Treatment acceptance: could have, should have, would have

By Sally McKenzie, CMC

When it comes to treatment acceptance — or lack thereof — it seems as though a lot of time and energy are wasted on that familiar trio “could have, should have and would have.” You spend hours analyzing how things could have been if you had just used a different approach. How things should have been if you had just taken more time to educate the patient on why the treatment was necessary. How things would have been if you had listened more carefully to the patient.

Oftentimes, dental teams mistakenly view the treatment presentation as a one-time event that is a make-it-or-break-it situation. You either win or you lose based on that 15 minute song and dance. In reality, patient treatment acceptance begins long before you sit across from him or her eager to present the best that your dentistry has to offer. Consider our patient, Mary, who goes to Dr. Smith’s office.

“Dr. Smith’s office is great for cleanings and that, but he always seems so rushed. He takes a quick look at my teeth after the hygienist cleans them and sends me on my way. I want to ask about veneers, but I never feel like I should bother Dr. Smith,” Mary said.

“Oftentimes, dental teams mistakenly view the treatment presentation as a one-time event that is a make-it-or-break-it situation. You either win or you lose based on that 15 minute song and dance. In reality, patient treatment acceptance begins long before you sit across from him or her eager to present the best that your dentistry has to offer. Consider our patient, Mary, who goes to Dr. Smith’s office.

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Fetter retires from National Museum of Dentistry

Rosemary Fetter, executive director of the National Museum of Dentistry for the past 10 years, is retiring.

“We have benefited enormously from her commitment and passion for our museum,” said Board of Visitors Chair Michael Sudzina. “Under her leadership, the National Museum of Dentistry has become the premier dental museum in the world.”

During Fetter’s tenure, the National Museum of Dentistry became an affiliate of the Smithsonian Institution and was designated by Congress as the official museum of the dental profession in the United States.

“I leave with a tremendous sense of pride and appreciation for the work of our friends, supporters and staff in helping to bring the museum to this level of accomplishment,” said Fetter, whose retirement is effective June 30.

The museum is located on the campus of the University of Maryland Baltimore, home of the world’s first dental school.

To learn more about the museum, visit www.smile-experience.org.

(Source: National Museum of Dentistry)
Dentists and cardiologists should work together to prevent disease, experts say

By Fred Michmershuizen, Online Editor

The cooperation between the cardiology and periodontal community is a critical first step in helping patients reduce their risk of these associated diseases, according to a consensus paper developed by the American Academy of Periodontology (AAP) and The American Journal of Cardiology (AIC).

“Periodontal disease can have an increased risk for cardiovascular disease, and it is important to help develop clinical recommendations for our respective specialties. Therefore, you will now see cardiologists and periodontists joining forces to help our patients,” said Dr. David Cochran, a periodontist, and Dr. Jon Suzuki, a cardiologist, who were both involved in the creation of the consensus paper.

As a result of the paper, cardiologists may now examine a patient’s mouth, and periodontists may begin asking questions about heart health and family history of heart disease.

The clinical recommendations include the following:

• Patients with periodontitis who have one known major atherosclerotic cardiovascular disease (CVD) risk factor — such as smoking, immediate family history for CVD or history of dyslipidemia — should consider a medical evaluation if they have not done so within the past 12 months.

• A periodontal evaluation should be considered in patients with atherosclerotic CVD who have signs or symptoms of gingival disease, significant tooth loss or unexplained elevation of hs-CRP or other inflammatory biomarkers.

• A periodontal evaluation of patients with atherosclerotic CVD should include a comprehensive examination of periodontal tissues, as assessed by visual signs of inflammation and bleeding on probing; loss of connective tissue attachment detected by periodontal probing measurements, and bone loss assessed radiographically. If patients have untreated or uncontrolled periodontitis, they should be treated with a focus on reducing and controlling the bacterial accumulations and eliminating inflammation.

• When periodontitis is newly diagnosed in patients with atherosclerotic CVD, periodontists and physicians managing patients’ CVD should closely collaborate in order to optimize CVD risk reduction and periodontal care.

The clinical recommendations were developed at a meeting held in early 2009 of top opinion leaders in both cardiology and periodontology. The consensus paper also summarizes the scientific evidence that links periodontal disease and cardiovascular disease and explains the underlying biological and inflammatory mechanisms that may be the basis for the connection.

