Online Edition

AGD Impact

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The Newsmagazine for the General Dentist

July 2013, Vol. 41, No. 7

The Financial Pinch

Coping With the Rising Pressure of Dental School Debt

ICONS

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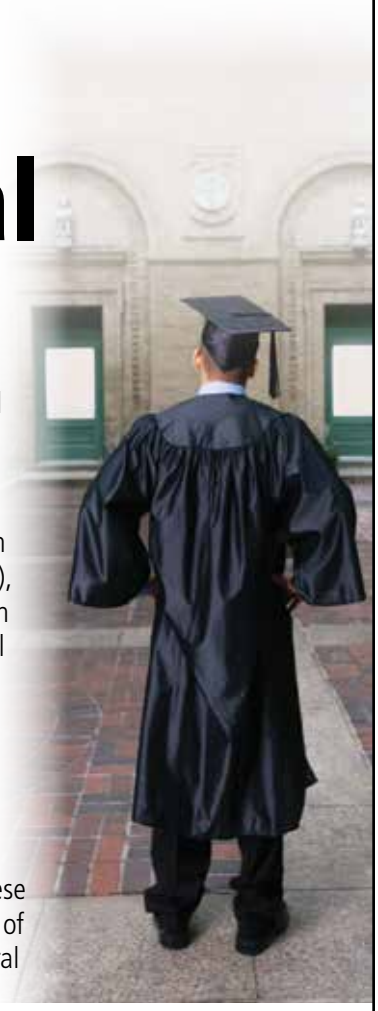
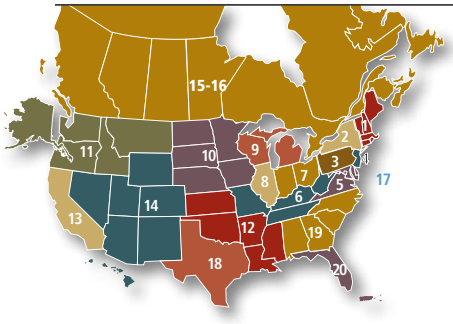


The financial impact of dental school debt is daunting for many, and rising education costs are affecting new generations of dental students. According to data from the American Dental Education Association (ADEA), the average U.S. dental school tuition and fees for resident first-year dental students rose 50 percent from 2000 to 2010. Plus, a 2011 ADEA survey of graduating seniors indicated that the average student debt among new dentists was almost $246,000 at private schools and $178,000 at public schools. Price tags such as these continue to change the career paths of dental students, as well as the general dentistry profession.

Advocacy: The AGD Difference



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Keep the conversation going with the AGD on all of your favorite social media sites—and be a part of the latest general dentistry news as it's happening!

Cooperation, Trust, and Teamwork

We are born for cooperation and teamwork, as are our feet, hands, maxilla, and mandible. We need other people to help us make up for what we do not have.

Cooperation stems from the Latin "co-," meaning "with," and "opus," meaning "work." Therefore, quite literally, cooperation means working with others, as a team.

All of us must become team players if we are to succeed in our complex dental profession. Our staffs are playing different instruments with different parts, but when they perform together from the same musical score, they produce beautiful results—they produce value.

As their leader, the dentist must become a trust builder, because trust has been shown to be the most significant predictor of individual satisfaction in the office. Trust between co-workers isn't just a nicety; it's a mandatory ingredient in relationship growth and teamwork. Without trust, there can be no cooperation within an office team; each staff member will protect his or her own immediate interests, to the detriment of the entire office.

Low-trust environments struggle with rampant turnover, absenteeism, unresolved conflict, low morale, and dissatisfied patients, all of which have a direct negative effect on the bottom line. In low-trust offices, staff members tell you what you want to hear. There is apathy, backbiting, and disloyalty, as well as an unwillingness to take responsibility for mistakes. Staff members live in fear and suspicion, and the ramifications are endless, inevitable, and costly.

We must trust and believe in our staff members until they prove themselves untrustworthy. That trust begins with you, their leader, and your willingness to trust them unconditionally. This goes against the common practice of waiting for people to prove themselves before you trust them. Trust breeds trust; mistrust breeds mistrust. The surest way to help people prove themselves as trustworthy is to trust them.

