**Midwestern Society of Orthodontists: Top 10 2013 annual session highlights**

**New leaders installed, budget and bylaws approved, top clinicians honored**

The Midwestern Society of Orthodontists (MSO) returned to MSO territory in Kansas City, Mo., for the 2013 MSO Annual Session from Sept. 20–22. More than 410 attended the meeting, featuring a doctor and staff continuing education program presented by Drs. Mark Berkman, Aaron Mellen, Chung Kau, Sebastian Baumgaertel and Abraham Lifshitz, and Amy Eirsch, Cathy Sundwall and Mary Kay Miller.

The following new leaders were installed to serve the MSO membership in 2013-2014: Drs. John Crawford of Kenosha, Wis., as president; Deb Lien of Rochester, Minn., as president-elect; and Ara Goshgarian of Lake Forest, Ill., as secretary-treasurer. Dr. Ross Crist of Sioux Falls, S.D., successfully completed his term as the 2012-2013 president and will continue to serve on the MSO board as immediate past president. Dr. Brent Larson of Minneapolis continues to serve as the MSO Trustee to the American Association of Orthodontists Board of Trustees.

Dr. Jane Bentz of Wisconsin was recognized at the MSO Annual Business Meeting on Sept. 21 for her service as MSO component director as she retires. Dr. Scott Arbit of Wisconsin and Dr. D. Spencer Pope of Illinois were welcomed to service at the conclusion of the meeting as new incoming component directors. Dr. Brian Jesperson of North Dakota was recognized for his full eight-year term of service as the MSO representative to the Council on Orthodontic Practice.

These MSO Delegation members were elected to represent the MSO at the AAO 2014 House of Delegates: Drs. Ara Goshgarian — chairperson, Mike Durbin — vice chairperson, Ross Crist, Deb Lien, Ginny Mennemeyer, Dennis Sommers and Kim Stafford; alternates Steve Marshall, John Kanyusik and Ryan VanLaecken.

* See MSO, page 8

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**NESCO and MASO join up for Puerto Rico meeting**

By Sierra Rendon, Managing Editor

The Northeastern Society of Orthodontists (NESO) and Middle Atlantic Society of Orthodontists (MASO) will host a joint meeting from Nov. 14–17 in Rio Grande, Puerto Rico.

Event planners say attendees will benefit from the clinical presentations by Drs. Silvia Allegrini, Lyse Johnston, Brent Larson, Jim Vaden, Rolf Behrente, Lisa Alvetro, Jay Bowman and Gerald Samson as well as Andrea Cook and Rosemary Bray.

Some topic sessions include “How to Treat Class IIs – Both Dental Class IIs and Skeletal Class IIs,” “Band Aid – When, Where and Why Teeth Should be Banded Rather than Bonded,” “Everything You Need to Know About Taking Perfect Impressions,” “How to Communicate More Effectively,” “What I Can Do to Run a More Efficient Office” and much more.

To make your reservations online, go to https://resweb.passkey.com/go/NESOMASO2013. You may also call the Wyndham Rio Mar Beach Resort toll-free at (800) 474-6627.

For more general program information, visit www.maso.org/meetings/2013AS.cfm.
The career dilemma for graduating residents: academe or private practice

By Dennis J. Tartakow, DMD, MEd, EdD, PhD, Editor in Chief

There are compelling advantages to both private practice and academics. For each graduating resident, career decisions come down to determining which environment is best suited to his or her personality with regard to orthodontics.

Choosing a path that coincides with one’s beliefs, philosophy, personality and lifestyle is omnipotent. However, the process of education itself is changing. No longer can an orthodontist teach by the way he or she learned (show, tell, do).

• See CAREER, page 6
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Tooth movement: Health science or unhealthy cosmetics?

By Rohan Wijey B Oral H (Dent. Sci.), Grad. Dip. Dent. (Griffith), O.M.

If we aspire to be considered a scientific medical profession, orthodontics must continue to evolve with the research. This means re-orientation toward a more evidence- and health-based approach.

The weight of the literature rests with the fact that muscle function and posture (the way patients swallow and posture their tongue) is the most significant cause of malocclusion.²

A time for change?
The orthodontic tradition has been evolved by great minds throughout its 100-year history, such as Angle, Frankel, Graber, Ricketts, Garfiner and Little. However, if we aspire to be considered a scientific medical profession, orthodontics must continue to evolve with the research. This means re-orientation toward a more evidence- and health-based approach.