Although additional research will help identify the precise relationship between periodontal disease and cardiovascular disease, recent emphasis has been placed on the role of inflammation — the body’s reaction to fight off infection, guard against injury or shield against irritation. While inflammation initially intends to have a protective effect, untreated chronic inflammation can lead to dysfunction of the affected tissues, and therefore to more severe health complications.

Cardiovascular disease, the leading killer in the United States, is a major public health issue contributing to 2,400 deaths each day. Periodontal disease, a chronic inflammatory disease that destroys the bone and tissues that support the teeth, affects nearly 75 percent of Americans and is the major cause of adult tooth loss. While the prevalence rates of these disease states seem grim, research suggests that managing one disease may reduce the risk for the other.

“Both periodontal disease and cardiovascular disease are inflammatory diseases, and inflammation is the common mechanism that connects them,” said Dr. David Cochran, DDS, PhD, president of the AAP and chair of the Department of Periodontics at the University of Texas Health Science Center at San Antonio.

“The clinical recommendations included in the consensus paper will help periodontists and cardiologists control the inflammatory burden in the body as a result of gum disease or heart disease, thereby helping to reduce further disease progression, and ultimately to improve our patients’ overall health. That is our common goal.”
Robert S. Graham, RFC, CFM
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When it comes to stimulating dinner conversation, root canal therapy is not typically considered the most appetizing topic. That is unless the room happens to be filled with dentists who want to be the very best. Add to that a dynamic and entertaining speaker with years of experience in proper materials and methods of achieving predictable success in endodontics, and you have a most memorable evening.

Dr. Jeffrey Linden, a New York City-based endodontist, educator and lecturer, presented “Revelations in Endodontics: Foundations & Clinical Applications” at the Dental Study Club of New York’s meeting in May, held at the Harvard Club. In attendance were 46 dentists, including both specialists and general practitioners.

Linden’s presentation was entertaining as well as educational. Included in his slide presentation were pictures of Marilyn Monroe — who, lecture attendees learned, has a figure quite similar to the often-troublesome apical third of a root. Linden showed attendees how to use rotary instruments to properly clean and shape such shapely anatomy. He also discussed irrigation and obturation techniques.

Made up of about 100 members, the Dental Study Club of New York is an active, thriving group of dental professionals who are dedicated to ongoing education and collaboration. Each monthly meeting features a different topic and speaker.
him with questions,” Mary says.

Dr. Smith, meanwhile, is befuddled when patients don’t accept recommended treatment. Yet he gives little thought to the manner in which he and his team build, or erode, the foundation upon which successful treatment acceptance is based.

In Mary’s case, Dr. Smith doesn’t realize that he is undermining Mary’s trust in his care. Mary will be far less likely to proceed with recommended treatment because Dr. Smith has created the impression that he is always in hurry to get to the next patient, which makes her feel uneasy and unimportant. Worse yet, Mary is interested in a certain procedure but doesn’t even feel comfortable asking about it.

It’s a matter of trust

Certainly, patients trust you enough to come in for routine appointments. But when the patient needs or wants care that goes beyond “routine” procedures, have you and your team instilled in the patient the confidence, the dental education and the necessary trust in you and your practice overall for him or her to accept the treatment recommended? In some cases, patients are motivated to pursue treatment merely because they seldom question recommendations from their health care providers. But those patients are growing fewer and farther between each year.

Most patients today base major decisions, such as extensive dental treatment, on multiple factors: full comprehension of the need for treatment; the importance of the procedure to them in terms of quality of life, esthetics or health; possible ramifications if they choose to procrastinate or elect an alternative procedure; and how they feel about the practice as a whole.

Recommendation acceptance

When it comes to treatment presentation, we find that most dentists and teams understand the fundamentals of the concept, but they forget that patients base their recommendation acceptance on multiple factors.

In addition to always treating every patient as if she or he is the most important person in the room with you, and always taking the time to solicit questions from the patient, consider a few other ways in which you build trust with every patient and at every opportunity.

Be candid. Most patients are aware of some general risks in treatment so they are waiting for you to be frank about what, if anything, they might be faced with as a result of the treatment. If they are given advantages and disadvantages, research shows that patients are more willing to trust you to deliver their care. Patients always feel better when they know the benefits and risks of proposed treatment.

Always speak at the patients’ level of understanding. Jargon and “$10 words” can confuse patients and make them uncomfortable because they don’t understand, but they likely won’t ask you what you mean.

Exhibit clear confidence in your recommended course of treatment. A personal testimonial about recent treatment for another patient and the results obtained, for example, underscores that sense of security. It demonstrates that you have no doubt that you will get a good result for this patient.

