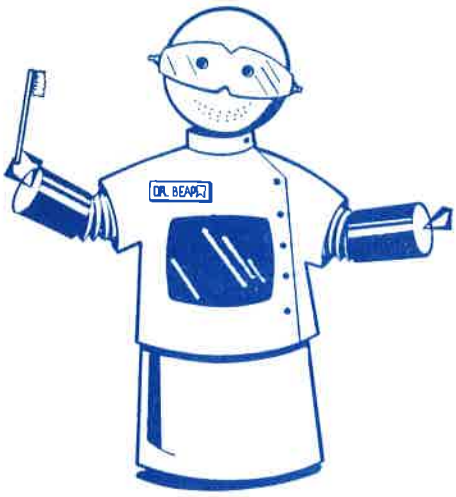
The technology of Pediatric Dental Care is also changing. Constant improvement in radiography equipment, materials, and techniques is helping to decrease the exposure of children to X-rays. The possibility of the development of nonionizing techniques is central to this decreased danger of exposure. Hopefully, other equally accurate diagnostic techniques will be developed in the not-so-distant future. The potential for caries and periodontal disease vaccines certainly remains, even given the complex nature of the oral bacterial flora. In Japan, research is being conducted on the use of lasers for the fusion of enamel fissure configurations. The potential for laser cavity preparation is also under serious and productive investigation. The technology of bonding is expanding also. Dentin and enamel may be simultaneously bonded in the very near future. Finally, better instruments and methods for predicting growth and development patterns are appearing. With these changes dentistry for children, a decade from now, may be significantly different based on imminent technological changes alone.

In summary, the dentist who works with children is practicing in an arena of continuous change and rapid evolution. The characteristics of the oral disease patterns are different. The health care delivery systems are changing and the technology becomes more sophisticated day by day. The individual practitioner must continue to emphasize the preventive means at our disposal, including home care, diet counseling, fluoride application in its various forms, and sealants. Radiographic procedures must be individualized. We must continue to provide access to dental care for all groups in our population. The National Dental Caries Prevalence Survey is extremely encouraging as an indicator of our success in combating oral disease in children. Our perceptions of change are therein verified. Most importantly, such studies, and those studies of our special committees, help us to more clearly view our paths to the future.

—Martin J. Davis, DDS
Reprinted from New York Dental Journal, *February 1983*

For Immediate Release:

IRVINE—Dr. Bartholomew Peabody, DDn, will be joining the Irvine-Tustin Pediatric Dentistry practice of Drs. Warren Brandli, Michael McCartney, Robert Dorfman, and Richard Therrell, effective April 8, 1983.



Dr. Peabody, who prefers to be known as Dr. Beap, is a highly-trained dentobot. His primary responsibilities will center around the education and prevention aspects of the practice.

"To our knowledge, we are the first pediatric dentistry practice in the world to employ the services of a full-time robot—actually, in this case, dentobot," commented Dr. Brandli, "and we're very excited at the prospect of the enthusiasm and interest he will generate for our preventive dentistry programs."

Dr. McCartney notes that the Pediatric Dentistry group has a deep commitment to preventive dental education, and it is this commitment which prompted the addition of Dr. Beap to the staff.

"We offer a comprehensive preventive dental education program to all of the children and young adults in our practice, and we regularly have preschool tours in both offices. Our preventive therapist also goes on regular speaking engagements. We are planning to incorporate Dr. Beap into each of these activities," added Dr. McCartney.

In addition to his work at the offices, Dr. Beap will be traveling to schools, conventions and parent groups.