Are we going to continue to accept relapse or retention until the death of the patient or the orthodontist? The science is there; the cause is muscle function and the solution is Myofunctional Orthodontics.

The orthodontic tradition has been considered a "fixed or removable retention for the permanent nor a cure." Orthodontics has thus proven its reliance on these interventions.

Despite this, traditional orthodontics may cause root resorption or enamel damage, exacerbate periodontal disease, increase the chance of caries and devitalize teeth. After this begins the need for long maintenance of permanent retainers, the burden of which is borne by both the patient and the dental practitioner.

Despite our status as medical professionals, has the orthodontic profession veered away from being a health science and moved toward the realm of cosmetics?

Premolar extractions

There is no better example than the prevalence of premolar extractions in private practice. Epidemiological data is sparse, but according to the most contemporary survey conducted of U.S. private practices, 25-85 percent of our children have healthy teeth extracted in the name of orthodontics.¹

The justification and rationale behind premolar extractions today rests with P.B. Begg’s 1954 assertion that the low incidence of malocclusion in primitive dentitions was due to gritty diets causing interproximal attrition. Begg suggested that this amounted to a premolar’s width in each quadrant.⁴ Begg’s research has been roundly refuted in the literature, not least because his own theory refutes his results: both crowding and attrition increased with age.

Do premolar extractions lead to more stability?

No. Little’s definitive 1981 study showed that mandibular anterior alignment in less than 30 percent of extraction cases 10 years post-retention, and in less than 10 percent of cases 20 years post-retention.⁷ Many other studies have corroborated this conclusion.

Although hygienists, dentists and all other specialists strive to preserve teeth, this principle seems outside the orthodontic profession’s orbit of thinking.

What causes malocclusion?

"Whenever there is a struggle between muscle and bone, you have a problem," wrote Graber in his seminal 1963 manifesto on orthodontics.² This means re-orientation toward a more evidence- and health-based approach.

The literature now accepts that the only solution is Myofunctional Orthodontics.²⁻⁶ The scientific medical profession, orthodontics must continue to evolve with the research. This means re-orientation toward a more evidence- and health-based approach.

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References


About the author

DR. ROHAN WIJEY works and lives in Australia on the Gold Coast. He practices at MBC’s clinical arm, MBC Clinics, and teaches dentists and orthodontists from around the world about early intervention and myo-functional orthodontic appliances.

Obituary: Orthodontist Dr. Earl ‘Buddy’ Broker

Dr. Earl “Buddy” Broker passed away on Aug. 15, 2013, following a brief illness. Broker was a founding faculty member of the orthodontic residency program at Einstein Medical Center Philadelphia. He continued in this capacity until his death.

In addition to teaching comprehensive orthodontics to postgraduate students, he also directed their education in temporomandibular disorders. Of note, he taught all graduates of the program including current residents in training.

Broker was born and raised in Philadelphia and graduated from West Philadelphia High School. Both his pre-dental and dental education occurred at Temple University, where he graduated with a DDS degree in 1961.

He then entered the orthodontic practice of Drs. Maxwell S. Fogel and Jack M. Magill as an orthodontic preceptee, completing his training in 1965. Pre-dating the official start of the orthodontic residency program, he joined the orthodontic staff at Einstein as an orthodontic fellow receiving a fellowship certificate, also in 1965.

He became a diplomate of the American Board of Orthodontics in 1995. He also served as a reserve dental officer in the U.S. Army Dental Corp from 1961 until 1968, receiving an honorable discharge as a captain.

Broker was a tireless supporter of Drs. Maxwell S. Fogel and Jack M. Magill in preparing for the start of the Einstein Medical Center Orthodontic Residency Program in the early 1960s. He assisted them in organizing program teaching materials and completion of accreditation application information.

For many years, Broker practiced both in Jenkintown, Pa., and Voorhees, N.J. More recently, he limited his practice activity to the Voorhees office.

In addition to caring for the orthodontic needs of his patients, his knowledge and expertise in treating temporomandibular disorders was highly regarded by patients who traveled great distances to seek his care.

Broker is survived by his wife, Joyce, sons Brian and Bradley and families, brother Gerald and sister Donna.
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We are moving toward an age where new academic skills, such as learning the methods of teaching and the process of course designing, have become new goals and standards of education. Yet as educational programs continue to be improved, old problems still linger in academics and have a direct bearing on who will direct our future and become our successors.