Be aware of the perception of “fairness.” Many issues having to do with trust are linked to the patients’ perception of the value they are receiving. Studies show that patients avoid dental treatment due to cost more than pain. Yet, if they feel that the costs measure up to the service received, there is no complaint. Many patients will not question fees if the practice has demonstrated that they can deliver superior service. From the first phone call to dismissal, consistently demonstrate the “value” for services that the patient is receiving.

In Mary’s case, Dr. Smith doesn’t like the “$10 words” that he uses in talking about procedures. “I think it’s a matter of trust,” Mary says.

In some cases, patients are motivated to pursue treatment merely because they seldom question recommendations from their health care providers. But those patients are growing fewer and farther between each year.
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Six-year followup photo photo courtesy of Joseph P. O’Donnell, DMD

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About the author

Sally McKenzie is CEO of McKenzie Management, which provides success-proven management solutions to dentistry nationwide. She is also editor of The Dentist’s Network Newsletter, www.thedentistsnetwork.net; the e-Management Newsletter from www.mckenziemgmt.com; and The New Dentist™ magazine, www.thenewdentist.net. She can be reached at (877) 777.6151 or sallymck@mckenziemgmt.com.

Fight oral cancer!

Did you know that dentists are one of the most trusted professionals to give advice? 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.
Dr. Neil Gotttehrer knows the power of the toothbrush. Not only can it destroy plaque build-up and protect you from gingivitis, but it may also be a vital weapon for fighting cardiovascular disease. His research suggests that with a mixture of power brushing, irrigating and rinsing, patients can reduce their periodontal risks associated with heart disease—which is great news for the eighty million Americans suffering from it. But, to give patients the best care possible, their dentists and their doctors have to communicate. That’s why Dr. Gotttehrer created the Stat-Ck™ periodontal risk exam. During this exam, a patient’s dental health is examined and assigned a letter grade—A through F. Like any test, failing grades may help warn dentists and physicians of potential heart risks. Dr. Gotttehrer works to give people better smiles and healthier hearts, which is why Smile PA is an Advance Practice.

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Five of the top 10 reasons why associateships fail

By Eugene W. Heller, DDS

The “American Dream” is still to own a home. The “Dentist’s Dream” continues to be the ownership of a practice. Thirty years ago, the dream was to graduate from dental school, buy equipment, hang out a shingle and start practicing. Today the road to ownership is a little different.

Due to extensive debt, most new graduates enter practice as associates to improve their clinical skills, increase their speed and proficiency and learn more about the business aspects of dentistry. Most hope the newfound associateship will lead to an eventual ownership position. Instead, many find themselves building up the value of their host dentist’s practice, only to be forced to leave. This forced departure is the result of a non-compete agreement when the promised buy-in/buy-out doesn’t occur.

The following reveal the first five of the top 10 reasons many associateships fail to result in ownership or partnership.

Reason No. 1: purchase price

If the purchase price has not been determined before the commencement of employment, the parties find themselves on different ends of the spectrum as to what the practice is worth and what the buy-in price should be.

When purchase price is established before the commencement of employment, three out of four associateships lead to the intended equity position. Conversely, if the purchase price has not been determined, nine out of 10 associateships lead to termination without achieving the ownership intended or promised.

Reason No. 2: the details

The more items discussed and agreed to in writing beforehand, the better the chance of a successful equity ownership occurring as planned.

The written instruments should be two specific documents — an Employment Agreement detailing the responsibilities of each party for employment and a Letter of Intent detailing the proposed equity acquisition.

Reason No. 3: insufficient patient base

Approximately 1,000–1,200 active patients are required per dentist in a dental practice. If the senior dentist does not intend to restrict or cut back on his/her number of available clinical treatment hours, then the conversion from a one-dentist to a two-dentist practice requires an active patient base of approximately 1,600–1,800 patients and a new patient flow of 25 or more new patients per month.

Many senior dentists count their number of active patients by counting the number of patient charts on a wall. However, the best way to estimate the active number of patients involves utilizing the hygiene recall count.

Insufficient numbers of patients and/or an insufficient new patient flow signals that all expenses relating to the new dentist are coming directly out of the bottom line. The practice then begins to experience financial pressure.

Reason No. 4: incompatible skills

The incompatibility in clinical skills between practitioners may include the possibility of one practitioner’s skill level being below standard, but it may also include different practice philosophies. On the surface, it would appear that having different skill levels and philosophies might be desirable. In reality, the patient base available to the younger practitioner may not lend itself to various types of dentistry.

