Informatics and IT in dentistry: a look forward

By John O’Keefe, B. Dent. Sc., M. Dent. Sc., MBA

In this edition, we conclude the interview Dr. John O’Keefe, editor of the Journal of the Canadian Dental Association, conducted with Dr. Titus Schleyer, associate professor and director of the Center for Dental Informatics, University of Pittsburgh.

This part takes a look at the impact of information technology (IT) on dental education, including continuing education, the future of the practice of dentistry and opportunities for organized dentistry.

Is training in IT by dental schools increasing?

Well, I hear about courses in computing for dental students once in a while from places where I haven’t heard it before, so the answer is “anecdotally, yes.” I think people probably are paying more attention to that now.

Even at the University of Pittsburgh we do have a course on computing in dentistry, but I cannot say that I am 100 percent comfortable asserting that our graduates are completely capable of managing an IT infrastructure, either by themselves or with the help of others.

The IACA Conference heads to San Francisco

The city of San Francisco hosts the IACA Conference from July 30 to Aug. 1. You can register for all lectures and workshops online at www.TheIACA.com. *IACA Conference, pages 10A & 11A

Dentist says xylitol prevents caries

By Fred Michmershuizen, Online Editor

Aside from regular brushing, flossing and dental check-ups, a good way to prevent caries is to chew gum sweetened with xylitol, a Florida dentist says.

“It may seem counterintuitive to parents, but using chewing gum with xylitol can actually help to promote healthier teeth,” says Delray Beach, Fla.-based dentist Dr. Craig Spodak.

Xylitol is a naturally occurring organic compound. It is roughly as sweet as sucrose with only two-thirds the calories.

“Of course, consumers need to remember that the best way to prevent cavities and gum disease is to visit the dentist every six to 12 months and to undergo a yearly periodontal screening after the age of 40.”

In studies, xylitol appears to inhibit bacterial growth, including Streptococcus mutans — the main bacteria implicated in dental decay.
help of consultants. The problem is that there is not enough time in the curriculum and the extra training one must go into enough depth to graduate dentists who are very comfortable at managing IT. And, of course, there is the problem of attitudes.

The other day my IT manager told me about a dental student who wasn’t able to copy a file onto a USB drive. When she suggested that he should be able to do this, he said: “I’m here to become a dentist, not an IT person.” Well, this guy is in for a surprise later on.

I think one of the big barriers to productive IT use in dentistry is the fact that a lot of people struggle and learn only by trial and error. That pain could be reduced and we could be a lot more efficient and waste less money, time and effort with better educational approaches to this and with a better consulting infrastructure.

Let’s face it, some dentists hire consultants with relatively little understanding of what they can do, and then it turns out that the consultant really doesn’t know very much. It is a little bit like having your kitchen renovated: Once you get to the end of the job, then you discover that the contractor really was, but you typically do not know that up front.

Do you see information technology and communication technologies playing a bigger role in the next five to 10 years in the area of continuing education? The industry, and also academia to some degree, have invested significant resources in online learning and distance education. It’s not as if this is a particularly new subject. We’ve had distance education way before the Internet started. So we’re simply talking about a new technology that’s not going to go away. I think partially remote learning and distance education can help dentists stay more in touch. Think about the rural dentist who doesn’t have that much access to local courses versus the dentist in a big city who does. So the rural dentist just doesn’t have the options that other people have and, in that case, it might be very helpful to take a course over the Internet.

Clearly, one challenge is when courses are offered by corporate interests. For instance, let’s take implant companies. We really have to look very closely at the validity and correctness of the material that’s presented.

What I mean is that there is an inherent bias there that sometimes shines through very clearly, and sometimes information doesn’t get presented that would put the product in a little bit more balanced light.

On the other hand, with universities and other providers who follow ethical guidelines closely or who take the mandate of providing balanced information seriously, that fear is not there as much. But clearly I think that’s an issue.

Another issue is the quality of the instructional material and the presentation. As you know, we’ve done some research in that area in the past, and many years ago the quality just wasn’t very good.