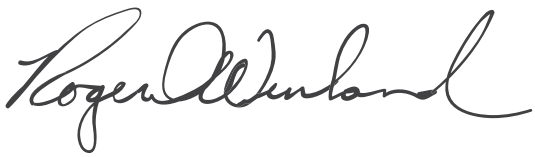
You can help build trust among your staff by listening to them and attempting to understand their feelings, perspectives, and experiences. When you make time for your staff, recognize their efforts, celebrate their accomplishments, and value their opinions, a trust bond develops.

As their leader, you must keep your integrity intact, demonstrating through your actions that they can believe what you say without question, know you will keep your promises, and can be assured you will be open with them. Always refrain from gossip, because untruths, exaggerations, and backbiting quickly suffocate trust.

You must respect staff members' values, because close-minded leaders rarely build open relationships. Care about your staff, because thoughtfulness, respect, kindness, and a belief in them will breed trust and a desire for teamwork. As their leader, resist pointing an accusing finger when things go wrong, because unhealed wounds will fester and infect relationships. Trust lies at the heart of cooperation and teamwork, and consistency is the path that leads you there.

One of the benefits and responsibilities of teamwork is how we make one another look. Great teams are composed of people who possess a genuine desire to make the team look good by their performance.

Team encouragement is the fuel for tomorrow, rewarding staff for who they are and giving them encouragement to do all that they can and become all they set out to be. In the words of author and speaker Florence Littauer, "We all need encouragement. We live without it, just as a young tree can live without fertilizer, but unless we receive that warm nurturing, we never reach our full potential and, like the tree left to itself, we seldom bear fruit." ◆



Roger D. Winland, DDS, MS, MAGD
Editor

The opinions expressed here are those of the writer and do not necessarily reflect the views of the Academy of General Dentistry.

A Great Dentist Goes to Washington 2013

On April 15 and 16, 75 dentists and dental students converged upon Washington, D.C., to participate in the Academy of General Dentistry's (AGD) seventh annual government relations conference, **A** **G**reat **D**entist Goes to Washington. This intensive, hands-on advocacy training event allowed 61 AGD members, 10 dental students, and four members of allied general dentistry groups to practice their advocacy skills and speak with nearly 140 legislators about topics and issues important to general dentistry.

Prior to the conference, AGD leaders identified three legislative topics of importance, and during the conference, AGD attendees had the opportunity to speak with key legislators about the following:

- Reducing dental student debt as a means to increase access to oral health care to the underserved. Because of their substantial student loans, many new dentists are forced

by economic necessity to select practice options that are more lucrative as opposed to those that are more personally rewarding and that meet important needs, such as practicing in underserved areas.

- Repealing the McCarran-Ferguson Act and its unfair practices of shielding the insurance industry from most federal antitrust laws.

- Eliminating the 2.3 percent tax on medical devices, which took effect on Jan. 1, 2013, as mandated by the Patient Protection and Affordable Care Act of 2010 (PPACA).

Likewise, AGD leaders utilized their time in Washington, D.C., to speak with legislators and officials at various federal agencies on the above issues and others that concern AGD member dentists, their practices, and their patients. Some of those meetings were as follows:

- AGD Immediate Past President Jeffrey M. Cole, DDS, MBA, FAGD, and AGD lobbyist Patrick O'Connor met with Rep. David Joyce (R-Ohio) to follow up on a visit Dr. Cole made in February regarding dental-related appropriations, including Title VII and a midlevel provider demonstration program. They—along with Myron J. Bromberg, DDS, and American Student Dental Association (ASDA) Immediate Past President Colleen Greene—met with Reps. Brad Sherman (D-Calif.) and Tom Petri (R-Wis.) about the Earnings Contingent Education Loans (ExCEL) Act of 2013.

- AGD President Linda J. Edgar, DDS, MEd, MAGD; Joseph A. Battaglia, MS, DMD, FAGD; ASDA member B. Alexandra Barton; and AGD Executive Director/CEO John Thorner, JD, CAE, met with staff from the U.S. Senate Committee on Health, Education, Labor, and Pensions regarding the inclusion of oral health literacy in the Healthy Lifestyles and Prevention America Act. They—along with ASDA member Aaron Bumann—also spoke with staff from the House Committee on Education and the Workforce about dental student debt and promoting oral health literacy.