DR. BEAP—THUMBNAIL SKETCH

Name: Bartholomew Edubot Automaton Peabody —Dr. Beap. *AGE:* First designed in 1969, refined in 1982. *Marital Status:* Single. *Occupation:* Dentobot. *Height:* 47½". *Weight:* Approximately 200 pounds. *Hobbies:* Collecting beep/horn sounds. *Last Book Read:* "The Preppie Dentobot." *Pet Peeve:* Computers who look down on human beings. *Favorite Color:* Likes all bright colors. *Secret Desire:* To have teeth. *Favorite Quote:* "Bid them wash their faces, and keep their teeth clean." (Shakespeare)

—Warren E. Brandli
Michael J. McCartney
Robert L. Dorfman
Richard E. Therrell

P.S.: Dr. Beap arrived too late to be included as our best Practice-Building idea in the recent CSPD publication. Dr. Beap will be at a table clinic at the next CSPD annual meeting at La Quinta in 1984.

Another Thought for the 1980's

It is not unreasonable to say that today many large American corporations are run like the Soviet economy. The culture of most business corporations exalts logic and rationality. Hence, it is analysts rather than innovators who tend to get ahead. Now, however, successful business strategies result not from vigorous analysis but from a particular state of mind. In what I call "the mind of the strategist," insight and a consequent drive for achievement, often amounting to a sense of mission, fuel a thought process which is basically creative and intuitive rather than rational. Strategists do not reject analysis. Indeed, they can hardly do without it. But they use analysis *only* to stimulate the creative process, to test the ideas that emerge, to work out the strategic implications of those ideas or to otherwise permit the exploration of "wild" ideas that rigorous logic would not admit. Great strategies, like great works of art or great scientific discoveries, call for technical mastery in the working-out. But they originate with insights that are beyond the reach of conscious analysis.

—Kenichi Ohmae

Practice-Building Seminars Scheduled

LOS ANGELES—A series of resort-site seminars on "Marketing Your Dental Practice—A How-to Approach" have been scheduled by The Dentists' Company, a wholly-owned subsidiary of California Dental Association.

Thousands of dentists and dental auxiliaries already have profited by their attendance at these seminars which focus on how to increase patient referrals, 70 ways to promote a dental practice—legally and ethically, using direct mail successfully, and the staff/spouse roles in practice promotion. promotion.

Seminars will be held July 17-20 in Maui, August 24-26 in San Diego, and September 28-30 in Las Vegas. Fee for the course, including a bound workbook with practical, how-to advice, is $285 for dentists and $140 for dental auxiliaries and spouses. Participants are eligible for 12 units of continuing education credit.

Instructor is Paula Perich, director of marketing for the California Dental Association, who is an acknowledged leader in the marketing of health care services and a sought-after speaker on the national circuit.

For additional information, write The Dentists' Company at 6151 West Century Boulevard, Suite 900, Los Angeles, CA 90045.


Quail Lodge

Eighth Annual Seminar Held at Quail Lodge in Carmel Valley

The Eighth Annual Meeting of CSPD was a tremendous success. Having a winter of such heavy rains, Carmel Valley was lush and green, and just gorgeous. Everyone present seemed to have a variety of things to choose from to do during their free time. It was a great place to lay back and relax or browse around town and visit with old friends.

The few days we were there seemed like minutes. It's always a great opportunity to hear from such an authority as Stephen Wei; there didn't seem to be enough time to hear all that he had to share. Perhaps now that he is a resident of our state we'll hear from him more often. The information we gather from fellow practitioners is invaluable, and the memories created by participating in the women's tour, fun run, golf tournament and tennis tournament were the icing on the cake. We extend our thanks to everyone who attended for making this such a great weekend, and we'll look forward to seeing you at La Quinta next March. Meanwhile, refresh your memory by trying to name everyone you see in the photograph on the opposite page. (Send your names to the Editor.)

Dr. Robert Musselman Speaks at Quail Lodge

Dr. Musselman is the current president of the American Academy of Pedodontics. He is also the chairman of the Department of Pedodontics at LSU. We were pleased to have Dr. Musselman speak during our luncheon on Friday. His words were brief, but encouraging to us out here in California. His early involvement and efforts to establish regionalized representation in the academy demonstrated his concern in developing an organization which is clearly effective in a fair representation of the pediatric dentists of the nation and not merely a traditionally active few.