Partially as a reaction to that, the ADA’s Standards Committee for Dental Informatics has come out with guidelines for the design of educational software that we helped develop. So hopefully the quality of what’s out there has improved, but I don’t really have any data to support that hope.

Beyond the IT sector, what are the most important developments that may have an impact on the future of the practice of dentistry in North America?

The one I would point to is better accountability for how we spend our health care dollars in general, and dental care dollars in particular.

We have this movement in the United States toward a much more accountable way of providing services.

Children on Medicaid receive less care for cleft lip and palate

Children with cleft lip and/or palate experience significant differences in obtaining dental care depending on the type of insurance coverage they have. Those with Medicaid are more often refused care, have fewer checkups and report less satisfaction with their dental care, according to a report in the May 2009 issue of the Cleft Palate–Craniofacial Journal, the official publication of the American Cleft Palate–Craniofacial Association.

Parents and caregivers of 171 children ages 7 to 12 with cleft lip and/or palate were interviewed for a study. Although 85 percent of the children received regular dental care, those who did not were predominantly covered by public insurance rather than private insurance.
health care and measuring outcomes, probably leading in many aspects when you compare it to the rest of the world. In dentistry we haven’t had much of this, but I think it’ll come.

In America, dentistry is about 5 percent of total health care costs. So not many people have paid attention to how this money is being spent when there are a lot of bigger pieces to look at. But I think measuring what goes in and what comes out is definitely in the future of dentistry, too.

The ADA is working, once again, on developing diagnostic codes. What we need to do as a profession is to relate diagnoses to treatment and treatment outcomes, and we have not really done that in an explicit way.

Yes, I am sure it happens in some dental offices. Dentists who are into detailed record keeping write lists of problems, then they write what they did, and obviously from the record you can tell whether the patient improved or not.

On the other hand, I have also seen dentists simply dictate treatment plans. In that case, there’s no evidence from the record whatsoever what was wrong with the patient in the first place.

So that approach doesn’t lend itself very well to the “pay for performance” approaches that are emerging in American health care, and eventually, dentists have to face up to that reality.

Do you see diagnostic codes being a reality within the next 10 years in the United States? I would hope so. The American Dental Association clearly has gotten the message that diagnostic codes should be developed, and I think the Department of Health and Human Services probably didn’t hide the fact that if dentistry doesn’t come up with them, then they’ll come from somewhere else.

I think that’s something that the ADA and other stakeholders in the dental profession would not like to see.

On the other hand, the ADA is now in its second attempt to develop SNODENT (a set of diagnostic codes for dentistry), and it appears to be a large, cumbersome and difficult process.

I probably would have picked a different strategy. A limited set of codes, on the order of a few hundred, can probably describe 70 to 80 percent of the conditions that general dentists encounter on a day-to-day basis. I would have started with that and built out from there.

Are there any opportunities that you see for the leadership of organized dentistry to advance our profession? I think we can become better dentists collectively in many ways, but I think one of the things we haven’t really exploited that much in this context are electronic data. Right now we spend a lot of our time duplicating on the computer what we had on paper.

For instance, the electronic patient records as we know them right now, most of them actually do look like somewhat poor imitations of the paper records we have. And, that’s not really what computerized records or what informatics should be about.

We have great opportunities to use digital data in much better ways, which is why it’s so much fun to do dental informatics research all day long. What we need to do is we need to invent those ways.

We need to imagine what we can do, not just be constrained by the knowledge of what we have done.

For instance, one project we’re working on is a three-dimensional model of the patient as the centerpiece of a general dental record.

In my mind, it is perfectly possible to create the virtual patient on the computer, and we’re working on it.

This is not such a huge technical challenge. The challenge is to imagine what you can do with this model, how the information should be presented in the context of this model, how the dentist should interact with it, and what value-added functions this system provides to the dentist.

I’m a firm believer in creating things that help improve patient care and that help dentists do their work more effectively and efficiently.

Thus, I think leveraging information technology is probably one of the biggest opportunities in dentistry.