- AGD President-Elect W. Carter Brown, DMD, FAGD; Gigi Meinecke, DMD, FAGD; Dr. Cole; O'Connor; and Jessica Brousseau, of the lobbying firm Kent & O'Connor, met with Sen. Charles Grassley (R-Iowa) to discuss corporate dentistry. Brousseau, along with Drs. Brown and Meinecke, also met with Rep. Paul Gosar, DDS (R-Ariz.), and staffers for Sen. Tim Scott (R-S.C.) to discuss oral health literacy and dental student debt.

Read more AGD Advocacy action alerts.

Additionally, during their stay in Washington, D.C., conference attendees heard from economist and former U.S. Treasurer Angela Buchanan, who shared an insider's view of the latest in Washington politics. James Paluskiewicz, deputy chief of staff and legislative director for Rep. Michael Burgess (R-Texas), discussed current congressional priorities, including implementation of the PPACA and its impact on insurance and Medicare/Medicaid coverage.

Participants ended their conference on April 16 with words from Reps. Gosar and Mike Simpson, DMD (R-Idaho). Both legislators encouraged attendees to share their advocacy skills with colleagues and to motivate other AGD members to become involved in the issues important to general dentistry. For more information about the conference, visit *www.agd.org/education-events/eventsexhibits/government-relations-conference.aspx.* ◆

AGD Visits ASDA Student Lobby Event

For the second consecutive year, the AGD's government relations conference featured a unique collaboration between the AGD and ASDA. Ten ASDA representatives participated in the AGD's conference event and accompanied AGD members on their congressional appointments.

During this time, ASDA President Jiwon Lee educated AGD members about her organization and its shared desire to impact continuing education, leadership development, and advocacy throughout general dentistry. Additionally, on April 15, Drs. Cole and Brown met with dental students during ASDA's National Dental Student Lobby Day event—also held in Washington, D.C.—and informed ASDA members about the AGD's advocacy efforts and legislative strategies. O'Connor also spoke with students during the ASDA event, advising them on effective lobbying techniques. ◆

AGD Joins Coalition for *Pro Bono* Legislation

Introduced as Senate Bill 466 and House Bill 963 on March 5, 2013, the Coordination of *Pro Bono* Recommended Dental Care Act would authorize a national grant program to provide medically recommended dental care at no cost for low-income children and adults. Under the program, volunteer dentists would treat patients with medical conditions such as diabetes, cancer, autoimmune disease, and kidney disease, as well as those who need heart or joint replacements or transplants.

In March, the AGD sent letters to the bill's sponsors, Sen. Robert Menendez (D-N.J.) and Rep. Diana DeGette (D-Colo.), expressing support for the legislation. Additionally, on April 1, the AGD participated in an Organized Dentistry Coalition initiative, joining 20 other organizations in sending letters to other congressional members, asking them to support the bill.

The AGD fully supports this legislation because Medicare often does not cover routine dental services, and will not pay for the coordination of medically recommended dental care—which could prevent underserved patients from receiving necessary care and compromise their existing chronic conditions. As of press time, H.B. 963 was with the House Energy and Commerce Subcommittee on Health, while S.B. 466 was with the Senate Committee on Health, Education, Labor, and Pensions. For more information on this legislation and more, visit *www.agd.org/advocacy.aspx*. ◆

The Academy of General Dentistry (AGD) makes sure that general dentists can speak up when it matters the most. That mteans monitoring the issues and relaying the facts so our members can unite their voices on legislative and regulatory activities that affect their practices. Read on to find out what's happening throughout the country.

REGION 1: CONNECTICUT

Dental Hygiene Task Force

Introduced on March 6, 2013, Connecticut House Bill 6589 would create a task force to review the scope of practice for dentists and dental hygienists; consider potential changes to hygienists' scope of practice; review hygienists' education, examination, and training requirements, and consider potential changes to theses requirements; and consider the potential licensure and scope of practice for an advanced dental hygiene practitioner or another midlevel dental professional. The bill was referred to the Joint Public Health Committee on March 6, 2013, for review and received a public hearing on March 15.

