Dentist offers advice on dental care for chemotherapy patients

Virtually everyone knows someone who has battled cancer, and the effects of chemotherapy and radiation on a patient’s hair, eyebrows and digestive system are widely known among the general public. But what many people don’t know about is the havoc that such treatment wreaks on teeth and gums.

Dr. Steven McConnell of Marin County, Calif., said he is seeing an increase in the number of patients seeking dental care after completing cancer treatment. He said he has found a few simple home-care routines can help patients alleviate the dental side effects of cancer treatment.

“The primary goal of supportive care is to help stabilize the mouth by restoring moisture, minimizing anything that causes dryness, balancing the pH of the mouth and strengthening the tooth surface,” McConnell said.

As soon as radiation or chemotherapy treatments start, oral health is immediately affected. The mouth becomes drier and gum recession and mouth sores start occurring. A common complaint is difficulty eating, drinking and swallowing. Often patients must rely on IV nutrition, as eating and drinking is too painful. As the mouth becomes drier, the teeth also become weaker and more susceptible to decay.

This is a critical time to have regular hygiene visits to promote optimum oral health. However, McConnell said, most oncologists often discourage hygiene appointments. Frequently, the side effects of a dental cleaning can increase the bacteria levels in the bloodstream and risk the health of a patient while she or he is in treatment.

During this time of treatment, supportive dental care is imperative to dental health. McConnell

Nation’s Capital Dental Meeting

The Community Dental Health Coordinator (CDHC) pilot program, funded by the American Dental Association (ADA), is entering its second year. The three-year program trains student classes of six each at its three U.S. program sites to become community health workers with a special focus on dental skills, and work in underserved communities, helping residents improve their oral care.

A second group of students is now being welcomed into the program, while the initial student group moves on to six-month clinical internships, the second phase of their training. In most cases, it is expected that CDHCs will return to work in their
Award to help dental students offer dental care to troops

The ADA Foundation awarded its 2009 Bud Tarrson Dental Student Community Leadership Award to the University of Nevada at Las Vegas (UNLV) School of Dental Medicine in recognition of an oral health treatment program for National Guard troops.

The UNLV School of Dental Medicine will receive $5,000 with the award to enhance student education and outreach to underserved populations.

“This selfless effort by these dental students exemplifies what the ADA Foundation and the Tarrson Access to Oral Health Care Award are all about,” said Dr. Arthur A. Dugoni, president of the ADA Foundation.

“We are improving the lives and dental health of others by connecting people and investing in the human potential of so many individuals.”

In 2008, UNLV dental students founded the Southern Nevada Ferrin Memorial Clinic to help meet the oral health needs of National Guard troops deemed non-deployable because of dental problems. Some of these troops cannot access dental care because they are not on active duty, making them ineligible for military benefits. The program has since expanded to include all local military veterans with limited access to dental care.

The first clinic, held in July 2008 at the UNLV School of Dental Medicine, treated 19 patients. Since then, there have been six additional clinics, with approximately 50 patients receiving free treatment at each session, including more than 100 veterans. UNLV dental students, supervised by Nevada licensed dentists, provided treatment that included restorations, root canals, extractions, crowns and dentures.

The clinic honors the memory of a UNLV dental student’s brother killed in action in 2004, while serving in Operation Iraqi Freedom.

Created in 2005 in memory of philanthropist Bud Tarrson, former CEO and owner of the John O. Butler Co., the Tarrson Award recognizes one exemplary volunteer community service project developed by dental students enrolled in a predoctoral dental education program.

A Chicago native, Tarrson was a director of the former ADA Health Foundation (now ADA Foundation) from 1994 to 1999.

Between 2004 and 2008, the Tarrson Award honored outstanding community service on the part of a practicing dentist or lay person. In 2009, the ADA Foundation rededicated the Tarrson Award program to highlight significant dental student outreach to vulnerable communities.

“The new approach to this annual award program supports the efforts and acknowledges the initiative and outreach of dental students across the country,” said Linda Tarrson, who initiated the award in honor of her late husband.

“Selecting this year’s recipient was difficult because there are so many outstanding student programs that are supporting the ideals of professional service and outreach to the community.”

She added, “I’m extremely proud of the UNLV program and its students for their desire to go beyond what is expected and to be of service to those in the community who are truly in need of oral health care.”

The ADA Foundation is a catalyst for uniting people and organizations to make a difference through better oral health. Since 1991, the ADA Foundation has disbursed nearly $31 million to support such charitable activities.

In addition to funding grants for dental research, education, scholarships and access to care, the foundation supports charitable assistance programs, such as relief grants to dentists and their dependents who are unable to support themselves due to injury, a medical condition or advanced age; and grants and loans to those who are victims of disasters.

(Source: ADA Foundation)

About the ADA Foundation

The ADA Foundation’s primary goal is to connect people and organizations in order to effect a positive difference via improved oral health.

For more information about grants awards through the ADA foundation, please visit www.adafoundation.org.
Meridian chart shows teeth and organ relationships

Many people are familiar with Chinese medicine or acupuncture and have heard about meridians, the channels through which energy flows in the body. Each organ, gland and body structure has an associated meridian, including the teeth.

What does all this mean to health and wellness? Well, if someone has a bad tooth, the energy flow through the meridian belonging to that tooth will be altered. This in turn can affect the health of the other organs on that meridian.

For example, tooth #14, the upper left first molar tooth, is on the same meridian with the kidneys, liver, spleen, stomach and breast. So, if this tooth has a problem, it may affect energy flow through the meridian and the health of those organs may be affected as well.

Dr. Thomas L. Stone, MD, a pioneer in alternative medical diagnosis and treatment strategies, once attended a dental health seminar, and when he was asked why an MD would attend a dental conference, he said, “I know you dentists are killing my patients. I just want to find out how you are doing it.”

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Considering the anatomy of a professional-looking Web site

By Mars Kay Miller

Your Web site is where your business resides online and the hub of your Internet marketing campaign. It is the virtual representation of who you are and what you are all about. Always incorporate good design principles to ensure your Web site reaches out to the maximum number of new patients and engages as many people as possible. When you are promoting your treatment and services online, people cannot see you physically like they would if they met you in your office. People do judge you by your cover. This is where a good Web site design comes in.

In any professional practice, dentists and doctors spend hundreds of thousands of dollars on office design, decorating, marketing materials and customer service. Convenient locations should be chosen and appropriate signs displayed so patients have little if any difficulty finding your office.

Your office should be clean and tidy and your staff members should emit a professional air with everyone dressed accordingly. The entire presentation is a marketing strategy to show patients you care about quality and are someone they can trust to provide expert treatment.

First impressions matter
The same is true with your Web site. If your Web site is old and outdated and is difficult to navigate, looks as if you hired your next door neighbor to set it up or, worse yet, you don’t have one at all, you are literally forcing patients to contact your office for a new patient exam.

Splash pages are the first pages you see when you arrive at a Web site. They normally have beautiful imagery with words like “Welcome!” or “Click here to enter.” They are pictures with no real purpose other than to entertain. Visitors are not on your site to be entertained; they are there for content rich information. If they want entertainment, they will go to YouTube.

No. 1: Do not use ‘splash’ or ‘flash only’ intro pages
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No. 2: Provide simple and clear navigation
Provide a simple and straightforward navigational menu that even a young child will know how to use. Stay away from complicated flash-based menus or multi-tiered dropdown menus.

If your visitors cannot figure out how to navigate your site, they will leave it. Design your site for an Internet-challenged newbie. Keep it easy and simple.

No. 5: Keep your text paragraphs
If a paragraph is too long, split it into smaller separate paragraphs or bullet point the content for easy reading.

No. 6: Reduce the number of images on your Web site
Images make your site load slowly and, in many cases, a profusion of images is unnecessary. If you think every image is essential on your site, make sure each one is optimized correctly for quick loading.

No. 7: Keep your text paragraphs at a reasonable length
Online reading of text is different than reading the printed word. The brain processes the information differently when read off a computer. If a paragraph is too long, split it into smaller separate paragraphs or bullet point the content for easy reading.

No. 8: Make sure your Web site complies with Web standards
Go to www.w3.org and make sure your Web site is compatible. If your Web site looks great in Internet Explorer but doesn’t work properly in Firefox and Opera, you will lose prospective new patients. With all the problems with Microsoft, Firefox and Opera browsers are becoming more popular every day.

No. 9: Extra large/small text size
There is more to Web design than graphics. User accessibility and comfort is a big part of it also. Design the text to be legible and correctly sized. This enables your visitors to read it without straining their eyes.

No. 10: Text and background page color
On a computer, some colors are more difficult to read than others. Studies report black text on a white background is the easiest to read. White text on a black background, although it looks nice, causes eye strain and is difficult to read. A light background with dark colored text is always your best option.

As a business owner, it is your job to make sure your Web site does what it’s meant to do effectively.

Even though you are not a Web designer, it is your marketing responsibility to ensure your Web site does what it is supposed to: engage and direct new patients to contact your office for a new patient exam. Don’t let minor mistakes in design stop your site from perform-
Changing dentistry 4mm at a time.

Over 10,000 new users have made SureFil® SDR™ flow one of the fastest-growing products.

Since launching SureFil® SDR™ flow in September 2009, over 10,000 dentists have tried the first and only bulk fill flowable posterior composite. What’s even more impressive is that over 90% of them said they would continue to use it. SureFil® SDR™ flow has self-leveling handling that provides excellent cavity adaptation, and it can be bulk filled in 4mm increments, dramatically streamlining your posterior restoration. Contact your DENTSPLY Caulk rep or visit www.surefilsdrflow.com to learn more.
One or two employees don’t make a ‘team’

If you are losing good employees on a regular basis, do you know why?