I know that sounds like a hammer looking for a nail because I am in dental informatics, so it’s logical that I would pick this, but I think it has some credibility.
‘To elevate dentistry around the world ...’

An interview with Dr. Sam Kherani, president of the International Association of Comprehensive Aesthetics

By Robin Goodman, Group Editor

For those readers not familiar with the IACA, can you please tell us about the organization?

The IACA is a leading organization in dentistry that brings together like-minded professionals who wish to promote a comprehensive understanding of esthetics that is grounded in science and predictable longevity.

The IACA prides itself in being the most inclusive and innovative organization of its kind in the world. The mission statement of the IACA says it all, “To elevate dentistry around the world through an exchange of doctors’ experiences and knowledge for the betterment of humanity. To remain a dynamic dental organization that serves as a catalyst for the fusion of contributions from all disciplines that serve mankind in attaining health and beauty.”

The IACA is a place where you’ll find a group of uplifting and passionate dentists who love what they are doing. We realize that we can all learn from each other, and this is the basic foundation of the IACA.

What is the main focus of the IACA?

The main focus of the IACA is to create an association of professionals that see value in such an association, and whose primary objective is to move the profession forward and be relevant to the public that it serves.

The IACA does this primarily by sourcing out speakers espousing various philosophies, ideas, techniques and research that can be shared with all, which would then lead to the constant positive evolution of the profession for the benefit of the final recipients, the patients.

The IACA works hard to be a truly inclusive organization for posterity. The IACA was established to not just provide a venue for a dentist to attend and receive advanced dental education. We wanted to provide an enjoyable experience for the dentist, family and his/her team.

I understand that the IACA has an annual conference. Can you tell readers about that?

The annual IACA conference allows members to get together and share information with each other, assimilate information from the highly valued speakers who present each year, and attend workshops that endeavor to teach new techniques and technologies.

It also fosters social interaction which, as we know, is the purveyor of knowledge. As the saying goes, “you learn more outside of the classroom.” This year’s IACA conference is being held at the Westin St. Francis in San Francisco from July 30 through Aug. 1. Complete information, including speakers and lecture titles, can be found on the IACA Web site at www.TheIACA.com.

In addition to the conference, what other perks do members receive?

IACA members enjoy Webinars presented by leaders in the industry, camaraderie with like-minded individuals, information that is free of any bias from the organizers, significant value for the investment in time and resources, leading edge discussions and forums and much more.

The IACA was established and developed to be dynamic, and an entity that easily changes and evolves as it grows. The IACA was created to be a forum for all dental philosophies to be heard and discussed, and our members appreciate that.

Who can join the IACA?

Any individual who makes a contribution to the comprehensive esthetics of the human population can join the IACA. This includes dentists, physicians, dental hygienists, dental assistants, dental technicians, chiropractors, physiotherapists, etc.

www.dental-tribune.com

Missed the last edition of Dental Tribune? You can now read some of its content online!

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Shamshudin (Sam) Kherani, DDS, FAGD, LVIW, is a graduate of the University of Western Ontario and has been in general practice since 1981 with a special interest in adhesive dentistry. Prior to joining LVI full-time as a clinical director, he served as a clinical instructor at the institute as well as a regional director. He currently serves as the president of the International Association of Comprehensive Aesthetics (IACA). Kherani can be reached at (888) 584-5257 or by e-mail at s.kherani@theiaca.com.
Teams are becoming increasingly important in today’s organizations. Whether they are striving to improve quality, increase efficiency or focus on customer satisfaction, people support what they are involved in.

The focus on employee participation requires a more facilitative, empowering and less directive controlling leadership style. Facilitative leaders learn to use the abilities of their groups to solve problems and make decisions.

What is a team?

I recently read a great definition of a team: A group of people with a high degree of interdependence geared toward the achievement of a goal or the completion of a task.

In other words, members of a team agree on a goal and agree that the only way to achieve the goal is to work together. Some groups have a common goal but do not work together to achieve it.