Expanded Function Dental Assistants

Connecticut lawmakers also are considering Senate Bill 993—introduced on Feb. 27, 2013—which would create expanded function dental assistants. Also with the Joint Public Health Committee, the bill was the subject of a public hearing on March 15, 2013.

REGION 1: RHODE ISLAND

Dental Board Change

Rhode Island Senate Bill 539, introduced on Feb. 28, 2013, would add one certified dental assistant to the Rhode Island Board of Examiners in Dentistry. The bill passed the Senate on May 21, 2013, and is now with the House Health, Education, and Welfare Committee.

REGION 11: OREGON

Increasing Oral Health Care Access

Introduced on Feb. 22, 2013, Oregon House Bill 3082 would require public and private prekindergarten through 12th-grade schools and residential child care facilities to provide children with a fluoride rinse after serving a meal. The bill also would require the Oregon Department of Education to post on its website the names of dentists who provide dental services at reduced rates or no charge for students from low-income families. The bill is currently with the Ways and Means Committee.

REGION 12: MISSISSIPPI

Rural Scholarship Program

On March 20, 2013, Gov. Phil Bryant signed Mississippi House Bill 776, creating the Mississippi Rural Dentists Scholarship Program, which identifies qualified university and college students from rural areas of the state for dental school admission.

REGION 13: CALIFORNIA

Retired Volunteer Dentist Certification

Under California Assembly Bill 836, the Dental Board of California could not require retired dentists to complete more than 60 percent of the continuing education hours required of other licensed dentists. The legislation, introduced on Feb. 21, 2013, defines retired dentists as those who have practiced dentistry for 20 years or more in the state, have reached the age of retirement under the federal Social Security Act, and customarily provide their services free of charge to any person, organization, or agency. The bill passed the Assembly Committee on Business, Professions, and Consumer Protection on April 25, and is currently with the Senate Standing Committee on Business, Professions, and Economic Development.

REGION 18: TEXAS

Dental Service Agreements

Introduced on Feb. 19, 2013, Texas House Bill 1480 would define a dental service agreement as an agreement between a dentist and a dental service organization—an entity that is wholly or partly owned by a nondentist—under which the dental service organization provides services related to the nonclinical business aspects of a dental practice, supervises or manages the employees or contractors of the dentist, or employs or otherwise contracts with a dentist in his or her professional capacity. Referred to the House Committee on Public Health on March 5, 2013, the bill would not affect or change the practice of dentistry, authorize a person to practice dentistry who is not licensed to practice dentistry, or authorize a person not licensed to practice dentistry to employ, contract with, or otherwise control another in the practice of dentistry. The bill received a public hearing on April 3 and remains with the committee.

Finding That Feeling of Freedom

Choose to Live the Life You Want

Every so often, I reflect on the lyrics of the Eagles' song "Desperado": "Freedom, oh freedom, well that's just some people talkin'. Your prison is walking through this world all alone."

Those lyrics have resonated with me throughout my career, and they couldn't be more relevant today. With all the pressures we face these days—economic struggles, insurance company issues, government regulations, etc.—it's difficult to feel like we are truly free. Many of us feel more like we're stuck and have to do certain things. This is a feeling that I call "bondage."

"With all the pressures we face these days—economic struggles, insurance company issues, government regulations, etc.—it's difficult to feel like we are truly free."

All of our choices place us somewhere on the freedom-to-bondage scale. Certainly you can be at one extreme or the other, but most of the time you're somewhere in-between. Why is that? Which choices have prevented you from experiencing complete freedom? Does it have to be that way? Do you have to experience the deadening feeling of bondage—the feeling that you have no choice?

It's important to remember that you do have freedom to make decisions. If you don't make decisions, you are stuck in no man's land, a place that kills your spirit. You must recognize when you've placed yourself there and do something to get out as quickly as possible.

What are your choices? What do you want for your life? Your practice? Your patients?

Believing that we really do have choices may be difficult, especially when we are overwhelmed by regulations from the government, state boards, the IRS, and so many more—including our fellow dentists. We also may find it hard to believe we have choices when we think of our team members and how much we sometimes struggle to keep our team motivated, focused, and accountable. We can get sucked into a trance of fear, which prohibits us from making decisions in the best interest of our practices, our patients, and ourselves.