Reason No. 5: timeframe

The failure to identify when the buy-in or buy-out is to occur and when to execute it can result in failure to achieve an ownership status.

The Letter of Intent may have stated that the buy-in was to occur in one to two years, but certain behaviors and signs during the continuance of employment relationship might give an indication that the senior doctor is having difficulty honoring the intended buy-out or that the associate does not feel ready to consummate the transaction within the original outlined timeframe.

Either position might result in the demise of the buy-in as involved parties lose patience over such delays.

Summary

This article has been aimed primarily at a one-dentist practice evolving to a two-dentist practice; however, the issues apply equally to larger group practices.

One-to-two-year associateships with the senior dentist retiring at the end of the associateship and a three-to-five-year partnership ending with the new dentist purchasing the remaining equity position of the senior dentist at the end of five years can also benefit from the insights provided in this article.

Unfortunately, nothing can guarantee a successful outcome will occur. However, by identifying the potential pitfalls at the beginning of the relationship, chances of success can be greatly improved.

Look for the remaining five reasons in the next edition of Dental Tribune.

About the author

Dr. Eugene W. Heller is a 1976 graduate of the Marquette University School of Dentistry. He has been involved in transition consulting since 1985 and left private practice in 1990 to pursue practice management and practice transition consulting on a full-time basis. He has lectured extensively to both state dental associations and numerous dental schools. Heller is presently the national director of Transition Services for Henry Schein Professional Practice Transitions. For further information, please call (800) 730-8883 or send an e-mail to hsfs@henryschein.com
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ARIZONA
Shaw- 2 Ops, 2 Hygiene Rms, GR in 2007 $655,995
CONTACT: Tom Kembl @ 602-516-3219

CALIFORNIA
Alturas- 5 Ops, GR $351K, 3 1/2 day work week #14279
Bakersfield- 7 Ops, 2,200 sq ft, GR $1,316,000 #14280
Central Valley- 4 Ops, 2,000 sq ft, 2007 GR $500K #14266
Dixon- 4 Ops- 2 Equipped, 1,100 sq ft, GR $132K #14265
Fresno- 5 Ops, 1,500 sq ft, GR $1,415,181 #14250
Fresno- In professional park. Take over lease #14292
Lindsay/Tulare- 2 practices, Combined GR $1.4 Mill #14240
Madera- 1,650 sq ft, 3 Ops, GR $449K #14269
Madera- 7 Ops, GR $1,921,467 #14283
Modesto- 2 Ops, 1 GR $1,997,000, Same loc for 10 years #14289
Oroville- 5 Ops days of hygiene 2005 GR $138K #14178
Pineville- 6 Ops, 2,000 sq ft, GR $2,800,000 #14291
Red Bluff- 8 ops, GR over $1Mill, Hygiene 10 days a wk. #14251
Reno- 4 Ops, 1,950 sq ft #14229
San Francisco- 4 Ops, GR $875K, 1,500 sq ft #14288
San Marino- 6 Ops, 2,200 sq ft, 2008 GR $762K #14284
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Southern- 11 Ops, 3,500 sq ft, GR $1,804,628 #29101
Kane County- 4 Ops, building also available for purchase #22115
Rockfall Area- 5 ops solid practice. Very good net #22118
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MAINE
Auburn- Looking for Assoc. GR $2 Million #21111
Leavittson- GP looking for practice #28107
CONTACT: George Lane @ 603-641-1527

MICHIGAN
Suburban Detroit- 2 Ops, 1 Hygiene, GR $125K #31105
Grand Rapids Kentwood Area- 3 Ops, Building available. #31102
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MINNESOTA
Central Minnesota- 10 Ops, 4,685 sq ft, GR $1.9 Mill #35101
Eastern Central Minnesota- 10 Ops, 4,685 sq ft, GR $1.9 Mill #35101
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Crow Wing County- 4 Ops #32104
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Minniapolis- Looking for associate #32105
Rochester Area- Looking for associate #32106

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Reno- 4 Ops, approx $550K, large lot #11615
Port Charlotte- General practice for sale #18109
Port Charlotte- 3 Ops, 1 Hygiene Rm, GR $295K #18115
Southern- General practice for sale #18102
CONTACT: Jim Puckett @ 602-887-9069

NEW HAMPSHIRE
Central New Hampshire- 2 Ops, GR $650K #30119
Eastern New Hampshire- 5 Ops #30119
CONTACT: Alex Lyvick @ 603-210-2492