A new era of orthodontic education is dawning, and just how it will go is a co-nundrum — anyone’s guess. There are new creative programs in orthodontic education that address the reduction of “qualified” orthodontic faculty members. Historically, at least since the 1990s, issues regarding recruitment and retention of qualified orthodontic faculty members have been, and still are, important and challenging topics at many orthodontic conferences, as noted by Roberts in 1997. When an environment for both academic and research can become a reasonable career choice for graduating residents, the future of orthodontics will be positive (Bednar, 2007; Turpin, 2007; Peck, 2003). In past years, many residents had solid interests in teaching and research as a career choice (Larson, 1998). However, those days are gone.

Orthodontic education has been in a state of flux — academics and research have not become competitive with full-time clinical practice as career options (Peck, 2003). Specifically, the problems associated with recruitment and retention of full-time orthodontic faculty members have been, and are still, on a spiraling decline (Turpin, 2007). The preservation of pedagogy in orthodontic education, the potential social justice implications and impact on the public are directly related to (a) education of well-trained orthodontists, (b) health-care delivery, (c) outreach programs, (d) welfare-agencies, and (e) public service communication.

When applicants are interviewed for a residency position, many speak about their aspirations of joining a faculty and becoming active in research after graduation. For an applicant holding a PhD, he or she often mentions full-time teaching in addition to becoming a researcher. However, by the end of his or her educational program, goals soon became more about clinical practice and making money rather than an academic career; no longer is teaching or research a priority. Bednar (2007) stated, “In 2004-2005 there were 250 funded yet unfilled full-time faculty positions at dental schools across the country, 19 of which were vacancies in orthodontic programs.”

According to Turpin (2007), two of the most urgent problems facing orthodontics were attracting more qualified individuals for careers in orthodontic education and replenishing the attrition of full-time postgraduate faculty positions at dental schools across the country. The University of Michigan School of Dentistry. These workshops, led by recognized orthodontic teaching experts, included an interactive format with topics such as:

- Principles of course design starting with the end in mind
- Methods to encourage active learning in the classroom and clinic setting
- Methods for successfully incorporating technology into the classroom
- Another related program for faculty members was the James L. Vaden Educational Leadership Conference, held on May 3. This conference emphasized excellence in orthodontic education, concentrating on graduate program standards. These programs will hopefully change the decline of “educated” orthodontic faculty members and the increased attrition of full-time postgraduate faculty positions.

However, at the present time, alea iacta est — the die has been cast. Why would a graduating resident forego the incentives of private practice and a decent starting salary, to accept low paying academic position with little hope of advancement and a mounting financial struggle, especially when the major focus of his or her education has been to treat patients? As noted 10 years ago by Johnston (2002), sadly there is still no market for a career in academia as there was prior to the 21st century. If experience has taught us anything, it is that money talks! Most new graduates make decisions that are personal matters, i.e., supporting a family, paying back educational loans and living a decent lifestyle.

One measure of an individual is how well he or she can overcome adversity. The future of orthodontic education is also at the crossroad of adversity — the trying times associated with academic careers in education.

Until profitable career options in education become a reality, the supply of orthodontic educators and researchers will be limited. American-educated residents are blinded by future prospects of earning a living and may never regain their sight toward considering a career in academics.

Until academia becomes a profitable career option, orthodontic education may experience a diminished or daunting outlook. For the new orthodontic graduates, regardless of whether their path leads to academics or private practice, aspirations should be concentrated on practicing to the best of his or her ability.

References are available upon request from the publisher.
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MSO members approved the 2014 MSO Budget and a MSO Bylaws revision based on changes to the AAO Bylaws regarding membership dues, assessment and waivers that were approved at AAO 2013 House of Delegates. Components are encouraged to also update their bylaws accordingly.

The 2013 MSO Earl E. Shepard Distinguished Service Award was presented to Dr. Keith Levin, Winnipeg, Manitoba, at the MSO Annual Member Business Meeting. Levin is an MSO past-president and was elected speaker of the AAO House of Delegates, and he served on the AAO Board of Trustees from 2010-2012 inclusive.

The MSO Board will be reducing printed communication costs in the future by moving toward more electronic communication to members via the MSO website and member email blasts. Concise printed information will be mailed as needed in the future in lieu of a traditional twice-a-year printed newsletter. Members are encouraged to keep their email address up-to-date with the AAO as MSO will be utilizing this email address in the future for electronic communication.