For example, many teams are really groups because they can work independently to achieve the goal. Some groups work together but do not have a common goal.

What do team members want?

Team members are seeking empowerment. They want to get involved in the way decisions are being made in the workplace. People have rediscovered the advantages of learning through the sharing of experiences and insights. This trend has created a demand for new forms of leadership.

New team techniques are required to involve these team members. Could one of those techniques include team games and activities?

‘Team play’

Let’s look at the definition of an instructional game or activity: A structured process that involves participants interacting with one another to share their experiences and insights.

There are two key elements: experience and interaction. Participants take an active role in jointly experiencing an event, reflecting on it and sharing what they learned from it.

Because teamwork involves participants interacting with one another, it makes sense that they should also learn in situations presented by games and activities.

Science research indicates that people learn more effectively and apply their newly learned knowledge and skills more effectively through games and activities. Research on such diverse areas as stress, anxiety and creativity reinforce the generalization that we need to play more in...
order to improve our learning.

Recent studies on the nature of intelligence have eliminated traditional IQ measures as the sole indicator of effective performance. Newer frameworks of intelligence emphasize that there are several avenues to learning other than the conventional use of language and logic.

Games and activities tap into alternative intelligences. Events that are accompanied by emotions result in long-lasting learning. Games and activities that include appropriate levels of cooperation within teams and competition across teams add emotional elements to learning.

Sample activities

Feedback from these activities can also provide opportunities for practicing interpersonal skills.

Two Truths & A Lie

One of the activities I like when conducting in-office consulting is called Two Truths & A Lie. I use this when working with a team that has been together for a number of years. Each team member will tell two truths and a lie about themselves. The other team members will guess which one is the lie. Because they are trying to stump their teammates, a team member will typically reveal something about themselves that the other team members did not know.

During the activity, keep focused on the goal to prevent the activity from becoming an end in itself. After the activity, there must always be a debriefing discussion. Ask participants to share their insights with one another. Ask them to report on what they learned from the activity, and to develop action plans based on the newly learned principles.

One of the most insightful statements I heard during a debriefing after this activity was the fact that “we may not know our long-term patients as well as we think we do.”

Could there be an emotional “hot button” that we are not finding out about those patients?

Slogans

Another favorite is an activity called Slogans. This activity will give team members an opportunity to reflect on the image of the team. All you do is provide a list of the following slogans to your team and have them identify the companies to which they belong:

1) The Real Thing
2) Drivers Wanted
3) Think Different
4) Find your own road
5) In touch with tomorrow
6) It’s all within your reach
7) Where do you want to go today?

Have them choose the slogan that best represents your team and discuss why.

[And here are the company names: 1) Coca Cola, 2) Volkswagen, 3) Apple, 4) Saab, 5) Toshiba, 6) AT&T, 7) Microsoft.]

Endless possibilities

These are just a couple of activities to get you started. There are, after all, “Endless possibilities!”

The important thing is to remain flexible. Although games and activities have rules, don’t become obsessed with them.

An important requirement for effective teamwork is to maintain your sense of humor and to take serious things playfully. So lighten up and have some fun!

Sherry Blair at the IACA Conference

Thursday, July 50
1:50–3:50 p.m.

Do You Need A Title to Lead?

Many different definitions of leadership have been interpreted by how many different people?

“Bass’ (1989, 1990) theory of leadership states that there are three basic ways to explain how people become leaders. The first two explain the leadership development for a small number of people. These theories are:

1) Some personality traits may lead people naturally into leadership roles. This is the Trait Theory.
2) A crisis or important event may cause a person to rise to the occasion, which brings out extraordinary leadership qualities in an ordinary person. This is the Great Events Theory.
3) People can choose to become leaders. People can learn leadership skills. This is the Transformational Leadership Theory. It is the most widely accepted theory today and the premise on which this presentation is based.
• To empower people to take control of their lives in order to make a positive difference.
• Identify leadership traits and how to apply them.
• Develop principles and skills to influence others.

For more information about the IACA Conference, see pages 104 & 114.
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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 didn’t occur.