NEW JERSEY
Rockingham County- 2 Ops, Home Office #37102
CONTACT: Dr. Thomas Kelleher @ 603-661-7325

NEW MEXICO
Carson City- 5 Ops, 2 Hygiene, 2,200 sq ft, GR $1 Mill #37105
CONTACT: Dr. Dennis Hoover @ 800-519-3458

NEW YORK
Most Valled- 2 Ops, 2 Hygiene, GR $381K #38102
Rochester Area- Looking for associate #32106
Minneapolis- Looking for associate #32105
Hastings- Nice suburban practice with 3 Ops #32103
Crow Wing County- 4 Ops #32104
Hastings- Nice suburban practice with 3 Ops #32103
Minniapolis- Looking for associate #32105
Rochester Area- Looking for associate #32106

NEW YORK
Wake County- 4 Ops #42144
Wake County- 7 Ops, High end office #42123
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CONTACT: Barbara Hardee Parker @ 919-848-1555

OHIO
Akron- Excellent Opportunity, 2,300 Active Pts, 6 days of Hyg. #44144
Columbus- 4 FFS practice for sale #44125
Darke County- 35 yrs, 1200 Act. Pts, GR $530K #44139
Dayton- 10 Ops, Associateship with buy-in option #44121
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CONTACT: John Jumder @ 513-357-6670
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Boulder County- Ortho practice for sale #47118
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Pittsburgh Area - High-Tech, GR $425K #47135
Mon Valley Area- Practice and building for sale #47112
CONTACT: Dan Slais @ 412-855-0317
DuPage County- 6 Ops, GR over $1,000K, Sale price $718K #47135
Carrollton- 6 Ops, GR $381K, Listed at $290K #47120
Lackawanna County- 1 Hygiene, GR $515K #47138
Lancaster County- Associate positions available #47116
West Chester- 6 Ops, 10 years old, asking $225K #47134
CONTACT: Sharon Mascetti @ 484-788-0471

RHODE ISLAND
Southern Rhode Island- 4 Ops, GR $750K, Sale $456K #48100
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CONTACT: Sharon Mascetti @ 803-788-0471

TENNESSEE
Knoxville Area- 3 Ops, 10 years old, $225K #47108
CONTACT: Dr. Peter Goldberg @ 617-680-2930

TEXAS
San Antonio- 5 Ops, 2 Hygiene Rms, GR $1.2+ #40108
CONTACT: Dr. Peter Goldberg @ 617-680-2930

UTAH
Salt Lake City- 5 Ops, 2 Hygiene, GR $1.2+ #40108
CONTACT: Dr. Peter Goldberg @ 617-680-2930

VIRGINIA
Burlington- General practice #51101
Danville Area- 3 Ops #55105
CONTACT: Dr. Peter Goldberg @ 617-680-2930

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Greater N.Y. Dental Meeting’s Live Dentistry Arena attracts record number of attendees

A total of 57,854 registered attendees during its 2008 meeting solidified the Greater New York Dental Meeting (GNYDM) as the largest dental convention and exposition in the United States. Included in these results were 17,710 dentists from all 50 of the United States and 125 countries around the globe.

The GNYDM has always been known for its impressive array of cutting-edge educational programs. Among the new additions initiat- ed, the shining star was the Live Dentistry Arena. While many dental meetings offer workshops where attendees watch a pre-recorded surgery, the GNYDM led the way out of the “recorded past” and into the “living now.”

The new Live Dentistry Arena allowed attendees to feel as if they were seated right beside the world-renowned clinicians performing procedures on patients in real time. This unique educational experience was conducted directly on the exhibit floor and was offered with no tuition costs.

Multiple 60-inch displays were strategically placed for easy viewing around the Live Dentistry Arena while attendees watched some of the most highly respected educators in the world conduct live patient demonstrations. These procedures featured the latest materials and equipment available on the market.

The arena was filled on a first come, first seated basis. This history-making program not only filled the arena’s seating for 300 persons during the entire four days of the exhibition, but also had up to another 100 attendees standing or seated on the floor outside the seating area.

As general chairman of the GNYDM, the first dental meeting offering this four-day extravaganza, Dr. Clifford Salm commented: “The chance to watch dental procedures performed live, not pre-recorded or on an inert model, affords an amazing educational opportu- nity. We were thrilled to showcase such a unique program right on the exhibit floor.”