Dr. Musselman addressed the question: What does the AAP do for me? This very common question has always been a very puzzling question to anyone who has been involved in organized dentistry. The mere fact we are pedodontists and have a specialty practice is dependent upon the activity of the Academy. The tremendous power of various groups at higher levels of organized dentistry—political groups, insurance groups, or public groups which would seek to restructure our delivery of health care—is staggering; not necessarily to change us, but more to serve their own needs. Everyone involved in pediatric dentistry benefits from the efforts of the AAP.

We should keep in mind that even though our time may not permit us to become involved, our mere contribution by belonging and signing our name to create a larger body of members gives us more clout.

Dr. Musselman was here by CSPD's invitation in order to encourage the AAP with our support of pediatric dentistry coming from the West Coast. Dr. Musselman's respect for our organization was apparent and welcomed by the groups.

To the Supporting Sponsors of the Quail Lodge Meeting:

As members of CSPD we'd like to extend our appreciation to Dentamatics of California and Moore Business Systems. These companies donated money to cover some of our printing costs to help subsidize our annual meeting. We found their computer displays informative and we were pleased to have them.

News from the Dental Schools

This issue features the graduating pedodontic students from UCLA, UCSF, and USC.

From UCLA the following information was received about the five graduating postdoctoral students:

- **Tim Ballweber** was born and raised in Western Montana. He attended Western Montana College where he received his B.S. in education majoring in art and biology. Following graduation in 1976, he taught elementary school for one year in Montana. He then attended Loma Linda University School of Dentistry and while there met and married his wife, April. He received his DDS in 1981 and immediately started his residency in pediatric dentistry at UCLA. Upon completion of this, he will then go on to a residency in orthodontics. After his educational training, he plans to return to the Northwest to establish a dual specialty practice for children's dentistry.
- **Leopoldo A. Becerra** was born and raised in Mexico City. He received his bachelor's degree from La Salle University in Mexico City in 1975. Polo attended dental school at the Universidad Tecnologica de Mexico and received his DDS degree with honors in 1979, and was the president of the Students Society at the university. After graduation he began a private practice and at the same time was appointed to the Scientific Commission for the Student Group of the Mexican Dental Association. Then in 1981, Polo went on to pursue his postgraduate training in pediatric dentistry at UCLA. Upon completion of the program, he plans to practice and teach part-time, either in Mexico or in California.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- **John W. Bull** was raised in Grand Junction, Colorado and received a bachelor's degree in psychology at Baylor University. He received his DDS degree from Washington University in St. Louis and served in the Army Dental Corps for two years before moving to the Panama Canal Zone. Following eight years of practice in Panama, Dr. Bull returned to the United States and became a postdoctoral student of pediatric dentistry at UCLA.
- **David A. Chin** is a native of San Mateo, on the San Francisco Peninsula. He received his bachelor of arts degree from the University of California at Davis in 1976 and then attended graduate school in microbiology at California State University, Long Beach. He then attended Northwestern University Dental School in Chicago, surviving two of the decade's coldest winters. After graduation in 1981, he came to UCLA for postdoctoral studies in pediatric dentistry. Dave plans to work in private practice and teach part-time.
- **Saskia Estupinan Wood,** born in Quito, Ecuador, received her DDS degree from the Universidad Central in Quito, Ecuador, ranking first in her class. She worked for several months in the Amazon jungle doing dentistry for children as well as adults. She came to live in Los Angeles with her husband, David Wood, who is now a pediatrician at Harbor-UCLA Medical Center. Her future plans include working with her husband in Third World countries in the field of dentistry and public health, and also working at the university doing research and teaching.