The following reveal the next five most common reasons many associateships fail to result in ownership or partnership.

Reason No. 6: access to patient base

Insufficient access to the patient base by the associate can take different forms. Perhaps the senior dentist never intended to turn over existing patients, but rather to give the associate new patients or patients obtained only by the associate’s own efforts. Under such circumstances, the productive capability of the associate would be greatly compromised.

If the intended result is a partnership between the dentists, one of the most important things that the associate is buying is “equal access” to the existing and new patient base.

The patient base comprises the goodwill value of the practice and typically constitutes 70 to 80 percent of the value of a practice.

If the senior dentist fails to recognize the need to turn over existing patients to the associate, then the associate will be frustrated by his/her efforts to provide dentistry, earn his/her salary and improve skills.

It is usual for the senior dentist to be concerned about turning over existing patients; however, this must occur if the relationship is to blossom into ownership.

Reason No. 7: letting go

This problem is related to the senior dentist’s unwillingness or inability to “let go” and turn treatment responsibility over to the new dentist. In the case of a senior dentist who is close to retirement, this may be a very emotional decision. When the senior dentist has identified retirement pursuits, there will be a greater ability to turn over practice responsibilities to another dentist.

The new dentist who is considering an associateship should investigate the senior dentist’s outside interests and activities in support of an easier transition. Good signs indicate that the senior dentist will have no problem “letting go.”

Conversely, the senior dentist who is proud of the number of hours “lived” at the office or who has no other interests in life, should raise serious concern on the part of the new dentist as to whether or not this dentist is willing to let go.

Reason No. 8: philosophically speaking

Different business and/or practice philosophies may result in incompatibilities that may retard successful completion of the practice sale. This particular problem deals with integrity issues as well. It is important for the new dentist to ascertain the attitudes and philosophies demonstrated by the senior dentist.

A senior dentist who is willing to share his/her practice numbers, profit and loss statements and tax returns with the new dentist generally indicates a dentist who is open and honest. A dentist who is unwilling to share numbers and personal financial information will probably not change.

One important question to ask a dentist who has been in practice for more than 20 years is the status of that dentist’s retirement plans. If the senior dentist is having financial stresses after 20 years of practice, the partnership will probably not occur.

A dentist who has a well-funded pension/profit-sharing plan and a portfolio of personal financial accomplishments, provides a strong indicator that the practice will be strong enough to launch the new dentist into a similar state.

Reason No. 9: a good match

Unfortunately, personality conflicts are a frequent reason for associateships failing to lead to buy-ins/buy-outs. If two dentists have conflicting personalities, there may be stress and friction within the practice, which will spill over onto the staff and patients.

Common-sense rules can easily determine whether a potential for conflict exists. The assessment for personality conflicts will be ongoing during the initial interview process.

If there are significant concerns about compatibility for dentists who will be in a partnership arrangement spanning from three to five years, the warning signs should be carefully evaluated at the outset.

If a long-term relationship is intended, it may be prudent to seek professional personality assessments.

Reason No. 10: good advice

The final reason has, in fact, nothing to do with the dentists or the practice. Instead, individual attorneys have proceeded to cause problems in the relationship.

It is extremely important that both dentists realize the boundaries that must be set relative to their attorneys’ involvement in finalizing the buy-in/buy-out arrangements. Attorneys should be your advisors, not your decision-makers.

The negotiations relative to the proposed buy-in/buy-out were conducted at the onset of your relationship as detailed in the Letter of Intent.

Attorneys are not hired to “renegotiate” the transaction. Attorneys’ personalities and styles should not spill over into the dentists’ relationship.

Problems occurring while producing the Employment Agreement and the Letter of Intent may be an indication of significant problems that can be anticipated at the conclusion of the employment period and during the preparation of Partnership Agreements.

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. However, by identifying the potential pitfalls at the beginning of the relationship, chances of success can be greatly improved.