Never wishing to rest on its laurels, the organizers of the GNYDM have already begun work to both enhance the existing Live Dentistry Arena, and to add a second arena as well. Many programs, including additional seminars and workshops will also be added to the redesigned exhibit floor.

Be sure to watch the Web site, www.gnydm.com, for information and updates on this year’s Live Dentistry Arenas and all of the other new programs offered at the 85th annual meeting. Remember, there is never a pre-registration fee.

Mark your calendar for Nov. 27 to Dec. 2 to be a part of the excitement of the 2009 Greater New York Dental Meeting and experience all that New York has to offer! For additional information please contact the Greater New York Dental Meeting at 570 Seventh Ave., Suite 800, New York, N.Y., 10018-1806; telephone (212) 598-6922; fax (212) 598-6954; info@gnydm.com.
Former hygienist now dentist, president of AGD

In an interview with Dental Tribune, Dr. Paula Jones, president of the Academy of General Dentistry (AGD), discusses her love of dentistry, some of the challenges facing dental professionals today and how the organization she leads is addressing these challenges.

By Fred Michmershuizen, Online Editor

Would you please tell our readers a little bit about you and your background?

I graduated from Indiana University in 1975 as a dental hygienist, and after working for three years found that I loved the practice of dentistry so much that I wanted to be able to perform more procedures. In order to be able to perform more dental procedures than I was allowed to do as a hygienist, I knew that I would have to attend dental school. I took courses at night to achieve all the requirements for dental school and was accepted to Case Western Reserve University in 1978. One of my favorite instructors there introduced our class to the AGD, and I have been a member ever since. I thought that I could not go wrong by joining an organization that was all about lifelong learning.

Once I heard about fellowship in the AGD, that became my next career goal after graduation. I am proud to say that I did achieve this personal goal in 1995 and received it at the AGD Annual Meeting, which was held in Baltimore that year. So now I feel as if my dental career has come full circle because I will be leaving my presidential term in Baltimore this coming July. I had also received the AGD Distinguished Service Award in 1995, so Baltimore holds many fond memories for me.

What are some of the AGD’s short- and long-term goals?

Advocacy for general dentists and our patients and membership go hand-in-hand with our core competency of education. Our fellowship and masterships are highly regarded in the dental community and a personal goal of many of our members, all of whom are dedicated to lifelong learning. With dentistry in the minds of policymakers throughout Washington as a part of health care reform and in the individual states with access to care issues, it is more important than ever that the AGD speaks for the general dentist.

Advocacy has become a key goal for the AGD, both now and in the future. If general dentistry is to retain its autonomy in a world of change, then we must be at the discussion table, wherever that may be. Advocacy is what our members are demanding, and that is what we are providing in many different ways. We advocate for our patients as well. Check out our consumer Web site — knowyourteeth.com — to see the benefits and education that we provide for the general public.

What can those who plan to attend the upcoming AGD meeting in Baltimore expect?

Our Annual Meeting & Exhibits, to be held in Baltimore July 8–12, is the premier general dentistry event of the year. There are a number of new and exciting highlights for our attendees this year, such as: joining AGD at the University of Maryland Dental School to experience cutting-edge continuing dental education and the cutting-edge facility; attending the opening general session with keynote speaker Cal Ripken Jr., Baseball Hall of Fame member, who played his entire baseball career for the Baltimore Orioles; participating in the AGD Premier Celebration on Saturday evening; networking at the welcome reception in the Exhibit Hall; and more dental team courses to help train teams in the best practices in dental care.

Free registration is available for all dental students, residents and recent graduates. Dental team members also receive free registration when their dentist registers for the full meeting. To learn more about AGD 2009 Baltimore or to register for this event, visit www.agd.org/baltimore09.

In your view, how is the current economic downturn affecting AGD members and their patients?

I have had many mixed messages from our members. Many are severely affected by the economic downturn of our country, while some say that they are as busy as ever. The common thread seems to be the fact that patients are not pursuing cosmetic dental procedures like veneers and whitening as much...
and only agreeing to treatment that is absolutely necessary, and many are postponing the larger comprehensive reconstructive treatments until the economy picks up.

One favorable issue for dentistry is that it is a health care profession and health care is a necessity, not usually an elective treatment. There is still a huge need in the general population for routine dental checkups and restorative treatment.

The downturn in treatment acceptance and busyness among dentists seems to be most affected by a geographic consequence — if the economy is very bad in a particular area and unemployment is high, this seems to be where the dentists are most affected.