But I encourage you to embrace the belief that you can make any choice you want. You can bet that your resolve will be tested. But I hope that will not deter you. If you need to, get the support you need to make the difficult decisions. No one said you had to do it alone, Desperado.

Where do you start? Identify your top three values—those things that you hold in the highest esteem—and write them down. Post them somewhere visible so that you are reminded of them every day. As opportunities or challenges appear, decide how you can best express your values in the choices you make. Stay true to yourself, and don't worry about the rest.

When you find yourself feeling constrained or limited, consider other choices you could make to move you closer to what you really want. As a general rule, I always think of three possible choices—at least—before making my decision. There is always that third choice lurking out there, waiting to be found, beyond choices "A" and "B." By becoming conscious of our day-to-day choices and their effect on us, we can make different choices that will lead us to a different, more fulfilled life.

Freedom is waiting for you. It's time to live the life you want and live it to the fullest. I hope you can find the courage to make the choices that are right for you. ◆

Don Deems,
DDS, FAGD

Doing Away With Downtime

Methods for Reducing Missed Appointments

On a daily basis, doctors and staff probably spend more time discussing and dealing with cancellations, broken appointments, and no-shows than any other patient issue. Downtime is not just a source of endless frustration—it is the single most obvious source of lost practice revenue. A full appointment book translates to production and revenue only if your patients actually come in. If your practice loses one or two appointments per day, either on the hygienist's schedule or on the doctor's schedule, the lost production could be anywhere from $150 to $700, depending on the procedure—that money quickly adds up. Improving practice performance in this one area alone could improve the financial future of your practice dramatically.

Reasons for patient cancellations

Before you address any patient cancellation issues your practice may have, it's important that you understand why patients cancel appointments or just don't show up at all. Some common reasons include:

- The patient does not believe he or she really needs the scheduled treatment.
- You have not developed a strong, trusting relationship with your patient.
- Financial resources aren't available to pay for the suggested treatment.
- The patient is afraid of experiencing pain during the procedure.
- The patient doesn't seek out preventive care. He or she only visits the dentist when pain is present.
- The patient's appointment time conflicts with his or her busy schedule.
- There is a change in the patient's insurance coverage.

Your office must address these fundamental issues thoroughly and consistently in order to see a decline in appointment cancellations.

Ways to combat patient cancellations

It is not possible to eliminate cancellations completely. However, with proper systems in place and a motivated, diligent staff, it is possible to reduce broken appointments drastically.

Most offices think of taking hard-line approaches, such as imposing penalties or fines for not keeping appointments. Practices that depend on these policies often are located in underserved areas or maintain a high volume of patients through heavy insurance participation. However, for most practices, these strong-arm tactics won't work. Instead, try some of the following methods for reducing cancellations.

Use technology to educate your patients.

Use visual tools—including intraoral cameras, educational DVDs, and 3-D demo models—for diagnosis as often as possible, and use tables, charts, and other data recording tools whenever applicable. These visual devices help involve the patient in the diagnosis. When patients see what you see, they are more likely to understand the need for your prescribed treatment plan, and you won't have to persuade them.

Communicate the value and need for treatment.

Your dental assistants and hygienists play a crucial role in communicating with patients, so make sure they play a role in educating your patients about their treatment needs. Most dental conditions are dormant; comparing them to chronic medical conditions like high blood pressure may help patients understand them. Also, it's important to convey to patients the value

of preventive care appointments, and emphasize that regular exams and cleanings preserve health, eliminate suffering, and save money.

Discuss and receive approval of cost.

Once a patient understands the need for treatment, your front desk staff should discuss the associated treatment costs. If the patient has insurance, make it clear that you are only providing an estimate of out-of-pocket expenses. Look for verbal and non-verbal cues as to whether the patient can afford the suggested treatment, and only schedule the appointment after you receive confirmation of this. It's important to create an environment where patients can discuss financial issues candidly. If they cannot afford a proposed treatment, they should feel comfortable sharing that with you. This open dialogue will allow you to suggest other financial options, including third-party payment plans. If your patient still hesitates to schedule the appointment, there may be additional financial issues that your office may not be in a position to resolve.