By Sally McKenzie, CEO

I recently had a conversation with a dentist on ever-popular topic: employees. This clinician went on and on about how fortunate he was to have had the “best” office manager any practice could hope for, but now he was frantically looking for someone to replace her because she’d turned in her two-week notice. He was crushed.

I asked him what set this person apart from the others.

“Silent soldiers” she takes care of everything,” he told me.

I was intrigued. “Everything?” I asked.

The dentist went on to explain that he could delegate virtually anything to this person and it would be done.

I asked, “What would take care of insurance, collections, billing, payroll, recall, staff communications, case presentation, treatment planning? Why, she even oversaw the office parties. If it was someone’s birthday, she baked the cake. What a woman!”

In fact, he was about to start a newsletter and this employee was going to be responsible for writing, designing and distributing it. This “super manager” might as well have leapt tall buildings and worn a cape.

I was seeing red flags.

“I have problems with my other staff. My assistants don’t do things the way I want. The hygienist is too chatty. You know, the usual stuff. I just tell the office manager to handle it and she does.”

This was, indeed, a full-scale alert: no job descriptions, no accountability, no leadership. Clearly, there are significant problems at this practice.

The dentist had used the office manager as a gatekeeper to insulate himself from the other employees and from serious matters that required his direction and involvement.

Whatever issue he didn’t want to deal with, he just handed off to her, from clinical particulars to patient relations to business operations. Not only was she the office manager, she was the de facto leader, responsible for virtually every major system in the practice except the actual dentistry.

Good employees: hard to find and harder to keep

Dentists are often baffled when team members quit. They feel they have been blindsided.

They are left wondering what exactly drives the quality staff to go. In actuality, there are a number of reasons why staff members leave, even during challenging economic times.

Is it the money? Not as often as you might think, although employees will use this as grounds to make their exit because they don’t want to tell you or they are afraid to tell you the real reason.

Certainly, the members of your team want and appreciate salary increases, but money is definitely not the only motivator and it’s clearly not the best motivator to keep good employees.

As long as the staff are paid competitively there is far more to keeping your team intact than tossing a few more bucks their way.

Some leave because of how they perceive they are treated in the workplace. Human resources surveys routinely show that more than 40 percent of employees quit because they don’t feel appreciated by their boss.

Why is that important? Because 50 percent of job satisfaction is determined by the quality of the relationship that staff have with you, the dentist — that’s you.

In some cases, the dentist treats the employees disrespectfully. He/ she is a screamer, a micromanager or just a mean and nasty. These practices churn through good employees at a record pace.

The only ones who stay are the mediocre performers. They stick it out with a bad boss because they don’t have the confidence that they can find another job.

Certainly, many dentists are very nice people. They are not screamers or mean and nasty, but their idea of managing people is to tell them what they are doing wrong, where they are falling short and so on.

Alternatively, they say nothing, which is just as bad if not worse. Can you think of specific instances in the past few weeks in which you have clearly and directly told the top performers on your team that you appreciate their work and their contributions?

If not, I can virtually guarantee that they think you neither recognize nor appreciate what they are doing for you and your practice.

Silent soldiers

Oftentimes, when good employees leave, dentists claim they had no idea the employee wasn’t happy. Consider the “super manager” in the example above.

“Why didn’t she speak up? It’s not uncommon for the good employees to remain silent. They don’t want to bother the dentist.”

They just keep taking the pressure, being the good stewards that they are until they crack. In reality, there is probably little the “super manager” could have done to change her situation.

In situations such as this, the dentist simply will not or cannot see what is staring them in the face. This particular dentist believes that his office manager is responsible for “managing” every aspect of the office as the dentist sees it.

In addition, as far as the dentist was concerned: it worked, so why change it? For the employee, she saw only one way to remedy the situation: quit.

The fact is that it is easy to ignore the good employees. After all, they don’t have to be coddled. They can be counted on to get the job done, and they are low- or even no-maintenance.

The dentist tells himself/herself that these employees know what they are doing.

They are good. They are independent. They can handle the additional responsibility. They don’t need or want feedback or coaching.

Consider these recommendations and evaluate your Web site from a visitor’s point of view. If your Web site needs updating or changes, contact your Webmaster and talk it over. Your practice growth depends on it.

About the author

Mary Kay Miller is founder and CEO of Orthopreneur® Marketing Solutions. After 50-plus years as a business and marketing coordinator for professional practices, Mary Kay has narrowed her marketing expertise to Internet Web 2.0 marketing, SEO (search engine optimization) and the creation of marketing systems to save teams valuable time and effort.

Her book, “Marketing Your Practice Through Different Eyes,” was released in May 2008 and is a free 100-page eBook available on her Web site www.orthopreneur.com. It is the first multi-media eBook of its kind in dentistry and the first book ever written on marketing for both dentists and team members. It enables dentists and staff members to understand and experience for themselves how the Internet and Web 2.0 marketing engages and grabs the attention of today’s consumer.

(Upper Left Photo on Front Page © Saniphoto, Dreamstime.com)
However, thinking this is a big mistake.

Your top performers resent that they show up on time (or early), work hard every day, consistently meet or exceed their performance goals, and you say virtually nothing. But you’re going “gaga” over the totally unreliable assistant’s ability to actually take an X-ray that you can read!

Which leads me to another key reason why good employees are hard to keep: You refuse to deal with the problem performers.

There are few things more demoralizing to top-flight staff than a boss who looks the other way when others on the team consistently disregard office policies, bring poor attitudes to work, generate conflict, make excuse after excuse for why they were late, why they were sick, why they simply cannot get their jobs done.

Believe me, your silent soldiers know exactly who’s doing just enough to get by. Yet, they get the same pay raises, same vacation time and the same perks as top performers.

Understandably, capable staff will only tolerate this for so long. As Vince Lombardi once said, “There is nothing more unequal than the equal treatment of unequals.”

Ultimately, the good employees arrive at the conclusion that the dentist is either a coward or simply prefers the poor performers, so they choose to leave and go to a practice where their contributions are appreciated and the culture encourages rather than discourages excellence.

Wake-up call

It usually takes a seriously troubling event — such as a major financial shortfall, the departure of a critical employee, etc. — for the clinician to wake up to the fact there might be a problem.

From there it takes an outsider, such as a practice management consultant, to sit down with the dentist and discuss his/her frustrations, why he/she cannot trust other staff members, determine where the system shortfalls are occurring, assess training weaknesses and get to the bottom of why the dentist cannot, or will not, lead his/her team.

The case of the super manager above is particularly unfortunate because clearly the dentist had a very dedicated and highly competent employee, which is common. Practices will have one or two rock-solid staff and a host of mediocre chair warmers.

Instead of creating systems of accountability, instituting training programs, developing job descriptions, etc., clinicians will simply pile the critical duties on those that they know they can count on. Ultimately, everyone loses.

The good employees eventually break or burn out. The weak employees are never given the opportunity to grow and flourish.

Moreover, the dentist is losing a fortune because, whether he/she acknowledges it or not, things are falling through the cracks simply because there are not enough capable hands on deck to ensure they don’t.

If you’re losing good employees, don’t just sit back, shake your head and tell yourself “good help is hard to keep.” Find out what is driving the exodus and seek outside assistance if necessary.

Once you get to the root of the problem, I guarantee you’ll see the improvement in your bottom line.

As Vince Lombardi once said, ‘There is nothing more unequal than the equal treatment of unequals.’

About the author

Sally McKenzie is CEO of McKenzie Management, which provides success-proven management solutions to dental practitioners nationwide. She is also editor of The Dentist’s Network Newsletter at www.thedentists.net; the e-Management Newsletter from www.mckenzie.mgmt.com; and The New Dentist™ magazine, www.thenewdentist.net. She can be reached at (877) 777-6151 or sallymck@mckenziemgmt.com.
Does your practice extend open credits to your patients? This is an important question as veteran dental practice owners know that their practice’s fiscal health, profitability and success require balancing a prudent patient financing policy.

Balance allows the flexibility to accommodate your patients, and it needs to be firm enough to avoid cash flow/collection problems that may have material consequences for both the clinicians and staff. Even a temporary cash flow problem is stressful for a practice owner, creating the potential for uncertainty in making the payroll.

What is a dental practice’s uncollectible percentage? While this number will vary substantially (due to many factors ranging from service mix, use of practice management software, aggressive or lax payment policy compliance), when averaged, it shows the nationwide number of approximately 2.5 percent. Many practice owners think they can live with 2.5 percent. However, further inspection reveals a more in-depth appreciation of collection effectiveness on a practice.

Let’s suppose a practice grosses $1 million annually. If the practice has bad debt or “uncollectible receivables” of $25,000, that is 2.5 percent, then that write-off number would be correct (See Table 1).

Accounts receivable trends for any business, from a FORTUNE 500® company to a dental practice, are almost identical. Receivables are like gravity. You can’t resist gravity and you can’t resist receivables’ falling effects of time on receivables. Each day goes by and the value over time. Table 2 shows the nationwide number of 90 percent based on the total practice annual revenue.