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 transition consulting on a full-time basis. He has lectured extensively to both state dental associations and numerous dental partnerships. Heller is the national director of Transition Services for Henry Schein Professional Practice Transitions. For further information, please call (800) 750-8885 or send an e-mail to hsfs@henryschein.com
IACA schedule at a glance

Grab a highlighter and mark the lectures you want to attend

Join like-minded professionals at the Westin St. Francis in San Francisco from July 50 to Aug. 1 for the 5th annual IACA Conference.

The conference’s daily program is designed to present a comprehensive understanding of esthetics that is grounded in science and predictable longevity.

And with a host city like San Francisco, you’ll not want for any food or fun activities once the learning is done at 6 p.m. every day.

Check out the schedule on these two pages!

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**Thursday, July 50**

**Sponsor:** MicroDental/DTI

8:15 a.m. Opening

8:30–10 a.m.
- Higher, Swifter, Stronger, Neal Jeffrey
- Dental Service Excellence
- John & Jimmy Garcia

10–10:30 a.m. Break

10:30 a.m.–noon
- Bynum “Unplugged.” It’s Your Life: The World Is Watching YOU!, Dr. Matt Bynum
- Controlling New Patient Exam Dynamics, Dr. Steve and Joey Burch
- Common TMJ and Jaw Problems That Can Affect Outcomes in Comprehensive Aesthetic Dentistry, Dr. Larry Woford
- The Scientific and Clinical Basis of Neuromuscular Dentistry, Dr. Bob Jankelson
- Workshops: Las Vegas Esthetics; HOYA ConBio

Noon–1:30 p.m. Lunch

1:30–3 p.m.
- Do You Need a Title to Lead?, Sherry Blair
- We Are All Connected, Dr. Doug Chase Dr. Ronald Jack-
- son, Ms. Sally McKenzie
- Risk Management Plus Expert Witness Basics, Dr. David Miller
- Workshops: Aurum Ceramic Dental Lab; Ivoclar

3–3:30 p.m. Break

3:30–5 p.m.
- The Power of “UN,” Dr. Fred Calavassy
- Implants for Dummies; Everything You Need To Know But Were Afraid To Ask!, Dr. Leo Malin
- What About the Maxilla? The Cranial, Skeletal and Dental Position of the Maxilla and Its Relationship to Occlusion, Function and Smile Design, Drs. Bob Walker/Kaye McAr-
- thur
- Science-Based Adhesive Excellence for Indirect Resto-
- rations, Dr. Byoung Sub
- Workshop: MicroDental/DTI

5–6 p.m. Reception
Friday, July 31

**Sponsor:** Williams Dental Laboratory

8:15 a.m. Opening

8:30–10 a.m.
- Economic Stimulus Panel, Drs. Bob Beebe, Brad Durham, Prabu Raman, Ron Willis and Bill Dickerson moderating
- If Your Practice Isn’t What You Want It to Be, It’s Your Own Darn Fault!, Ashley Johnson

10–10:30 a.m. Break

10:30 a.m.–noon
- Unconventional wisdom or conventions stupidity?, Drs. Michael Sernik/Brett Taylor
- Integrating Sleep-disordered Breathing, Dr. Kent Smith
- Transitioning Your Practice, Dr. Tom Snyder
- Workshops: Williams Dental Lab, Myotronics

**Noon–1:30 p.m. Lunch**

1:30–3 p.m.
- Effects — Diagnosis and Treatment for Upper Airway Obstruction in Pediatric Orthodontic Patients, Dr. Jay Gerber
- Giving Your Patients Something to Smile About: Direct Resin Artistry, Dr. Ronald Jackson
- If You Are Going To Do It, Do It Different: Results and Case Presentation, Dr. Art Mowery
- Supporting Your Partner or Doctor Through His or Her LVI Journey, Susan Duncan/Farzana Kherani
- Workshops: BISCO