What is something you would like to see changed about the way dentistry is practiced today in the United States?

I personally feel that the dental team concept has served us, and our patients, very well over the past 50 years that I have been involved in practice. We as practitioners have become more efficient in the use of our chair time and scheduling, new and better dental materials and with the use of expanded function auxiliaries.

The preventive practice is still the gold standard and the reason that dentistry has been able to retain its autonomy in the health care profession when the practice of medicine has been specialized and splintered to the detriment of patients everywhere.

The only thing I feel that makes sense in changing the way dentistry is practiced is to try to achieve a better distribution of the existing dental workforce. There are geographical locations that are saturated with dentists, while other areas of the country are severely limited in the number of practitioners or absent any dental care at all.

I do not feel that a second tier of dental practitioners providing optimal care for every patient, not to provide a lesser educated practitioner — such as a proposed midlevel provider — for the segment of the population who, due to socioeconomic factors, are least able to afford to pay for their dental care.

Is there anything you would like to add?

Yes, thank you for asking. General dentistry today is at a crossroads with threats on every side.

There are specialists who are trying to restrict certain procedures that general dentists have historically been trained to provide for their patients.

There are the dental hygienists who are trying to develop the advanced dental hygiene practitioner who will be able to perform irreversible procedures such as cutting tooth structure, placing restorations and extracting teeth.

There are government entities that are trying to pigeonhole dentistry into the medical model and revamp the ever-successful practice of dentistry with the dental team as the core into something like the socialized and tiered practice of medicine.

There are the dental schools whose curriculums are turning out general dentists who have never extracted a tooth, never performed any kind of periodontal surgery and never placed an orthodontic bracket on a live patient.

We as a profession need to be vigilant and to speak with one voice. The Academy of General Dentistry is the only organization that speaks solely for the general dentist. We encourage membership in the American Dental Association as well, but know this — if we do not stick together as a profession we will be torn apart by the forces mentioned above that would like nothing better than to have general dentists as an impotent group that directs the practice of dentistry by remote, electronic means and to have as little contact with the patient as possible.

For your readers that may think this notion is farfetched, then maybe you should move to Minnesota or Maine, where this farfetched scenario is becoming a reality.
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Dentistry meets ‘cloud computing’ match in DentalCollab by Modulus Media

Web-based software unites centralized, treatment management system with an online social networking system to create a ‘Treatment Workspace’

TORONTO, CANADA, June 8 — Modulus Media, a Toronto-based technology development and marketing company, announced the June 26 launch of DentalCollab, a Web-based software available at www.DentalCollab.com, which finally unites a centralized, treatment management system with an online social networking system to create the ideal “Treatment Workspace” for the field of dentistry.

For those new to this terminology, the “cloud” in cloud computing is a metaphor for the Internet. As an expression, cloud computing entails offering Web-based software services via the Internet where the data and software are stored on servers managed by the service provider.

Thus, cloud computing users do not need to spend untold dollars on hardware, software, upgrades or ancillary support services, but need only to pay for the services they use.

Some of the more trusted and familiar cloud computing services are online banking, e-mail accounts such as Gmail™ or Yahoo! Mail®, social portals such as Facebook and MySpace and Internet-based photo albums on sites such as Flikr® or Webshots.

Similarly, DentalCollab is a cloud computing service that allows the dental community to not only facilitate all aspects of treatment management, but also to collaborate with specialists, consult with patients, coordinate with referrals, mentor or be mentored by peers and share cases with labs and suppliers.

Through its creation of a shared Treatment Workspace, DentalCollab allows practitioners completely secure patient information management and includes seamless treatment planning, while also facilitating networking with experts anywhere on the planet who have a computer with Internet access.

The Treatment Workspace is an easily navigated mini-Web page where all those involved in a patient’s care can coordinate their efforts as well as share and manage vital information.

Additionally, the practice can schedule appointments, follow-ups and reminders, consult with patients and manage multiple schedules for even the busiest practice.

“Our comprehensive software allows you to easily interface many of your other programs such as charting systems, digital X-rays and patient financing services, thus consolidating your information,” said DentalCollab founder Shane Powell.

DentalCollab uses the same hardware and software security provisions that online banking providers use — end-to-end encrypted data infrastructure; back-ups/data redundancy, 24/7 system monitoring; permissions/roles-based user management; and 256-bit bank-grade security certificates with a $100,000 warranty.

Finally, dentists have a place to do everything they need, and want, to provide the utmost in treatment planning and meet the modern needs of their techno-savvy patients by going beyond the traditional methods of contact via telephone and snail mail.