<table>
<thead>
<tr>
<th>Practice Annual Revenue</th>
<th>$1,000,000</th>
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<tbody>
<tr>
<td>Eligible Receivables</td>
<td>$850,000</td>
</tr>
<tr>
<td>Bad Debt</td>
<td>$25,000</td>
</tr>
<tr>
<td>Bad Debt as a % of Eligible Receivables</td>
<td>2.5%</td>
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<tr>
<th>Practice Annual Revenue</th>
<th>$1,000,000</th>
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<tbody>
<tr>
<td>Less: Cash Payments</td>
<td>$150,000</td>
</tr>
<tr>
<td>Less: Credit Cards</td>
<td>$250,000</td>
</tr>
<tr>
<td>Eligible Receivables</td>
<td>$600,000</td>
</tr>
<tr>
<td>Bad Debt</td>
<td>$25,000</td>
</tr>
<tr>
<td>Bad Debt as a % of Eligible Receivables</td>
<td>4.2%</td>
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Table 1: Value of aged accounts receivable

$1 is worth the following amounts over time

| Days | Value
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<tbody>
<tr>
<td>31</td>
<td>1.00</td>
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<tr>
<td>61</td>
<td>0.75</td>
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<tr>
<td>91</td>
<td>0.50</td>
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<tr>
<td>181</td>
<td>0.25</td>
</tr>
<tr>
<td>365</td>
<td>0.01</td>
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</table>

It is prudent to offer patient financing when you examine what consumers are advised to pay on a graded scale. Data reveals the recommended consumer order of payments is as follows:

1) Child support. By law, credit bureaus must report any information received about overdue child support, as long as it’s verified by the proper agency and is not more than seven years old. Consumers are told this should be the No. 1 payment priority. Penalties, considered quite serious, include garnished wages, liens on property and a suspended driver’s license. Dentists should be aware that finance companies might consider an open child support lien on a credit bureau report as very negative.

2) Mortgage. After more than 90 days, late mortgage payments can end up on a credit record. Mortgagees also tend to have hefty late payment fees, and if a mortgage holder misses two or more, a lender may start foreclosure proceedings.

3) Car loans. Repossession laws vary in some states repossession happens after only one missed payment. Mass transit isn’t applicable everywhere and the risk of not having a vehicle probably impedes a person’s ability to work.

4) Taxis. The Internal Revenue Service (IRS) is tough when taxpayers don’t pay on time. Penalties accrue with time and the clock keeps going from the time of the infraction.

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6) Department store cards. Many will negotiate and/or accept lower payments for various periods of time.

7) Utilities (electric, gas, water). Utility companies may work out payment schedules for consumers (though security deposits for future services will be a factor). Nationwide, rules vary as regional regulators have rules protecting homeowners from losing vital services

By Keith D. Drayer

 Dos your practice extend open credits to your patients? 

<table>
<thead>
<tr>
<th>Practice Annual Revenue</th>
<th>$1,000,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less: Cash Payments</td>
<td>$150,000</td>
</tr>
<tr>
<td>Less: Credit Cards</td>
<td>$250,000</td>
</tr>
<tr>
<td>Eligible Receivables</td>
<td>$600,000</td>
</tr>
<tr>
<td>Bad Debt</td>
<td>$25,000</td>
</tr>
<tr>
<td>Bad Debt as a % of Eligible Receivables</td>
<td>4.2%</td>
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</tbody>
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(*) Cash = Cash + Checks

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($1 million annually. If the practice has bad debt or “uncollectible receivables” of $25,000, that is 2.5 percent, then that write-off number would be correct (See Table 1).

Accounts receivable trends for any business, from a FORTUNE 500® company to a dental practice, are almost identical. Receivables are like gravity. You can’t resist gravity and you can’t resist receivables’ falling effects of time on receivables. Each day goes by and the value over time. Table 2 shows the nationwide number of 90 percent based on the total practice annual revenue.

<table>
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Table 2: Value of aged accounts receivable

$1 is worth the following amounts over time

| Days | Value
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>31</td>
<td>1.00</td>
</tr>
<tr>
<td>61</td>
<td>0.75</td>
</tr>
<tr>
<td>91</td>
<td>0.50</td>
</tr>
<tr>
<td>181</td>
<td>0.25</td>
</tr>
<tr>
<td>365</td>
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By Keith D. Drayer

Dos your practice extend open credits to your patients? This is an important question as veteran dental practice owners know that their practice’s fiscal health, profitability and success require balancing a prudent patient financing policy.

Balance allows the flexibility to accommodate your patients, and it needs to be firm enough to avoid cash flow/collection problems that may have material consequences for both the clinicians and staff. Even a temporary cash flow problem is stressful for a practice owner, creating the potential for uncertainty in making the payroll.

What is a dental practice’s uncollectible percentage? While this number will vary substantially (due to many factors ranging from service mix, use of practice management software, aggressive or lax payment policy compliance), when averaged, it shows the nationwide number of approximately 2.5 percent. Many practice owners think they can live with 2.5 percent. However, further inspection reveals a more in-depth appreciation of collection effectiveness on a practice.

Let’s suppose a practice grosses $1 million annually. If the practice has bad debt or “uncollectible receivables” of $25,000, that is 2.5 percent, then that write-off number would be correct (See Table 1).

Accounts receivable trends for any business, from a FORTUNE 500® company to a dental practice, are almost identical. Receivables are like gravity. You can’t resist gravity and you can’t resist receivables’ falling value over time. Table 2 shows the effects of time on receivables. Each $1 of accounts receivable at 90 days is statistically only worth $0.72.

Thus, the case can be made for dental practices to devote more focus to their “payment is due upon priority. Penalties, considered quite serious, include garnished wages, liens on property and a suspended driver’s license. Dentists should be aware that finance companies might consider an open child support lien on a credit bureau report as very negative.

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When It's Time to Buy, Sell, or Merge Your Practice
You Need A Partner On Your Side

ALABAMA
Birmingham—4 Ops, 2 Hygiene Rooms, GR $575K $11018
Birmingham Suburb—3 Ops, 3 Hygiene Rooms #10016
Florence—Beautiful Modern Office, more than expand, to GR $650K
#11101
CONTACT: Dr. Jim Cole @ 404-313-1573

ARIZONA
Avondale—Doctor seeking to purchase general dental practice. #12110
Shaw Low—2 Ops, 2 Hygiene Rooms, GR in 2007 $455,995
Phoenix—General Denist seeking Practice Purchase Opportunity #12108
Phoenix—4 Ops - Equipped, 1,515K, 5 Working Days #12111
Nov. Scottsdale — General Dentist seeking Practice Purchase Opportunity #12109
Uph. Tucson—6 Ops - Equipped, 1 Hygiene, GR $900K
#12112
Tucson—1,800 active patients, GR $850K, Asking $650K #12116
CONTACT: Tom Kimbel @ 602-516-3219

CALIFORNIA
Alturas—3 Ops, GR $511K, 3 1/2 day week work #14279
Atwater—2 Ops, 1,080 sq. ft., GR $177K #14187
El Sobrante—5 Ops, 2 Equipped, 1,380 sq. ft., GR $550K #14102
Fresno—5 Ops, 1,500 sq. ft., GR $1,061,500 #14129
Greater Auburn Area—3 Ops, 1,680 sq. ft., GR $1,487K #14104
Madera—7 Ops, GR $1,219,467 #14283
Medford—12 Ops, GR $1,075,000, Same location for 10 years #14287
Modesto—2 Ops, GR $884K wdly, net income of $144K #14108
N California Wine Country—4 Ops, 1,500 sq. ft., GR $95K #14102
Pine Grove—Gr, nice 3 Op fully equipped office/practice $110,000 #14509
Porterville—6 Ops, 2,000 sq. ft., GR $3,200,000 #12191
Red Hill—6 ops, 2000 GR $1,000,950 Hygiene 10 days a wk. #12160
CONTACT: Dr. Dennis Hoover @ 805-519-7348

Redding—5 Ops, 2,200 sq. ft., GR $1,012K #14293
SLO County—5 Ops, 4,000 sq. ft., GR $900K #14273
CONTACT: Dr. Dennis Hoover @ 805-519-7348

Miami—5 Ops, Full Lab, GR $853K #11817
CONTACT: Jim Packard @ 865-287-8900
Jacksonville—GR $1.3 Million, 2000 sq. ft., 7 Ops, 8 days hygiene #18118
CONTACT: Dennis Wright 800-730-8883

GEORGIA
Atlanta Suburb—3 Ops, 2 Hygiene Rooms, GR $865K #19129
Atlanta Suburb—3 Ops, 2 Hygiene Rooms, GR $613K #19128
Atlanta Suburb—3 Ops, 1,370 sq. ft., GR $448,561 #19131
Atlanta Suburb—Pediatric Office, GR $240K #11913
CONTACT: Dr. Jim Cole @ 404-313-1573

ILLINOIS
Chicagoland—6 Ops, GR $700K, Sale Price $616K #2128
1.5 HR SW of Chicago—5 Ops, 2007 GR $440K, 26 yrs old #22122
Chicago—3 Ops, GR $400K, Any Day #22119
Galena—GR $490K, located in Historic Bed & Breakfast Community #21210
Western Suburbs—5 Ops, 2,200 sq. ft., GR $15M #21220
CONTACT: Al Brown @ 630-781-2176

MARYLAND
Southern—11 Ops, 3,500 sq. ft., GR $1,640,625 #29201
CONTACT: Shawn Mazzetti @ 443-788-4071

MASSACHUSETTS
Boston—2 Ops, 1,000 sq. ft., Sale $147K #10122
Boston South Shore—3 Ops, GR $300K #10125
North Shore Area (Boxcox County)—5 Ops, GR $500K #10132
Western Massachusetts—5 Ops, GR $1 Million, Sale $514K #10116
CONTACT: Dr. Peter Goldberg @ 617-680-2940

Middle Gape Cod—6 Ops, Sale price $777K #10213
Boston—2 Ops, 1 Hygiene, GR $400K #10130
Middlesex County—7 Ops, GR $500K #10130
New Bedford Area—4 Ops, Sale $425K #10119
CONTACT: Alex Livak @ 617-210-2582