1:30–3 p.m. Break

3:30–5 p.m.
- Minimal Preparation for Porcelain Veneers, Dr. Ross Nash
- Physical Referrals and the Medical-Dental Connection, Dr. Lee Osler
- Working Smarter: Managing Your Practice & Future for Financial Gains, Dr. David Keator
- LVI Global’s 2009 National Marketing Effectiveness Survey, Mr. Bob Weiss
- Workshops: Imaging Systems

3–6 p.m. Reception

Saturday, Aug. 1

**Sponsor:** Arum Ceramic Dental Laboratories

8:15 a.m. Opening

8:30–10 a.m.
- The Intersection Between Neuromuscular Dentistry and Physiology, Dr. Norman Thomas
- Team Panel: Image — Is It Everything?, Sherry Blair, Ginny Hegarty, Judy Kay Mausolf, Sally McKenzie, and Heidi Dickerson moderating

10–10:30 a.m. Break

10:30 a.m.–noon
- Increase Your Production in A Down Economy, Dr. Dick Barnes
- Materials Update, Dr. Mark Duncan
- The Power of Team, Dr. Lori Kemmet
- Connecting You to Your Potential: Image Is Everything, Judy Kay Mausolf

**Noon–1:30 p.m. Lunch**

1:30–3 p.m.
- The Transformation of Endodontics in the 21st Century, Dr. Stephen Cohen
- 5 M’s of A Successful Practice, Sally Mckenzie
- Introduction to Scan Interpretation, Bill Wade
- The Smartest Investment You’ll Ever Make, Dan Solin
- Workshop: Cadent iTero

3–3:30 p.m. Break

1:30–5 p.m.
- Periodontal Disease and the Systemic Link, Dr. Dee Nishimine
- What Does Your EQ Say About You?, Ginny Hegarty
- Epigenetic Orthodontics: Restoration of Craniofacial Health and Esthetics, Dr. Dave Singh

3–6 p.m. Reception
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Until now, dental professionals had only two options for treating caries: fluoride and other remineralization therapies if caries was not too advanced, or the “wait and see” until it was time to use the “drill and fill” approach.

Caries infiltration is a major breakthrough in micro-invasive technology that fills, reinforces and stabilizes demineralized enamel without drilling or sacrificing healthy tooth structure.

“Icon represents a new category of dental products,” says Tim Haberstumpf, DMG America director of marketing. “It is the first product to bridge the gap between prevention, fluoride therapy and caries restorative.”

“Icon’s micro-invasive infiltration technology can be used to treat smooth surface and proximal carious lesions up to the first third of dentin (I-I). In just one patient visit, Icon can arrest the progression of early enamel lesions and remove white spot lesions.”

When a dentist discovers incipient caries that is beyond preventive therapies though too early for restorative treatment, Icon offers a simple alternative to the “wait and see” approach.

With Icon, the dentist can offer immediate treatment without unnecessary loss of healthy tooth structure. Icon prevents lesion progression and increases life expectancy for the tooth.

Icon also provides a highly esthetic alternative to micro-Abrasion and other restorative treatments for cariogenic white spot lesions. White spot lesions infiltrated by Icon take on the appearance of the surrounding healthy enamel.

“Icon infiltration system is simple and user friendly,” Haberstumpf says. “Total treatment time is about 15 minutes, so it saves patients time and frees up additional chair time.”

After isolating the tooth with a rubber dam and placing wedges to separate the teeth, the tooth surface is prepared with a 15 percent HCl gel to open the pore system of the lesion body. Next, the surface is rinsed, dried with ethanol and air-dried with air.

The Icon Infiltrant resin, which has a high penetration coefficient, is applied onto the lesion, excess material is removed and the material is light cured.

The manufacturer recommends applying a second layer of the infiltrant, followed by additional light curing.

For complete information, detailed product descriptions, treatment steps, a training video and an overview of the 12 international studies currently being conducted with Icon, visit the Drilling No Thanks! Web site at www.drillingnotthanks.com.

Icon will be available in the United States in September in Proximal and Smooth Surface kits.

The Icon kits provide everything necessary for treatment except the rubber dam, including: specially designed dental wedges; patented perforated applicator tips for the materials; individual syringes filled with Icon-etch, Icon-Dry (ethanol), Icon-Infiltrant; and both written and diagrammatic instructions.