The three graduating pediatric dental students from UCSF are **Michael McKeever**, **Steve Bumgarner**, and **David Rothman**. The January 1983 issue of the *Bulletin* gave biographies of Steve and David, who in 1982 were new to UCSF. Both had transferred from the discontinued residency program at Children's Hospital Medical Center in Oakland after completing their first year of training. The following is information received about Michael:

- **Michael E. McKeever** was born in Mexico City, Mexico in 1952. At age six his family moved to Merrick, New York, where he was raised. He graduated from the State University of New York at Stony Brook in 1974, receiving a B.S. in biology. In 1977, he graduated from the New York University School of Dentistry. He received the Radiology Award for that graduating class. He became a member of National Health Service Corps in 1977 and continued in that service until 1981. During that time, he established the dental clinic in El Rito, New Mexico and later worked at another health clinic in Santa Fe, New Mexico. In 1981 he received a Service Award from the National Health Service for his work in New Mexico. In June 1981, he became a Pedodontic Resident at the University of California in San Francisco. Michael is planning to enter private practice in California.

From USC there are five graduating residents from the postdoctoral pedodontic program:

- **Ron Fujioka** plans to be practicing in the Covina area.
- **Ana Corta Gomez** will be practicing pedodontics in Mexico City.
- **Darrel Launspack** will be joining forces with **Rick Grabowski**'s Bakersfield practice.
- **Jose Garcia Pina** will be treating the little ones in Campico, Mexico.
- **Edward Tritico** will be returning to his home state of Texas.

CSPD wishes the very best to all these new pediatric dentists. They are fortunate to have had some of the finest training available in the world.

To a Pedodontist

How many times have you heard it said,
"A children's dentist—you are out of your head!"?
So often you are asked to answer the question,
"Whatever made you choose that profession?"

To coax a smile from a tearful small boy,
To watch his glee as he chooses a toy,
To guide with care the growth of his jaws,
Are hardly the tasks that bring much applause.

Yet each day holds a triumph or two
When wee ones announce, "I like you."
Some days force you to use all your wiles
To dry up the tears and break out the smiles.

How can you measure the worth of your giving
When each child teaches you more about living?
Someone once said, more knowing than we,
"Let the little children come to Me."

—Madeleine D. Brandli

Patient Right of Access to Dental Records

On February 5, 1982, the Governor signed Assembly Bill 610, adding to the Health and Safety Code Sections 25250 through 25258, dealing specifically with the right of access of a patient to medical records. The law became effective January 1, 1983, and legal counsel recommends that CDA members be aware of and comply with the law. These additions

should be carefully reviewed. The law affects dentists in the following ways:

1. Gives the patient the right to inspect records upon submittal of a written request to the dentist, and upon paying a reasonable clerical cost for locating and making the records available. The dentist must allow inspection during business hours within five days after receipt of the written request.

2. Gives the patient the right to present a written request to the dentist for copies of records. This request must be complied with within 15 days after receipt. The dentist may charge 25 cents per page (or 50 cents per page microfilm copy), as well as charge for reasonable clerical costs incurred in making the records available.

3. Gives the patient the right to request X-rays or tracings from the dentist, and these must be furnished within 15 days after receipt of the request. The dentist need not provide copies of the X-rays to the patient if the originals are transmitted to another dentist designated by the patient.

Legal counsel recommends that those dentists who do not wish to part with their original X-rays not exercise the option of providing original X-rays to another dentist, but provide a copy of the X-rays to the patient, who may then give them to the new dentist. This gives the dentist the option of keeping the original X-rays, since most dentists do not want to part with their original X-rays.

4. Gives the dentist the right, as an alternative, to prepare a summary of the records that fulfill the requirements of the law, and to deliver the summary to the patient instead of allowing the inspection and copying of the records by the patient.

The dentist should be aware of the penalties that may be imposed for refusing to allow the inspection and copying of patient records. These include being charged with unprofessional conduct as well as being liable in a civil action seeking the documents. In the case of civil action, a judgment may include an award of costs and attorney's fees to the prevailing party, at the discretion of the court.