MICHIGAN
Suburban Detroit—2 Ops, 1 Hygiene, GR $231K #51105
Ann Arbor Area—Low Overhead - Well Run Practice GR $600K #11106
CONTACT: Dr. Jim D’Atri @ 313-510-0800

Detroit—4 Ops $23104
Fargo/Moorhead Area-1 Op, GR $185K #32107
Central Michigan—Mobile Practice, GR $700K #32108
Twin Cities—Move in & Practice Immediately GR $600K #32110
CONTACT: Mike Minor @ 734-516-2152

MISSISSIPPI
Eastern Central Mississippi—10 Ops, 4,685 sq. ft., GR $1 Million #53101
CONTACT: Danny Wright 800-730-8883

NEVADA
Reno—Free Standing Bldg, 1,500 sq. ft., 4 Ops, GR $75K #37106
CONTACT: Dr. Dennis Hoover @ 800-519-7348

NEW JERSEY
Marlboro—Associate positions available #31062
Mercey—3 Ops, Good Location, Turn Key, GR $191K #39112
CONTACT: Sharon Mazzetti @ 484-788-4071

NEW YORK
Brooklyn—3 Ops (1 Fully equipped), GR $175K #41113
Woodstock—2 Ops, Building also available for sale, GR $600K #41112
CONTACT: Dr. Dan Cohen @ 845-460-3034
Syracuse—1 Ops, 1,000 sq. ft., GR over $700K #41107
CONTACT: Matt Bank @ 315-265-1313
New York City—Specialty Practice, 3 Ops, GR in 2007 $575K #41109
CONTACT: Rich Zalewski @ 631-831-9324

NORTH CAROLINA
Charlotte—7 Ops — Equipped #24212
Foothills—5 Ops #42212
Near Wilmington—Dental energy clinic, 3 Ops, GR in 2007 $375K #41518
New Hanover Co.—A practice on the coast, Growing Area #42145
CONTACT: C. Gary Durham—Doctor looking to purchase #42127
CONTACT: Barbara Hanley Parker @ 919-848-1553

OHIO
Medina—Associate to buy in, part of practice in future #44120
North Central—GR $69K, 4 Ops, Well Established #44115
North Central—GR $700K, 5 Ops, Well Established #44115
CONTACT: Dr. Don Mitchell @ 614-820-8087

PENNSYLVANIA
Northeast of Pittsburgh—3 Ops, Victorian Mansion GR $1,2 Million $74120
CONTACT: Doc Shum @ 412-853-1557
Lakewoos Craftsmen—2 Ops, 1 Hygiene, GR $513K #47136
Chester County—High End Office, 4 Ops, Digital FBS + a few PPO’s #47141
Philadelphia Craftsmen (NE)—4 Ops, GR $500K, Ext 25 yrs #47142
CONTACT: Shawn Mazzetti @ 484-788-4071

RHODE ISLAND
Southern Rhode Island—6 Ops, GR $750K, Sale $465K #48102
CONTACT: Dr. Peter Goldberg @ 617-680-2940

SOUTH CAROLINA
Hilton Head—Dentist seeking to purchase a practice producing $500K a year #49193
CONTACT: Scott Arringer @ 704-814-4766
Columbia—7 Ops, 2,000 sq. ft., GR $675K #49102
CONTACT: Jim Cole @ 404-513-1573

TENNESSEE
Elizabeth—GR $500K #5107
Memphis—Large practice producing GR $2 Million #51112
Suburban Memphis—Leading Practice in Area GR $1 Million #51113
CONTACT: Greg Tate @ 865-41-1527

TEXAS
Houston Area—GR $1 Million wldly net income over $500K #52105
CONTACT: Dennis Wright @ 800-650-2373

VIRGINIA
Georgetown—Valley, 2,500 sq. ft., GR $392K updated equipment #53111
CONTACT: Bob Anderson @ 804-650-2373

For a complete listing, visit www.henryschein.com/ppt or call 1-800-730-8883
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Levin Group celebrates its 25th anniversary

Levin Group, a leading dental practice management consulting company, celebrates its 25th anniversary this year. Founded in 1985 by Dr. Roger P. Levin, a third-generation dentist, the company has grown from a small, part-time business into one of the leading dental consulting firms. Below, Dr. Levin, chairman and CEO of Levin Group, talks about how the Levin Group has changed and his views on the challenges dentists face today.

Why did you start Levin Group?
I wanted to help dentists and specialists improve the quality of their lives. That was the goal then, and that still is the goal today. Since 1985, Levin Group has been providing dentists and specialists the breakthrough systems and the leading-edge expertise that they need to grow their practices.

For dentists and specialists, a better quality of life starts with the practice because that’s where doctors spend the majority of their time.

Levin Group provides customized solutions that help dentists increase production and profitability, manage their practices more effectively and with more confidence, reduce stress and inefficiency, drive growth and referrals, and enjoy what they do more.

How has Levin Group changed since 1985?
I started the company as a one-man operation in a room in our dental office. I was always interested in the business side of dentistry. Colleagues liked what I was doing in my practice, and I developed a reputation as someone who could help other dentists improve their practices. This led to speaking engagements, which ultimately led to consulting to dentists and specialists.

Innovation has been a hallmark of our growth. As we developed new and innovative solutions, we continued to grow. I am grateful for the success and for Levin Group becoming a leading dental consulting firm here and abroad.

We have eight divisions, and locations in Baltimore and Phoenix, with more than 100 employees. We provide management consulting, marketing consulting, executive coaching, transitions and financial planning services.

What is new on the horizon for Levin Group?
In the next few months, we will be launching the Levin Group Practice Management Resource Center—a state-of-the-art Web portal for dentists and specialists who are looking for the best solutions to improve their practices.

In addition, we will offer a series of new products, including patient brochures, practice management books and audio presentations. We want every dentist and specialist to have the best management and marketing resources right at their fingertips.

What is the biggest challenge facing dentists and specialists today?
Doctors face incredible challenges now. They have to do so many things well. It begins with providing optimal patient care, but they also have to keep up with the latest clinical techniques and technologies, manage the practice, lead the team and operate a successful business.

But the biggest challenge for most clinicians is the business side of dentistry. Dental schools do a great job of turning dental students into excellent clinicians, but few dentists have the management skills to effectively and successfully run a dental practice. Especially in this economy, dentists are struggling to increase production. I hear this all the time and I reassure them that increasing production is still attainable. They need to work on getting the right systems in place.

Most practices have incredible potential, but too often that potential remains unrealized for a large portion of a dentist’s career because he or she never received the business training to maximize that potential.

Levin Group works with each and every client to reach his or her true potential, which includes continually increasing production, referrals and profits; enjoying a successful practice with high professional satisfaction; and reaching financial independence as soon as possible.

Any additional advice for today’s dentists and specialists?
Practice success depends on combining excellent clinical skills with excellent business skills. When dentists have both, they’ll be amazed at what they can achieve!

The best leaders realize that they can’t do everything and that they can’t do everything well. That’s why highly successful practitioners surround themselves with excellent management systems so they can focus on what they do best — practice superior dentistry and provide excellent patient care.

Doctors should love what they do. Too often, the business side of the practice takes away from the enjoyment of dentistry. With the right management systems in place, dentists can increase their production, lower their stress and enjoy what they do even more.

Mark Twain once said, “The secret of success is making your vocation your vacation.” With the right systems, dentists can do exactly that.

If you would like more information about the Levin Group’s programs and seminars, visit www.levingroup.com.

and keeping consumers safe.

8) Student loans. Federal student loans may be deferred during times of financial challenge. When loans are deferred, payments aren’t required, but you can’t qualify for deferment once the loan is in default, so don’t wait until you are behind in payments to apply. Continue making payments until your request is approved.

9) Health-care bills. Most medical bills aren’t reported to credit bureaus until they are sent to collection agencies. Doctors will rarely initiate a patient credit check before starting a major treatment case.

With health care bills ranked in order at No. 9 and a new era with a tough economy, can your practice benefit from a proactive approach to patient financing? DENTAL TRIBUNE | APRIL 2010

About the author
Keith D. Drayer is vice president of Henry Schein Financial Services. Henry Schein Financial Services represents the only 5.99 percent same-as-cash patient financing and no dedicated terminal program. Henry Schein is the leading distributor of services and products to office-based health care practitioners. Drayer can be reached at hsfs@henschein.com or (800) 443-2756.

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DENTAL TRIBUNE | APRIL 2010

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Total facial esthetics for every dental practice

By Louis Malcmacher, DDS

Esthetic dentistry has evolved during the last 50 years. This article will demonstrate some of the advancements of the past few years as well as where we are going in the near future.

Case study
This is an interesting case on a number of levels. The patient’s history is of a 42-year-old female who approximately two years ago wanted a smile makeover. Figure 1 shows her preoperative smile.

The patient presented with Class I occlusion and with a midline discrepancy. She wanted a more even appearance to her teeth and a whiter color. The midline discrepancy was of no consequence to her esthetically.

Her periodontium was healthy and she requested a minimally invasive approach. Teeth #8 and #9 are full porcelain crowns that are not the same shade as her natural teeth. Although the shade discrepancy is minor, this did concern her. She had read about a popular minimally invasive veneer and was referred to a dentist for those veneers.

Figure 2 shows this same patient after her minimally invasive veneer treatment. She presented in our office with these veneers and expressed her disappointment with these veneers done by her previous dentist due to a few reasons.

She felt that the teeth had no character, were “dead looking” and not lifelike at all, and the cusipsides especially were too bulky, both in their appearance and to the feel on the inside of her cheeks.

This picture is representative of the biggest challenges and complaints that many dentists have about no prep/minimal prep veneers — that they are too opaque and too bulky. At this point, the patient was not yet interested in further treatment to correct her smile even though she was unhappy with the results.