The MSO voice 2014 will be held Sept. 18-20 at the Planet Hollywood Resort in Las Vegas. Planet Hollywood Resort in the heart of the Vegas Strip is the perfect host venue for this progressive focused meeting.

Opening the lecture series was this year’s “VOICE of Excellence” lecturer, Dr. Kate Vig, past department chair of The Ohio State University Orthodontic Department. She was followed by a blend of well-established and new speakers. OrthoVOICE also hosted a special feature series beyond a traditional user meeting. Each has been followed by a creative mix of company-sponsored and OrthoVOICE-invited speakers, creating a well-rounded and progressive set of topics, organizers said.

“Each year brings new ideas that cause me to think differently about growing my practice,” said one of this year’s attendees.

Mark down another great OrthoVOICE! Having hosted some of the industries top educators as part of the “VOICE of Excellence Series,” OrthoVOICE has kicked off its meeting with names like Dr. Bill Proffit, Dr. Lysle Johnston and Dr. Vig. Each has been followed by a creative mix of company-sponsored and OrthoVOICE-invited speakers, creating a well-rounded and progressive set of topics, organizers said.

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OrthoVOICE is already focusing on the 2014 rendition of the meeting. Dr. Henry Fields was recently announced as next year’s “VOICE of Excellence” speaker, and OrthoVOICE will announce the rest of its 2014 speakers and topics in early 2014.

OrthoVOICE also announced something new for next year’s meeting: two groups will be hosting seminars alongside OrthoVOICE, creating added value for OrthoVOICE attendees. Ortho Classic and Orthotown will be offering their own meetings the day before OrthoVOICE and will allow attendees greater variety beyond a traditional user meeting.

More information will be released in early 2014 about the full program. OrthoVOICE 2014 will be held Sept. 18-20 at the Planet Hollywood Resort in Las Vegas. Mark your calendar and check orthovoice.com in January for more information. Doctors and exhibitors can also call OrthoVOICE at (402) 932-1298.

Following successful 2013 OrthoVOICE meeting, group looks ahead to 2014

OrthoVOICE speakers

Dr. John Crawford, president
Dr. Deb Lien, president-elect
Dr. Ara Goshgarian, secretary/treasurer

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Healthgrades: where prospective patients go to find a new dental care provider

When consumers fire up their web browsers, the vast majority of them start at a search engine. According to research from Pew Internet, 93 percent of online activities begin with a search.1 Health is a popular topic: 72 percent of Internet users looked online for health information within the last year.2

As you may expect, Google dominates searches with a market share of about 65 percent. However, health-care-specific search portals are growing in popularity as tools for helping prospective patients find a new dental care provider in their local area. Today, the No. 1 source for new patients searching and scheduling appointments with health-care providers in the United States is Healthgrades.

Healthgrades: a popular way to search for an orthodontist

Healthgrades is a leading online resource for consumers seeking comprehensive health-care information. Each year, more than 255 million visitors use Healthgrades.com to search, evaluate and connect with health-care providers that best meet their treatment needs. Healthgrades.com visitors represent the ideal demographic for orthodontists — they are overwhelmingly female (57 percent), highly educated (84 percent have some post-secondary education) and affluent (52 percent have annual household incomes greater than $75,000). Healthgrades offers orthodontic practices a large, highly focused audience of prospective patients. Interestingly, the third most searched category on the site is for dental service providers.

During the past 12 months, Healthgrades tracked more than 20 million searches for dental care providers. Most importantly, Healthgrades users don’t just search — they schedule appointments. More than half (54 percent) of Healthgrades visitors will schedule an appointment. Among those who schedule, 95 percent make an appointment within the first week they search, and 38 percent schedule the same day.

Healthgrades visitors can be considered an ideal target audience for growth-minded dental care providers. So what should your practice do to harness this traffic and fill your schedule?

Optimize visibility and new patient conversion with a Healthgrades enhanced profile

Healthgrades offers a basic profile that practitioners can “claim” for free. It includes limited information about your practice, such as name and address. However, it also includes third-party ads and competitive practice advertisements. Most critically, it does not provide visitors with a way to schedule an appointment with your practice. Healthgrades visitors can submit a review of your practice, but they are not verified as your patients. While a basic profile is better than no profile, the ability to gain top ranking or convert visitors into patients is severely limited.