—*Reprint from* OCDS Bulletin

A Few Humorous Statements from the Child Patients at University of the Pacific

1. Five-year-old Kevin, after receiving a mandibular block from a dental student: "You don't give sleepy juice very good. The dentist does it better 'cause he's older and in a better grade."
2. Damien, 13 years old, concerned about getting to basketball practice on time, to student: "I'll give you a quarter if you don't put the crown on today —(silence and shrug)—it's all I got."
3. Student to six-year-old Ryan: "Ryan, you're dressed up pretty fancy today—are you going to be in a movie?" Ryan: "No! If you go into the movies they make you get naked."
4. Student to four-year-old Denay, after viewing a post-trauma radiograph: "Well, Denay, it looks like you're going to live." Denay: (wide-eyed and full of anticipation) "With who?"
5. Five-year-old Kasandra at screening: "When I come in to be worked on, I want a girl dentist. I've got to make sure I'm safe."
6. Student to Teresa, eight years old, after disclosing tablet: "How come your tongue is red today?" Teresa: "'Cause I'm on the pill."
7. Eric Bystrom to James, a five-year-old, being questioned following anterior trauma. "Do any of your teeth bother you when you eat something cold like an ice cream cone?" James: "Yes." Eric: "Which ones?" James: "Only the double scoops."

—*Eric B. Bystrom, DDS*

Rationale and Guidelines for Pit and Fissure Sealants

Pit and Fissure Sealants

The American Society of Dentistry for Children and the American Academy of Pedodontics affirm the use of pit and fissure sealants as a safe and effective method of reducing tooth decay in the occlusal grooves, pits and fissures of posterior teeth.

Rationale

The recent survey of *The Prevalence of Dental Caries in United States Children,* conducted by the U.S. Department of Health and Human Services, reports that for the 45.3 million school children in the United States from 5-17 years of age, the average child has 4.77 decayed, missing, or filled permanent tooth surfaces. The occlusal surfaces, while representing only 12.5% of the permanent tooth surfaces at risk, experience 54% of the observed dental disease.

There is a need for special protection for the occlusal surfaces of these teeth. The deep developmental pits and fissures on the occlusal surfaces predispose them to carious lesions. Fluoridated drinking water and topical fluoride application are effective preventive services. The effect of fluoride, however, is preferential for smooth surfaces, with the occlusal surface receiving little protection.

Occlusal sealants are organic polymers which mechanically bond to acid-etched enamel. The resin forms an impervious barrier between the occlusal fissures and the oral environment, preventing the impaction of food debris and the ingress of bacteria.

Sealant retention consistently exceeds 90% in one- to three-year clinical trials. As long as the seal-

ant is present, the occlusal surface is virtually immune to caries attack.

Clinical trials extending to seven years indicate that increased sealant wear and loss occurs over time. Sealant retention, however, is still high. It has been demonstrated that occlusal surfaces remain free of carious lesions as long as the sealant is present.

Partial sealant loss sometimes occurs, but heightened resistance to occlusal caries is maintained, apparently, because resin tags continue to occlude the pits and fissures. There is no evidence at the present time to suggest that partial or total sealant loss increases the susceptibility of the occlusal surface to carious attack.

Sealants are indicated for teeth with deep developmental pits and fissures.

While extensive clinical testing has proven sealants to be an effective preventive measure, they are challenged on a cost basis. Unfortunately, there is little information to clarify the situation. The use of sealants, at the present time, relates more to preventive philosophy and to a desire to preserve tooth structure by preventing or delaying the need for restorative treatments than to clear-cut cost-effective benefits.

Guidelines

1. The placement of sealants should be limited to previously unrestored pits and fissures.
2. The placement of sealants should usually be accomplished as soon as possible following the eruption of the tooth.
3. Presence of interproximal caries should be ruled out prior to the placement of pit and fissure sealants.
4. Patients receiving sealants should ideally be on some type of preventive fluoride program to reduce the risk of smooth surface caries.