We see in Figure 3 this same patient a few months later. She is still unhappy with the appearance of the veneers, but a much greater concern is the fractures that have occurred with these veneers. Figure 4 shows a retracted close up view of her case.

The incisal one-third of the veneer had broken on tooth #5, the veneer on tooth #7 had completely come off and a temporary veneer was hastily placed, and the all-porcelain crown on tooth #8 had fractured at the gingival third. This is a combination of material and bonding failures as well as poor management of the case from the clinical and laboratory aspects.

This patient also reported having facial pain on both sides of her face and in her temple areas. You may also notice how square the angles of her jaws are. This was not due to her skeletal structure, but to the excessive function of her masseter muscles.

Upon occlusal examination, her occlusion was not equilibrated with in normal limits. That combined with the contraction intensity of her masseter and temporals muscles significantly contributed to her facial pain.

In addition to all of this, she expressed interest in smoothing the facial wrinkles around her lips, the crow’s feet wrinkles at the corner of her eyes when she smiles caused by the zygomaticus muscles, as well as the wrinkles in her forehead.

At this point, obviously, the patient is in need of retreatment of this case and we chose to use Aurum Ceramics Cristal Veneers for this case. Figure 5 shows the removal of all the veneer and composite materials as well as the two all-porcelain crowns on teeth #8 and #9.

Here is where this case really presents a challenge and why working with a talented aesthetic ceramic laboratory really starts to pay off. You can imagine that the all-porcelain crowns will be at least 5 to 4 mm thick circumferentially while some of these other Cristal veneers may range anywhere from 0.3 mm thin in some areas to 1 mm thick in other areas, even on the same tooth.

When working with a minimally invasive approach, the ceramist has to have an excellent understanding of the ceramic he or she is using in order to provide the dental clinician with a finished case where the shades of all the different restorations will all match together. This is especially true when doing no preparation/minimal preparation veneers. The right and left side views as shown in Figures 6 and 7 will show that aside from the two central incisors, all of the other preparations are minimally prepared in enamel, which will certainly pay off in the final strength of this veneer case when the correct materials are used.

At the preparation appointment, botulinum toxin type A (Botox) was received through the office to help with the wrinkles in her forehead. The patient also reported having excessive function of her masseter muscles.

Conducting your own inspection of patients’ oral cavities provides the perfect opportunity to mention that this is something they can easily do themselves as well. You can explain the procedure in brief and then let them know about the Web site, www.oralcancerselfexam.com, that can provide them with all the details they need.

Fight oral cancer!

Did you know that dentists are one of the most trusted professionals to give advice? Thus, no other medical professionals are in a better position to show patients that they are committed to detecting and treating oral cancer.

Prove to your patients just how committed you are to fighting this disease by signing up to be listed at www.oralcancerselfexam.com. This new Web site was developed for consumers in order to show them how to do self-examinations for oral cancer.

Self-examination can help your patients to detect abnormalities or incipient oral cancer lesions early. Early detection in the fight against cancer is crucial and a primary benefit in encouraging your patients to engage in self-examinations. Secondly, as dental patients become more familiar with their oral cavity, it will stimulate them to receive treatment much faster.

If dental professionals do not take the lead in the fight against oral cancer, who will? And in the eyes of our patients, they likely would not expect anyone else to do so — would you?
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“The greatest revolution of our generation is the discovery that human beings, by changing the inner attitudes of their minds, can change the outer aspects of their lives” – William James

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delivered to the following sites: 12 units to the forehead area for the forehead wrinkles and facial pain; 8 units in each lateral orbicularis occuli for the crow’s feet wrinkles; 12 units in each temporalis muscle and 20 units in each masseter muscle for the treatment of facial pain and to reduce the intensity of the muscle contraction; and 7 units in the orbicularis oris muscle to smooth the lip lines.

Figure 8 shows the completed case after insertion and after occlusal equilibration. These Cristal Veneers and crowns are excellent in terms of size and shape and have eliminated the bulkiness and lack of texture that the patient previously complained about.

Aurum Ceramics is known as a highly esthetic dental laboratory and it is now bringing their esthetic experience into the minimally invasive veneer market.

Figure 9 shows a close-up of teeth #7 through #10 and you can see the excellent adaptation, texture and color match that was achieved. As the clinician, I used the exact same shade of cement on every restoration in this case.

Aurum Ceramics did an incredible job in working with the Cristal Veneer Porcelain to achieve this match, which made my job seating these veneers incredibly easy.

Figure 10 is a lifestyle photograph of the patient. The patient reports that her facial pain is gone. Comparing this to the postoperative picture of the veneers she had previously, these veneers are very lifelike, not at all bulky and have definition. In addition, with the combined treatment of facial injectables and veneers, we were able to go beyond the teeth and give this patient a great looking, natural smile.

(Photos/Provided by Dr. Louis Malcmacher)

About the author

Dr. Louis Malcmacher is a practicing general dentist and an internationally recognized lecturer, author and dental consultant known for his comprehensive and entertaining style. An evaluator for Clinicians Reports, Malcmacher is a consultant to the Council on Dental Practice of the ADA.

You may contact him at (440) 892-1810 or e-mail dryowza@mail.com. His Web site is www.commonsensedentistry.com, where you can find information about his lecture schedule, Botox and dermal filler hands-on workshops, audio CDs, download his resource list and sign up for a free monthly e-newsletter.

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The second Sedation Dentistry Safety Week, which was held March 15–19, coincided with the switch to daylight-saving time, when tens of millions of Americans reset their clocks and made the extra effort to check their smoke alarms.

Once again this year, more than 10,000 dental professionals participated in the weeklong program, which was aimed at reinforcing their skills in providing for the health and safety of all patients.

Sedation dentistry, an increasingly popular method of receiving dental care, provides adult dental patients an anxiety-free, pain-free alternative to standard dental treatments. While ensuring that patients are the most comfortable they’ve ever been before, during and after each visit, the first and foremost priority of sedation dentists is always patient safety.

“One reason why so many adults who previously dreaded dental visits have become such ardent fans of sedation dentistry is because it is pain-free, amazingly effective, and most importantly, it is safe,” said Dr. Michael Silverman, who is considered one of the world’s leading sedation dentistry educators.

Silverman served as national chairman of the 2010 Sedation Dentistry Safety Week.

The five-day event was inaugurated in March 2009. Again this year, sedation dentists throughout the country joined with their team members to review key safety procedures that apply to each and every patient.

These dedicated health-care professionals also checked core safety equipment and supplies and spent time reminding patients of ways in which they can assist their dentists in making all dental visits both safe and enjoyable.

Silverman and his colleagues at DOCS Education, an educator of sedation dentists, hosted the weeklong program. Since its founding 10 years ago, DOCS Education members have provided more than 1.5 million adult dental patients safe treatments that adhere to or exceed standards recommended by the American Dental Association and approved by individual state dental boards.

Specific themes were assigned to each day of Sedation Dentistry Safety Week:

- Monday, March 15 — Annual Sedation Dentistry Safety Day
- Tuesday, March 16 — Myth Busting: Debunking the 7 Most Common Misconceptions About Safe Sedation Dentistry
- Wednesday, March 17 — Reality Bites: Highlighting Television Reality-Show Contestants Who Can Elevate Their “Star Appeal” With A Safe, Sedation Dentistry Makeover
- Thursday, March 18 — A Heart-to-Heart About Oral Health: Recognizing the Dangers of Avoiding the Dentist
- Friday, March 19 — Gold Medal Dentistry: The 2010 Safe Dentist of the Year Awards

All dentists who offer oral conscious sedation services to their patients were encouraged to participate in the 2010 Sedation Dentistry Safety Week, regardless of where they received their training.


(Dr. Michael Silverman)
DTSC Hygiene Webinar series

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• General dentistry
  “Many orofacial injuries during sports are preventable”
  In 1998, Orlando Magic center Adonal Foyle took an elbow from Utah Jazz’s Quincy Lewis to teeth #8 and #9, causing the teeth to luxate back. In 2001, Dallas Mavericks’ Dirk Nowitzki was elbowed by San Antonio Spurs Terry Porter and tooth #8 was knocked out. In 2005, Mavericks’ ...
  The list goes on and on, and this is only the NBA. We don’t have enough space to delineate all the dental injuries hockey players have endured ...
  www.dental-tribune.com/articles/content/scope/specialties/section/general_dentistry/id/1104
  • Dentistry: It really is the new medical specialty
  www.dental-tribune.com/articles/content/scope/specialties/section/general_dentistry/id/883
  “Platinum is a patient’s best friend”
  www.dental-tribune.com/articles/content/scope/specialties/section/general_dentistry/id/810
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  “Predictable apical microsurgery: Patient preparation (Part 1)”
  Surgery will never replace solid endodontic principles and should always be a last resort. Apical microsurgery consists of nine basic steps that must be completely performed in their proper order so we can achieve the desired result for our efforts ...
  www.dental-tribune.com/articles/content/scope/specialties/section/endodontics/id/929
  • Linden explains canal anatomy
  www.dental-tribune.com/articles/content/scope/specialties/section/endodontics/id/1064
  • Removal of warm carrier-based products with the Twisted File –
  www.dental-tribune.com/articles/content/scope/specialties/section/endodontics/id/928
  • Cosmetic dentistry
  “Aren’t you that guy on ‘Extreme Makeover’?”
  In an interview with Cosmetic Tribune, Dr. William M. Dorfman, the face of modern cosmetic dentistry, discusses his chosen career, his business, his television show — and his penchant for treating all of his patients as if they were celebrities ...
  www.dental-tribune.com/articles/content/scope/specialties/section/cosmetic_dentistry/id/543
  • New smile, new life: Innovative technologies and techniques can transform a smile
  www.dental-tribune.com/articles/content/scope/specialties/section/cosmetic_dentistry/id/544