Healthgrades has established a partnership with Sesame Communications and, as of October 2013, orthodontists will be able to secure an enhanced profile, which will offer several strategic advantages over a standard profile and will give your practice better access and exposure to prospective patients seeking a new orthodontist, according to the companies. A Healthgrades Enhanced Profile from Sesame provides practices with:

• Priority placement in searches: A Healthgrades enhanced profile gives your practice higher placement and greater visibility to patients searching for an orthodontist in your area. It provides premium positioning in its “featured listing” section at the top of the page as well as organic searches. On average, a visitor to Healthgrades.com will visit 1.9 profiles during the visit, so it is imperative your practice be featured at the top of the search results.
• Click-to-request appointments: Enhanced profiles allow patients to request an appointment with your practice by simply clicking a button on your Healthgrades profile. This quick, automated process removes a potential barrier for patients looking to make an appointment.
• Complete, practice-branded profile: Enhanced profiles offer comprehensive doctor and practice branding, including full bio, address, procedures, location directions and detailed contact information.

Healthgrades research shows that visitors to a complete enhanced profile will spend four times longer on your profile, which, again, will drive new patient conversions. While you can claim a basic profile at www.healthgrades.com, today Healthgrades enhanced profiles are only available from Sesame Communications. To get more information on Healthgrades’ enhanced profiles, visit www.sesamecommunications.com/healthgrades.

References available upon request from the publisher.
Technology: When to buy, when to wait

By Toby Buckalew, CIO, OrthoSynetics

During the past several years, technology products have become commonplace in our businesses. People utilize technology to save time, become organized, improve communication, automate tasks and reduce costs (among other things). However, technology requires periodic updates and replacements over time. Not doing so can result in increased costs in repairs, lost time, lost efficiencies and other hidden costs.

The key is to understand when to make the decision to buy and when to hold off on that new purchase.

When investing in technology products for your business — be they computers, printers, intra-oral plates or a new digital panoramic X-Ray — it is important to understand the technology life cycle. However, every technology item you purchase has a finite life. The specific lifespan of an item will vary upon a number of factors — making it impossible to have a single timeline for every item.

Every item does adhere to the same life cycle: new, performing adequately, diminishing performance and hampering performance. The reasons for the declining capability stem from advances in software that tax hardware, periodic hardware failure, intermittent malfunctions, changing technologies and mechanical wear.

Understanding the point in the technology life cycle at which you wish to replace an item is the basis of creating a technology acquisition plan. Many take a thrifty approach, in which they do not replace hardware until it hampers business. This approach has hidden costs in lost productivity, increased support costs/times and related expenses that — in many cases — produce a net result that actually costs more than replacing the aging equipment.

A cutting-edge approach for replacing technology dictates replacement of equipment when it is performing adequately but new equipment hits the market that may have better performance. This strategy replaces equipment on a rapid schedule. While this approach keeps technology up-to-date and new, the increased cost of constant replacement is not normally necessary and adds little benefit to the business. Additionally, being on the cutting edge of new software/hardware may not always be in the best interest of the business. Holding off for a few months (or more) on brand new technology usually benefits the business as it allows others to experience the issues allways involved with widespread release of new technology.

The sweet spot in technology acquisition is when technology begins diminishing performance. This is identifiable as a point in which operations, which were performing smoothly and with few issues and only an occasional hiccup, now are a constant annoyance — affecting business. The other factor that identifies this position is simple age. Equipment does wear out. The moving parts in computers deteriorate (such as the cooling fans on processors and power supplies). Silicone is sensitive to heat and wears out internally, leading to failure (think of all those integrated circuits and processing chips in the electronics and computers in the office). Intra-oral scanners can become moisture saturated, or (if cabled) inadvertent bites by patients can damage wires in the cord (even if not visible externally). The core strategy is to extend the use of your technology to achieve maximum return on your investment and replace it before it begins to hamper business operations.

For most technology elements in your business, three to five years is the point in which they reach the diminishing performance point in the life cycle. For other items, such as a digital pan/ceph, it may be eight years or longer — especially if serviced regularly. The difference between a five-year cycle and a three-year cycle could be quite small on the initial investment and replace it before it begins to hamper business operations.

Working and consulting in the health-care field and operations career servicing U.S. military facilities in Europe, Buckalew returned to the United States to continue his work after the end of the cold war. Working and consulting in the health-care field and in both cardiovascular practice management and convenient care industries, Buckalew specialized in the evaluation and implementation of technology, designing staffing and technology solutions for unique business needs.

When to buy new technology for your office? The key is to understand when to make the decision to buy and when to hold off on that new purchase. Photo/www.sxc.hu
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