—*Reprint from* Pediatric Dentistry, *Vol. 5, No. 1*

Editor's Note

Dear Members:

You have probably noticed our *Bulletin* seems to be getting larger. I am aware that a voluminous publication does not necessarily mean it is a good *Bulletin*. However, it does indicate there is a lot of information to be shared in our society. We have a dedicated group of board and committee members, each active in our behalf, and each with information necessary to pass on to our members. That news is always important and welcome, but what really thrills me is to have general members send me something to share in the *Bulletin*. It would be much easier and much more fun to actually edit material coming in rather than "bird-dog" people for material. I believe everyone has ideas, thoughts or feelings they would like to share. Most of us find ourselves embarrassed or would rather not take a stand and possibly be ridiculed. As doctors we make enough decisions all day long, we take a stand and get paid for it; why should we do it for free and risk non-acceptance? Perhaps we think we are too busy to write down a few clever ideas or funny things that happened in our office. Write me, tell me something about the pedodontists in your area you think we all might enjoy knowing. Please take the effort; you will be glad you did.

—*Lonnie Lovingier, Editor*

A Little Bit of Your Time Can Help a Child for a Lifetime

How often are you completely frustrated by patients who come in with a high number of preventable caries each visit? Your lectures on sweets, pamphlets on nutrition and going over the teaspoons of sugar in various foods have yielded few results.

Recognizing this problem, and taking into consideration the lack of time and money for extensive patient counseling, Dairy Council of California nutritionists have developed a time-efficient solution. As a non-profit nutrition education organization, DCC provides a self-instructional dental nutrition booklet to pediatric dentists at no cost. This nutrition booklet is widely accepted by children ten and older. It also has proven effective for parents of younger children who enjoy going through it and making nutrition changes for their family.

The booklet is graphically entertaining. It uses flip charts to answer the exercises, enabling children to go through it at home. They quickly learn skills that help them reduce their "acid attacks." They learn which sweets are their problem and more importantly how often in a day they have an "acid attack." A food grouping system allows them to evaluate their diet to see if basic nutrition needs are being met. Follow-up nutrition counseling can then be done in 5-10 minutes on the next visit.

The trick is to get patients involved in making a plan for changes. The following guidelines can be used for successful chairside counseling:

1. Patients learn best when they have to deal with only one concept. In the case of high caries, tell the patient that the *frequency* of sugars is the area you are most concerned about.

2. Since between meal sugars are the most damaging, focus on these first. The patient becomes aware of the sugars he eats *between meals* and can then add up the number of "acid attacks" during his day.
3. In order to reduce these attacks, offer the patient several *choices.* He can:
   - Omit the food
   - Substitute a food without sugar
   - Combine high-sugar foods usually eaten at different times
   - Eat high-sugar foods with meals
4. Get the patient to agree to *two or three changes* he is willing to work on. Trying to make too many changes at once sets the patient up for failure.

Use of the booklet combined with brief chairside counseling can help build nutrition education into your practice easily and quickly. Offering this service to your patients will promote an attitude of prevention in your office.

To receive a supply of booklets for your patients and other counseling suggestions, contact Elizabeth Bowersox, MPH,RD, Nutrition Consultant at (415) 464-0490. Dairy Council provides this program at no charge as an educational service.

Abstracts of Interest in Pediatric Dentistry from the American Association of Dental Meeting — March 1983

634 Effect of Fluoride in Wash Water on Microleakage of Composite Resin. A. M. YAARI* and Z. HIRSCHFELD. School of Dental Medicine, Univ. of Pennsylvania, Philadelphia, Pa.