Dental hygiene
“Pest control in gums gardening: Locally applied antimicrobials as adjuncts to nonsurgical periodontal therapy”
  The focused use of chemotherapeutics as antimicrobials can enhance the outcomes of nonsurgical periodontal therapy, resulting in healthier mouths for our patients ...
  www.dental-tribune.com/articles/content/scope/specialties/section/dental_hygiene/id/606
  “Top 10 causes of tooth discoloration”
  www.dental-tribune.com/articles/content/scope/specialties/section/dental_hygiene/id/778
  • Practice management
  “To retire or not to retire?”
  I am a 1965 graduate of NYU College of Dentistry, and I practiced until 2000. I was 58 at the time and was somehow bent on retiring in my late or middle 50s when most people thought that way.
  Social security was available at age 62 then, and the average age men lived to was 66. My dad died at that age and so did most of my friends’ fathers. Thus, I figured I could have a good 10 years to live the “really good life.” Boy has that changed ...
  www.dental-tribune.com/articles/content/scope/specialties/section/practice_management/id/1072
  • Good patient communication can help eliminate no-shows
  www.dental-tribune.com/articles/content/scope/specialties/section/practice_management/id/905
Daily schedule at a glance

Thursday, April 8
- Registration opens 7:30 a.m.
- Registered clinics 8:30–11:15 a.m. and 1:30–4:15 p.m.
- Participation clinics 8:30 a.m.–11:15 a.m. and 1:30–4:15 p.m.
- Capsule clinics 9–11 a.m. and 2:30–4:30 p.m.
- Exhibit hall opens 10 a.m.–5:30 p.m.
- University of Pittsburgh Alumni reception 11:45 a.m.–1:15 p.m.
- Howard College of Dentistry Alumni/Student reception 5:30–7 p.m.
- Monuments by Moonlight tour 7–10 p.m.

Friday, April 9
- Registration opens 7:30 a.m.
- Registered clinics 8:30–11:15 a.m. and 1:30–4:15 p.m.
- Participation clinics 8:30–11:15 a.m. and 1:30–4:15 p.m.
- Capsule clinics 9–11 a.m. and 2:30–4:30 p.m.
- Exhibit hall opens 10 a.m.–5:30 p.m.
- University of Maryland Alumni reception 11:45 a.m.–1:15 p.m.
- Howard College of Dentistry Alumni/Student reception 4–5:00 p.m.
- Monuments by Moonlight tour 7–10 p.m.

Saturday, April 10
- Registration opens 7:30 a.m.
- Registered clinics 8:30–11:15 a.m. and 1:30–4:15 p.m.
- Participation clinics 8:30–11:15 a.m. and 1:30–4:15 p.m.
- Capsule clinics 9–11 a.m. and 2:30–4:30 p.m.
- Invisalign Clear Essentials II 8 a.m.–5 p.m.
- LUMINEERS smile design workshop 8 a.m.–5:30 p.m.
- CNA risk management seminar 8 a.m.–12:30 p.m.
- Dental Hygiene Program 8:30 a.m.–4:15 p.m.
- Harvest Festival exhibit hall opens 10 a.m.–5:30 p.m.
- Columbia University Alumni Association reception 11:45 a.m.–1:15 p.m.
- Dental Hygiene luncheon 11:45 a.m.–1:15 p.m.

What to do in D.C.?

Or really, what isn’t there to do here?

By Robin Goodman, Group Editor

Aside from the obvious offerings our nation’s capital offers, there is quite a lot to do in this city of just less than 600,000 residents (as of 2009, that is, says the Census Bureau). Founded on July 16, 1790, the city was at first a separate municipality, but in 1871, Congress merged the city with its municipality so it officially (and legally) became known as the District of Columbia.

Cherry Blossom Festival

During the Nation’s Capital Meeting, attendees will catch the tail end of the National Cherry Blossom Festival, which runs from March 27 through April 11.

This festival does not take place only on the trees themselves, but rather is a citywide effort between the arts, city attractions, Japanese culture and restaurants.

Although the event ends in the middle of April, hotel discounts run through the end of the month, so take a couple of days to enjoy some local color before or after the dental meeting. Even though you will likely miss the peak date for cherry blossoms, April 1–4, the expected bloom dates range from March 28 to April 9. You can view the blossoms by foot, by bike or boat, so bring comfortable shoes.

For all the latest info on the festival, please visit the Web site at www.nationalcherryblossomfestival.org.

Free things to do in D.C.

Thanks to the local experts at www.washington.org, I now know that there are at least 100 free (and “almost free”) things to do in D.C.

Their list is broken down into 10 items under each of the following topic headings: African-American experience, arts and culture, around town, D.C. outside, economical eats and cheap happy hours, family-fun, GLBT-friendly, international D.C., musts for history buffs and performances.

I encourage you to visit the original list online, but have chosen a few items from some of the topic headings to feature here in the hopes they might spark your interest (mine certainly did!).

Performances

A family-friendly option is Satur-
day morning at the National Theatre, which offers anything from ballet to puppet shows. Get there early as tickets are free and are passed out a mere 30 minutes before the show begins (think: “you snooze you lose”). Visit them online for all the details, www.thenationaltheatre.com.

On Sundays there is a local drum tradition that is 40-years strong. When weather permits, you can listen to the drum circle at Meridian Hill Park from 3–9 p.m. Enjoy listening to the drum beats and see if you can keep up with the African dancing (don’t forget to bring your drum if you have one!).

In addition, on Sunday nights there is live music to be found at the National Gallery of art (www.nga.gov), which features a variety of musical options such as choral music and even opera. Once again, be prompt as the doors open at 6 p.m. and there is no admittance after 6:30 p.m.

OK, let’s say you want to sleep in, but are able to re-route your day before dinnertime on a Monday (provided you can stay that long, of course). There is a free performance at 6 p.m. and 7:30 p.m. by the Reflections Dance Company on April 12 in the Helen Heyes Gallery at the National Theatre.

Family fun
Get starry eyed at the Rock Creek Park, which houses an astronomy laboratory and allows you to see the stars on a dome-shaped ceiling (Did you know it’s the only planetarium operated by the National Park Service?).

There is regular programming on Saturdays and Sundays that shares a handful of the fundamental concepts in astronomy. Get more information at www.nps.gov/rocr.

How would you like to make some money while you’re in D.C.? Well, you can certainly see millions of dollars being printed at the Bureau of Engraving and Printing (www.moneyfactory.gov). The tour is 40-minutes long and heads out every 15 minutes during the hours of 9–10:45 a.m. and 12:50–2 p.m. (reservations for large groups can be made between 11 a.m.–12:15 p.m.). Once again, because this is a free activity, space is available on a first-come, first-served basis.

International D.C.
So, what will it be today: Chinatown? Germany? Mexico? Rome?
At the corner of 7th and H Street, NW, you can snap a photo of yourself under the Chinatown Friendship arch. If you have a taste for Chinese food after that, make a beeline for 619 H Street, NW, the home of Tony Cheng’s Restaurant.
Awarded a place on the list of Washington’s best 100 restaurants as well as a “Best Bargain Award” by the Washingtonian, you can either order off the menu or opt for the all you-can-eat buffet (www.tonychengrestaurant.com).

Take in some Mexican art at the Mexican Cultural Institute, portal.sre.gob.mx/intm. This year, the country celebrates its bicentennial of independence and the Mexican Revolution’s centennial. The current exhibition features the works of native Washingtonian Elizabeth Catlett, which she created in Mexico while part of an artistic collective.

“Sprechen Sie Deutsch?” If not, but you have an interest in German arts, culture and language, a visit to the Goethe Institut is definitely in order.

Located in the Penn Quarter, there is a collection of film presentations and discussions, literature and notable speakers (www.goethe.de/ins/usa/insd/enindex.htm).
The last microscope skeptic

By Patrick Wahl, DMD, MBA

I didn’t have a microscope, and I didn’t need one. And I sure didn’t like being lectured to or told how to live my life by those who had them. I had come back into practice in 2006 after a number of years away when I was speaking and consulting full-time. I returned to a specialty that seemed to have passed me by.

When I first practiced in the 1990s, microscopes had been the exception. Now, they had become the rule. But I already had an endless wish list of needed supplies and equipment in addition to all of those expensive rotary files. A microscope just wasn’t my first priority.

Practicing again after several years away was challenging. I sought out all of the information and help I could get, and began participating in the ROOTS e-mail discussion forum. I was amazed by what my colleagues were posting. What is a middle mesial canal? I didn’t remember any mention of them during my endodontic residency in the early 1990s.

Perhaps I could ignore canals that probably weren’t there. But there were several occasions when I could not find canals that I knew were there. Where is the mesial-lingual canal on this mandibular molar? How embarrassing!

There is such a thing as a mandibular molar with only two canals, and I knew this wasn’t one of them. I had to refer the patient to a real endodontist—one with a microscope.

A friend of mine and a world-class endodontist, Bill Watson, told me that one day, I would think of the microscope as I do the rubber dam — I won’t want to work without one, because it makes my life easier. Bill’s remark stayed with me.

I never did like the saying, “You can’t treat what you can’t see,” because I had been treating things I couldn’t see every day for years. But Bill’s point about the microscope, like the rubber dam, was the microscope makes life easier! Now that was right up my alley.

Most of my patients wanted me to use a microscope for endodontics. I had been afraid microscopes would be especially cumbersome and difficult to use, but the opposite has been the case.

I actually find the microscope much easier and more natural to use than loupes, at least easier to use than high-magnification loupes. The lowest power on the microscope is superior to the highest level on the loupes that I had used. And the highest power on the Seiler IQ is far more than I think I’ll ever need.