All syringes come in a special screw-type applicator to ensure the materials are gently and slowly extruded onto the tooth.

Icon Proximal is available in a mini-kit with two treatment units, or a package of seven units. Each proximal treatment unit contains enough material for two proximal lesions.

The Icon Smooth Surface mini-kit includes two treatment units and is also available in packages of seven units, enough material for two or three smooth surface lesions per unit.

DMG America manufacturers and distributes quality restorative materials and prevention products. For more information, call (800) 662-6383 or visit www.dmgaamerica.com.

Fight 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. Second, as dental patients become more familiar with their oral cavity, it will stimulate them to receive treatment much faster.

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.
Save lives, save your business

In good times and in bad, your office needs an emergency drug kit. Here are five reasons.

By Jeff Sheets

“An unforeseen combination of circumstances or the resulting state that calls for immediate action.” That’s how Merriam-Webster defines the word emergency — a word Americans are all too familiar with these days, thanks to the global economic downturn.

As damaging as it was “unforeseen,” that downturn has hurt businesses and consumers in virtually every sector of the United State economy, and therefore demands “immediate action,” just like the dictionary says it does.

Dentists and their patients are no exception to the rule. Like their peers in manufacturing, retail and travel, their businesses have been bruised by the recession.

And although recovery is inevitable, in dentistry and elsewhere, things are certain to get worse before they get better.

To cushion the blow when they do, dentists must mitigate their risks and minimize their risk exposure.

Among the largest risks facing dental practices are dental office emergencies, of which surveys have shown that there are more than 50,000 every year in the United States. Risk mitigation therefore starts with emergency planning and response.

Because while the world’s economic emerg-
PhotoMed/Canon Rebel T1i digital dental camera

Canon has recently released the latest in the popular Rebel series of digital cameras: the Rebel T1i. The T1i is a 15 megapixel camera and the first consumer level camera to offer HD quality (1080p) video capture.

Canon states in their user guide that you need a “class 6” SD memory card to capture 1080p HD video clips. You can also capture video at two lower resolutions: 1280 x 720 @ 30 fps, 640 x 480 @ 50 fps. (Call PhotoMed if you need help understanding the different modes.)

Like the Rebel XSi before it, the T1i features Live View, which allows you to use the camera’s LCD screen as a viewfinder (in manual focus mode).

Canon has also increased the resolution of the camera’s LCD screen from 230,000 pixels (Rebel XSi) to 920,000. This results in the ability to see incredible detail and clarity on the camera’s built-in screen. PhotoMed offers the Canon Rebel XS as a complete clinical camera system with a choice of Canon or Sigma macro lenses and macro flashes. Complete package contents and pricing can be found at www.photomed.net or call (800) 988-7765.

1) Protect your bottom line.
Although it can help you minimize the financial burden of an emergency, insurance is no match for prevention, planning and response, which can help you safeguard the investments you’ve made in your business.

2) Provide legal protection.
In the event of an emergency, having the right emergency response equipment may save your business from costly litigation.

3) Give you a competitive advantage.
Having equipment that other offices lack gives you a leg up on your competition, which can help you attract new patients and retain existing ones.

4) Promote professional development.
Emergency planning requires education, and professional development has been shown to increase employee engagement, loyalty and productivity.

5) Empower patients.
Because many patients are afraid of going to the dentist, just having an emergency drug kit can help you calm their nerves; and because happy patients talk, it can also help you stimulate referrals.

Jeff Sheets is a spokesperson for Savalife.com, a Fort Wayne, Ind.-based company that manufactures emergency drug kits and supplies emergency planning training materials for dental offices nationwide. He can be reached at jsheets@savalife.com.
Oral Healthcare Can’t Wait

Not all of your patients speak up about their dental and oral health issues. You can. Continue reminding them that their oral healthcare can’t wait and keep them coming to your practice. Download FREE marketing materials to raise awareness and keep business going strong.

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