Topical fluoride treatment of acid etched enamel is known to produce a precipitate of reaction products on the surface of the conditioned enamel, resulting in a poor bond between the resin and the enamel. The purpose of this study was to determine whether wash water from a fluoridated water supply containing 1 ppm F has an effect on microleakage of composite resin bonded to enamel. Concise enamel bond system was applied to the lingual or buccal surfaces of freshly extracted human posterior teeth. The enamel was cleaned with F-free pumice slurry, washed with deionized water, dried and the window area etched for 1 min.; then washed with 100ml of water spray containing either 0, 1 or 100 ppm fluoride. Twenty specimens were included in each group. After drying, a layer of unfilled resin followed by a 2mm thick layer of filled resin was applied to the conditioned enamel surface according to the manufacturer's instructions. All specimens were thermally stressed for 500 cycles at 0°C and 60°C. Microleakage was determined using the ^{45}Ca autoradiograph technique.

Microleakage was seen in 15% of the control specimens washed with F-free water; 65% of the specimens that were washed with 1 ppm fluoride and 95% of the specimens washed with 100 ppm fluoride showed leakage at various degrees of penetration.

These findings indicate that fluoride concentration of *1 ppm or higher in the wash water of acid etched enamel interferes with the bond of the resin,* and therefore it is recommended that F-free water be used to remove the acid from the enamel prior to composite resin application.

Classified

HAWAII—FOR RENT, a tropical paradise home on Kauai's North Shore. Located on the beach just past Hanalei. Call or write Dr. Larry Reichel, 733 Bishop St., Ste. 2275, Honolulu, HI 96813. Tel: (808) 523-6421.

I AM LOOKING for a full-time pedodontic associate to begin in July or August. Any dentist worth his/her salt will tell you they have a quality practice. (Ever heard anyone say they're average?) I guess I'm no different. If you can walk on water, please apply. If you can't, apply anyway (go ahead, go for it!). Send resume to 26 Greenwood Vale, Monterey, CA 93940.

PRACTICE & LIVE in beautiful Lake Tahoe. Ski, hike, fish & sail. Only Pedodontist in entire Lake Tahoe basin. Call (916) 544-5373 after 6:00 p.m. & weekends.

ASSOCIATESHIP. Dr. Bob Rube, 1982 Pedodontic Graduate of UCLA, looking for a place to practice. Have a great personality, good attitude, and will send resume. Call (213) 545-3055 or (213) 530-9656.

HAWAII. Pediatric Dentist or Dual Ortho-Pedo person needed on the Kona Coast of Hawaii. Two modern, efficient office locations. Well-established practice needs associate leading to full partner. Please mail inquiries and resumes to P.O. Box 1507, Kamuela, Hawaii 96743.

ASSOCIATESHIP WANTED. June 1983 Pediatric Dentistry graduate of UCLA, 1981 DDS Northwestern University. Seeking associateship in the Los Angeles area beginning June 1983. Will send curriculum vitae, call or write Dr. David Chin; 1811 Ocean Park Blvd., #E; Santa Monica, CA 90405, (213) 450-6532 or (213) 825-5619.

PEDODONTIST. 2 left-handers looking for a third to join quality-oriented pedo-based 3-office group practice also involving an orthodontist and a general dentist for adults. Excellent opportunity in this Southern California coastal community. Please call eves. (805) 484-3928.

ASSOCIATE WANTED in Sacramento 1 to 3 days per week. Please contact Richard A. Mandelaris, DMD, (916) 391-2101.

ASSOCIATE PARTNERSHIP—SAN DIEGO. Looking for association leading to partnership for established North County San Diego pedodontic practice. Practice is located behind 250-bed hospital in large MD, DDS speciality complex and adjacent to 6-member pediatric group. Current office has expansion capabilities. I would like someone with practice administration capabilities and ortho experience. Call Dr. Ron Bills, (619) 724-1102, or send resume to 3230 Waring Ct. Q, Oceanside, CA 92054.

All members are invited to place free classified ads. Non-members must pay $25. Send information to the Editor.

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Welcome New Members

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