The microscope also has a larger field of view, and the light is so bright you can usually see all the way down the canal to the apex. If it gets any brighter, I just might be able to see the future!

Why pay more to get less? I am amazed at the quality and ease of use of the Seiler IQ. There is a learning curve when it comes to mastering all its uses, but I was able to pull it over and see everything I needed to see on day one with my very first patient. The construction is rock solid and gorgeous. It goes where you need it, stays where you put it, and even comes standard with the inclinable head that is so necessary for dentistry.

Since adopting the microscope into my routine, I have already found a number of fourth canals in maxillary molars that I would not have found without the microscope. What is remarkable is how easy it is — how obvious the canals are with the magnification and light, and how easy it is to use a microscope for endodontics.

Some of the fourth canals I would have found without the microscope, but I would have done so blindly and would never have really known what I was dealing with.

It is surprising how clear everything is under the microscope. And with the microscope, I can use a Munce bur (www.cmengineering.com) — a surgical length bar with a strong but thin shaft — and actually see what I’m doing. Wow!

Last week, I found a mesio-lingual canal in a lower molar that I would not have found without the microscope. Again, what is remarkable is how easy and obvious it was as soon as I pulled the microscope over.

It was especially gratifying to me because I had sent two such cases to the best endodontist I know, Dr. Jung Kim in Wilmington, Del., last year when I couldn’t find them. They were...
probably hiding in the exact same configuration.

I found the mesial-buccal canal right away upon access. It was clearly a mesial-buccal canal, and it was equally clear there was an unfound mesial-lingual as well. No luck uncovering a mesial-lingual canal with a bur. No luck with an ultrasonic. No nothing.

I pulled the microscope over. It was obvious under such bright light and magnification that there was a ledge of dentin overhanging the lingual aspect of the mesial-buccal canal, and almost certainly a canal underneath. Indeed, the mesial-lingual canal was directly adjacent to the mesial-buccal canal. It could not have been easier to use a Munce bur to uncover the ledge.

I used to believe that only burs could uncover canals. Now, I am learning that often, our burs have already uncovered canals, but they will remain hidden under ledges, invisible to the naked eye without the magnification and light provided so easily by the microscope.

Just yesterday, I found my first middle mesial canal. Oh, I know that others have been finding them routinely for 15 years. Now, I will be, too.

At the lowest level of magnification (5x), it was as if there were three tiny light bulbs along the mesial aspect of the access floor — one bright white light corresponding to the mesial buccal canal; one bright light corresponding to the mesial lingual canal and an equally clear and bright light in the middle.

And I had never troughed between the mesial buccal and mesial lingual canals — I never had to. The bright light representing that third mesial canal was already visible.

I no longer want to do endodontics without a microscope, just as I would not want to do endodontics without a rubber dam. If you are interested in endodontics, if you treat any molars at all, don’t waste money on loupes. Get a Seiler iQ floor mount.

It’s affordable, extremely simple and natural to use, and its quality construction is obvious, like closing a door on a Mercedes.

Thank you, Glenn van As (glennvans@mac.com). Glenn is a general dentist who uses a microscope for every procedure. His DVD taught me everything I needed to know about microscopes, even before I bought one. I review it on occasion and pick up more tips each time.

Thank you, Stefan Luger (www.dentalmicroscopy.com). Stefan is the microscope consultant who sold me the microscopes and made sure they were installed correctly. Most of all, I want to thank the ROOTS endodontic e-mail discussion forum (www.rzroots.com), which helped me along the whole way. I hope you will join the discussion. Wahl has no financial interest in any of the companies mentioned in this article, and has received no compensation for writing this article.

(Photos/Provided by Dr. Patrick Wahl)

Dr. Patrick Wahl is an endodontist in private practice in Wilmington, Del. He completed his endodontic postgraduate training at the University of Pennsylvania and serves on the faculty of Temple University where he teaches a practice management class. He can be reached through his Web site, www.officemagic.com.

Hear Dr. Wahl speak
Dr. Patrick Wahl will speak at the meeting of the Virginia Dental Association in historic Williamsburg, Va., June 17–20, (www.virginiameeting.org), and at the Wichita District Dental Society in Wichita, Kansas, on Sept. 12, 2011, (www.wichitaadds.net).

About the author
Dr. Patrick Wahl is an endodontist in private practice in Wilmington, Del. He completed his endodontic postgraduate training at the University of Pennsylvania and serves on the faculty of Temple University where he teaches a practice management class. He can be reached through his Web site, www.officemagic.com.

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In studies published in the British Dental Journal, Lowe et al. and Whitworth et al. demonstrated blood on post-sterilization-assembled matrix bands and concluded that it is not possible to clean assembled matrix bands with any method currently available to dental practitioners.

Dr. Simon (Paddy) Jones is a leading U.K. dentist with a practice in the northeast of England. He qualified in 1985 and has worked mainly for the British National Health Service since then. For the past six years, he has also served as a vocational trainer for the Northern Deanery of Newcastle University Dental School. He is a keen sportsman, avid blues music fan and car rally enthusiast.

Jones came up with the idea for and designed Directa’s revolutionary Steriband Matrix Retainer out of the frustration and time wasted fiddling and loading matrix bands into conventional matrix retainers while dealing with cavities. He also wanted to minimize risks of cross-infection.

The Directa Steriband Retainer simplifies loading of a matrix band with its unique clamping device and easy loading design. Furthermore, the design eliminates tearing of matrix bands because the matrix can be removed from its retainer, even while still in the patient’s mouth. The matrix is removed horizontally, rather than vertically, and is easily dissembled in seconds for easier cleaning and decontamination in an ultra-sonic bath or washer disinfector.

For both patients and the dental team, all reusable matrix retainers pose a cross-infection risk, which demonstrates the absolute necessity to change the matrix band between every patient and not even attempt to sterilize it. Potentially, the dental nurse faces the greatest risk when removing a contaminated matrix band from the retainer, which is often a difficult and hazardous process.

Since Steriband Matrix Retainer was introduced onto the market, it has aroused a great deal of interest among dentists and dental technicians because of its ease of use and fast loading — with all types of matrix bands including Toffelmire and Siqveland, normal and ultra-thin, stainless steel and clear polymer — and safety features.

The price of Steriband Matrix Retainer has recently been lowered considerably due to improved production techniques, making it a must for all dental surgeries.

Information about Directa products and distributors may be found on www.directadental.com or by calling (203) 788-4224.

References
1) C L Whitworth et al., BDJ. Vol. 4, 2007
2) Lowe et al., BDJ. Vol. 192 No 1, 2002

Dr. Simon Jones, inventor of the Directa Steriband Matrix Retainer.

Directa’s Steriband Matrix Retainer (Photos/Provided by Directa)
Tri Hawk recently unveiled a new multi-faceted corporate marketing campaign for its proprietary line of dental burs. At the core of the campaign is a strategy to target only the most demanding bur users.

“Over the past 40 years, we have learned that many dental practitioners take the attitude that ‘a bur is a bur,’” said Tri Hawk founder and CEO Gustel Fischer. “More discriminating clinicians, however, are able to appreciate a bur that truly provides an unparalleled combination of cutting speed, user and patient safety, and resistance to breakage. Those are the people for whom Tri Hawk burs are designed.”

This new positioning is reflected in the company’s new tagline: “For the bur connoisseur.”

Key elements of the marketing campaign include: a more contemporary and distinctive logo; a greatly expanded Web site featuring a comprehensive online store; an all-new journal advertising campaign; an extensive catalog showcasing the company’s unique product line and history; and a high-impact trade show booth design.

The company has also expanded its offering of diamond burs to complement its extensive line-up of standard, surgical, metal-cutting carbide and finishing burs.

The campaign was launched successfully at the Chicago Dental Society Midwinter Meeting in February. According to Scott Macdonald, Tri Hawk marketing manager for North America; “We could not be more pleased with the reception of our new campaign. Despite the still-recovering state of the economy, our show sales were the highest we have experienced in eight years.”

According to Macdonald, Tri Hawk’s new booth attracted exceptional traffic, and the new catalog received glowing reviews from both existing and new customers.

Tri Hawk’s singular focus has always been designing, manufacturing and marketing the most effective dental burs possible, which the company says gives it a significant edge over competitors that produce a wide variety of products.

“We have an intense passion for burs for the simple reason that we consider them to be the most important instruments used by the dental practice,” said Fischer. In order to meet the needs of the most exacting dental practitioners, Tri Hawk employs proprietary bur designs, metal blends and manufacturing processes, and even designs its own bur-making equipment. Customer feedback and independent studies indicate that Tri Hawk burs provide a combination of cutting speed, strength and safety that is unmatched in the industry, according to the company.

In particular, Tri Hawk’s Talon metal- and crown-cutting burs feature an exclusive over-the-top blade design that allows the burs to cut not only horizontally but vertically as well. As a result, Talon burs are able to cut through even the most challenging materials in a fraction of the time of other leading burs.

About Tri Hawk Corporation

The privately held Tri Hawk Corporation, founded in 1969, has its corporate headquarters and manufacturing facility in Morrisburg, Ontario, Canada and U.S. headquarters in Massena, N.Y. Tri Hawk sells its products in more than 80 countries throughout the world, including Europe, South America, Africa and Asia. For more information, call (866) 874-4295, or visit www.trihawk.com.
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<th>Location</th>
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‘Romancing the spore’
Spores are romanced through each step of the sterilization process

By Patricia M. Pine, RDH

“The Way We Were” and “Romancing the Stone” are great old romantic movies. However, “the way we were” in sterilization should be just a memory in dentistry. Antiquated methods like cold sterilization no longer serve us.