Using DentalCollab means dentists can avoid costly software upgrades, hardware upkeep and the time wasted seeking out technical support or repairs.

“The DentalCollab software functions like a basic Web page, so it feels as if it is running on your own computer. This translates into a very short and fast learning curve,” explained Powell.

DentalCollab saves practitioners time and money. For more information, please visit the official Web site at www.DentalCollab.com or e-mail sales@dentalcollab.com.

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Enamel Bonding Surface
CR) Composite Resin
B) BeautiBond
E) Enamel Surface
D) Dentin Surface

Bond Strength After Thermocycling
(MPa)(%) 0 cycle 5000 cycle 10000 cycle

20 40 60 80

0 20 40 60

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One Adhesive: Two Powerful Monomers

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Enamel Bonding Surface
CR) Composite Resin
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E) Enamel Surface
D) Dentin Surface

Bond Strength After Thermocycling
(MPa)(%) 0 cycle 5000 cycle 10000 cycle

20 40 60 80

0 20 40 60

0 20 40 60

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“Now more than ever is when financing can play a positive role in enabling patients to get dental treatment. Instead of being confronted with a bill that requires them to pay all of it up front, patients have the opportunity to pay with low-cost financing over 12, 18 or 24 months with $0 down payment required.”

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Crosstex responds to the H1N1 (swine flu) virus

Crosstex® International, Inc., a division of Cantel Medical Corporation, and one of the largest manufacturers and distributors of face masks in the United States, is taking an increasingly aggressive role in meeting the demand for masks and infection control supplies in light of the recent H1N1 virus outbreak.

To keep pace with the record-breaking global demand for its face masks, Crosstex has doubled production of its entire face mask line. In particularly high demand are Crosstex Ultra Face Masks, which provide one of the highest levels of filtration available. This surge in orders of face masks — as well as other flu-related prevention supplies such as the N95 Particulate Respirator, SaniTyze® alcohol-based hand sanitizer and disinfectant wipes — has come from distributors, health care practitioners, private industry, hospitals and government agencies worldwide.

“Many people have asked how we were able to mobilize so quickly. The simple truth is that our parent company, Cantel®, has been developing services for the past two years with our help, which has been immensely invaluable to the success of our current efforts,” states Andrew Whitehead, vice president of sales and marketing at Crosstex.

“Since we are dedicated to preventing the spread of infectious disease in the health care community, we also have a social responsibility to help combat these threats when they affect the general public,” continues Whitehead. As part of this ongoing commitment, Crosstex supports a wide range of charitable organizations worldwide, including Feed the Children Foundation, a private organization that supplies food and other essentials to children and families in all 50 states and in 52 foreign countries. Crosstex recently donated half a million masks to the organization, making it possible for it to be prepared for the current H1N1 viral threat.

Crosstex is also spearheading public health education and awareness efforts. As part of these initiatives, Crosstex recently sponsored a local professional sporting event, where it distributed free SaniTyze hand sanitizer to more than a thousand fans along with swine flu prevention literature.

“Public education and involvement are essential to containing the spread of infectious disease,” states Whitehead. “Through the use of simple common sense precautions such as proper surface disinfection, frequent hand washing and the use of alcohol-based sanitizers, people can cut their risks significantly.”

For more information on how Crosstex can help you protect yourself, your family and your practice or business from infectious diseases, visit www.crosstex.com.

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Fusio Liquid Dentin represents the next generation in flowable composite technology. By effectively fusing together self-adhesive and restorative technology into one product, clinicians can now restore teeth faster than ever, saving both time and money.

Fusio Liquid Dentin’s ability to tenaciously bond to both dentin and enamel without a separate adhesive opens up new possibilities for this segment of restorative materials.

Pentron Clinical Technologies Product Manager Jeremy Grondzik states: “While it shares many of the same indications as a traditional flowable composite, its use as a dentin replacement material or a self-adhesive base liner shatters previous perceptions of where and how flowable composites can be used.”

This new generation of flowable composite is priced similar to traditional premium flowable composites and is available in the popular Vita® shades: A1, A2, A5 and B1.

Fusio Liquid Dentin is one of the latest innovations from Pentron Clinical Technologies, an established leader in the dental industry, offering a wide variety of products to suit your restorative needs.

As one of the pioneers of fiber post and nano-hybrid composite technologies, Pentron Clinical has successfully demonstrated its commitment to the technological advancement of dentistry.

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