The dental community continues to change and has gone full-throttle with new products for both clinician and patient comfort. Sterilization techniques have kept pace with science and given professionals new ways to “romance the spores.”

One of the most important safety techniques a dental office can provide for its patients is proper sterilization. Until there is a fear-ridden news story, patients don’t often think about sterilization because it is a behind-the-scenes technology.

Public fears began in the ‘80s with the AIDS scare in fear that HIV could be contracted in dental offices. Back then and now, the risk for transmission of HIV is small. What the public and many professionals don’t consider are the newer more virulent risks like MRSA, C-def, and H1N1 as well as the old stand-bys such as TB (See Table 1: Glossary of ‘bugs’).

As oral health-care professionals, we cannot take the sterilization process for granted. The consistency of sterilization practices requires a comprehensive program ensuring operator competence and proper methods of cleaning and wrapping instruments, loading and operating the sterilizer and monitoring the processes.

The goal in any sterilization department is to disassemble spore proteins to prevent harm. We need to romance the spores.

How to romance the spores
Warm baths, massages, thick spa towels and a bow around the package set the mood for romancing the spores. Spores are romanced through each sterilization step.

Spore-contaminated instruments are placed in the hot tub (the enzymatic bath) for a 20-minute, massage-removing bio-burden. After bathing, rinsing causes contaminated debris to sluice down the instruments.

This is followed by a natural drip-dry period on towels. This allows for visual inspection and prepares the instruments for entering the sauna.

Wrapping up for saunas is routine. Using paper pouches with inner and outer indicators is one option.

Tips to prevent tooth grinding

By Keri Kramer, Chicago Dental Society

How are Americans dealing with these difficult economic times? They’re taking the stress out on their teeth, if you ask dentists. In the fall of 2009, the Chicago Dental Society surveyed more than 250 of its members to see if stressing about the economy was wreaking havoc on patients’ oral health.

Nearly 75 percent of dentists surveyed said their patients reported increased stress in their lives. In addition, 65 percent of dentists said they have seen an increase in jaw clenching and teeth grinding amongst their patients.

Jaw clenching and teeth grinding, or bruxism, can be a temporary nuisance during stressful times that causes headaches and sleep problems, but it can also cause lasting problems for your teeth and gums.

It can lead to muscle inflammation, broken teeth or even damaged dental work, such as crowns and fillings.

Dentists are sharing the following tips with their patients to help them cope with the pressures of the world — before their teeth pay the price:

Take a pain reliever. If grinding and clenching is causing you headaches and muscle soreness in your jaw, take an anti-inflammatory medication, such as Advil or Aleve, shortly before bedtime.

Massage. Try massaging the muscles along your jaw line, from the joint near your ear all the way to your chin to relieve jaw soreness.

Avoid caffeine. Coffee may help you get going in the morning, but caffeine combined with stress can lead to increased muscle tension.

Increase your consumption of water. If cutting caffeine completely from your life won’t work for you, the least you can do is try to avoid it within several hours of bedtime.

Be careful with your diet. When the jaw muscles get inflamed, it’s best to go easy on them for a while by avoiding foods that require vigorous chewing. Ice and gum chewing are a definite no-no. And don’t even think about that triple-decker cheeseburger that almost requires you unhinge your jaw to eat it.

Exercise. You didn’t want to hear this one did you? However, exercise relieves stress and reduces anxiety, the two biggest culprits of grinding.

Meditate. Try a yoga class to achieve some relaxation. Even taking a moment before bedtime to do some deep breathing can be a big help.

Wear a mouth guard. If you have serious grinding and clenching issues, talk to your dentist about a mouth guard to wear at night.

About the CDS
The Chicago Dental Society recently held its 145th annual Midwinter Meeting, which brought more than 50,000 dental professionals to Chicago in February. The meeting is a forum for dentists to learn about new products, technologies and methods.

Table 1: Glossary of ‘bugs’

<table>
<thead>
<tr>
<th>MRSA</th>
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<td>C-Def</td>
<td>Clostridium difficult infection</td>
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<td>Swine flu</td>
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<td>TB</td>
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To find out more about these exciting programs and about membership in the ADIA visit our website at adiaonline.org.
Dear Reader,

The dentist I have worked with over the last 12 years has often told me his mother, Mrs. Dubats, always said to her children, “Do what you do best.”

At work, this comment most often comes after one of us has complained about something or played a practical joke. It has become a sarcastic comment in our office and one that we all understand.

While we have fun with this, I am not sure is the way Mrs. Dubats intended it to be used. You see, there is a deeper meaning to understand.

We should live by this saying. This is especially true in the hygiene department. Many of our team members complain that not all the hygienists do as much, with periodontal therapy, that some provide more passionate education than others, some perio chart all the time and some do not.

My answer to these complaints is, “Wow, you are so lucky to have that situation!” They don’t expect this response.

Having diversity on a team allows team members to focus on areas where they excel. For instance, take my office. I excel in treating periodontal patients, so I spend most my time doing that. My colleague is amazing with children, so she sees the majority of our little patients.

We don’t focus on what we may not be so good at, but instead we look at what we do well and what interests us. We have taken stressful situations and turned them into positive experiences.

Keep the thought, “do what you do best” in your mind for the next month.

Do what you do best and encourage others to do what they do best. Work as a team that is based upon strengths.

I believe it can change your life.

Best Regards,

Angie Stone, RDH, BS

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Reasons for sterilization failures

- **Improper packing:** Prevents penetration of sterilizing agent.
- **Improper loading:** Overloading or packages too close together.
- **Improper Timing:** Not enough time at proper temperature to achieve microbial kill; or a timer malfunction.
- **Improper temperature:** Not enough heat for proper time interval to achieve microbial kill.
- **Improper method of sterilization:** Heat-sensitive items melt or distort.

Another option is to “go naked” by using cassettes still wrapped and tied with a bow (indicator tape).

Cassettes keep instrument sets orderly, saving time and prevent accidental exposures. Both of these procedures must allow the whole (steam) to breathe through while denuding the protein that causes diseases... The romance is doomed to failure if the packets are stuffed together with no room to truly experience the warmth of the sauna. It becomes a competition with some packets selfishly grabbing all the heat and others enviously going without. The most important step: proper loading of the sterilizer.

The finale of this romance ends with the instruments free of disease-producing protein, completely dry and ready to be used the next patient safely. This sounds like a spa treatment or a made-for-TV movie, yet the consequence of messing up this romance is more than loss of a relationship; it could be loss of life.

**Was it a successful romance?**

The next question to answer is if the romance was successful. Are your instruments truly sterile? Authorities recognize bacterial spores, i.e., Bacillus spores, as the most resistant type of microbes, making spore testing the closest-to-ideal measure of eradication.

Routine weekly spore testing and biological monitoring of equipment for patient safety is not an option. It is a must.

A second spore test should then be performed. If the test is again positive, previously sterilized instrument packs must be removed from service. An immediate call for service on the unit is necessary and asking for a replacement sterilizer. Upon arrival of the temporary sterilizer, spore testing should be performed.

After repair of the original practice unit, there needs to be negative spore test in three consecutive empty chamber sterilization cycles.

Only then can the sterilizer be put back into service.

**What does OSHA have to do with this?**

The federal government requires OSHA training on an annual basis for each new employee hired. Use the lists and photos to assist in review of sterilization procedures as part of each new employee’s OSHA training as well as part of every employee’s annual training.
When was your last infection control training? Is everyone on the same page? Is it time to bring in a professional trainer?

**True romance**

Actually, the true romance isn’t really between the practice and the spore. The true romance is between the practice and the patients of record and the new patients they refer.

Eradicate patients’ spoken or unspoken fears by inviting questions about the behind-the-scenes sterilization process used in your practice by offering tours of your office.

Don’t assume patients of record already know how you effect proper sterilization. Creating trust and comfort by providing the best care on every level will result in referrals from content patients.

**Methods of sterilization**

- Remove bio-burden from instruments prior to packaging via ultrasonic device.
- Use sterilization pouches with both inner and external monitoring devices.
- Cassettes reduce possible exposures, increase organization of instruments and eliminate the need to handle highly contaminated instruments.
- Load pouches or cassettes into the sterilizer, leaving room for steam to circulate between each bag (see photo).
- Place pouches on separate trays. They must not touch sides, bottom, top or inside of the sterilization chamber.
- Place cassettes horizontal on each tray, or vertical on a special rack, with space for steam circulation.
- Monitor sterilizers with biological test strips and control indicators at least weekly.
- Maintain sterilization records in compliance with state and local regulations.

*Adapted from OSAP manual “From Policy to Practice 2004”*

**References**


(Photos/Provided by Patricia M. Pine, RDH)

**About the author**

Patricia M. Pine, RDH, has more than 30 years of experience. She is currently practicing as a periodontal therapist in Scottsdale, Ariz., utilizing her laser skills. Pine promotes risk management presentations that combine organizing the hygienists’ day while incorporating new technology and minimally invasive dentistry that is evidence-and scientific-research based.

Pine is founder of “U”nique Dental Organizational Services. She provides practices with safety exercises that keep teams up to date and safe in all aspects of infection control including OSHA guidelines. She encourages risk management in all venues of dentistry.

Time management, oral cancer, office policies and procedures, including recordkeeping are a few of her speaking topics.

Her career has been multifaceted and includes clinical dental hygiene, dental hygiene education, and speaking nationally and internationally. She has also contributed to several dental hygiene magazines. You may visit Pine’s Web site at www.uniquedentalservices.com. There you can take a short quiz that will test you on infection control updates by clicking on the in-office tab at the top.

(Images/Provided by Patricia M. Pine, RDH)
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