Proactively manage habitual cancellations.

Thankfully, the majority of your patients will keep their scheduled appointments. Usually, about 20 percent of patients are responsible for about 80 percent of all your no-shows and broken appointments. Here are some steps you can take to deal with these unreliable patients:

- Use a code on your practice management software to identify patients who have a prior history of cancellations.
- Do not book these patients' appointments in advance, but if they call on a day when there is an opening, ask them to come in.
- Do not give peak-demand appointment slots (such as early mornings, evenings, or Saturdays) to these patients.

Be considerate and reasonable in developing this list of chronic offenders. Consider the legitimate reasons that patients may have for canceling appointments, including health problems, car trouble, day care issues, a death in the family, or last-minute changes in work schedules.

Implement a schedule management system.

Your business staff is responsible for filling the schedule, but their job is not simply to answer the phone at the front desk. They need to be diligent and systematic when dealing with appointment cancellations and no-shows. Some practice protocols include:

- Consider the four-day schedule at all times. The front desk staff's main objective is to fill the schedule for that particular day of work, and the next day. However, looking at the schedule four days out can help identify problem areas, opportunities, and openings for new patients and emergencies.

- Call patients one day ahead of their scheduled appointments to confirm. Every attempt should be made to reach the patient directly, especially for long appointments. Consider using communication software (e.g., text and email communications) to reach your patients.

Learn more about communication software for your practice.

- Send hygiene patients a recall reminder card two weeks prior to their appointment. Since hygiene appointments are set six months ahead, there is a high probability your patients may forget them. In addition to the recall card, patients should receive a phone call, text, or email one or two days before their scheduled appointments.

- Call unreliable patients three days in advance. Your staff must talk to the patient directly and confirm the appointment. If the patient does not confirm, release the slot and make it available for other patients.

Develop a short-call list.

Most practice management software will allow you to develop a short-call list that consists of unreliable patients and patients who did not get their desired appointment time. It may take several months for your staff to develop a meaningful list, but it will help you fill any openings that might develop.

Peter Gopal, PhD

Hema Gopal, MBA, DMD

When patients leave your office with a future appointment, ask them which appointment times would be best for them and get their permission to call them if an appointment becomes available sooner than the one currently scheduled. In the event of a cancellation, your staff can contact patients on the short-call list to fill the open slot.

If missed appointments and the resulting downtime are a serious problem at your office, you should act immediately to put in place a system that not only deals with broken appointments, but also addresses the reasons your patients are cancelling in the first place. An effective system executed consistently by your team will help reduce missed appointments significantly—and help improve your practice's bottom line. ◆

Feeling Good and Looking Great

The Relationship Between Esthetics and Therapeutics

There is a misconception in dentistry that esthetic procedures and therapeutic treatment are two separate entities that have nothing to do with each other. However, nothing could be further from the truth. Dental esthetics is often very similar to dental therapeutics, and vice versa. In fact, nearly all of dental therapeutics falls completely within the realm of dental and facial esthetics.

More than 30 years ago, dental professionals fought a similar battle regarding the use of porcelain veneers. At that time, bonding a thin piece of feldspathic porcelain onto tooth enamel was revolutionary. The original porcelain veneers were no-preparation restorations, and controversy developed over whether they were actually therapeutic or just simply esthetic. During that time, dentistry was much more about function than it was about esthetics, and some believed that giving patients porcelain veneers for esthetic reasons was an unethical practice that cheapened dentistry.

This same outcry rose once again when tooth-colored restoratives were introduced. Prior to this time, amalgam was the restorative of choice and it served its therapeutic purpose well. Because of this, many dental professionals who preferred the newer composite resin restorations were told that they were doing unnecessary dentistry. Porcelain inlays and onlays also were hit with the same argument—gold was the material of choice for posterior restorations (it still is, but no one wants it), and those who chose otherwise were accused of giving into patients' desires without considering their best interests.

But as you all know, all of the above mentioned procedures are now well integrated into most dental practices and well accepted by the profession and patients alike. Although all of these therapies were developed in the name of dental esthetics, we learned over time that, when done well by the clinician, they all can be successful and serviceable for decades. Dental esthetics cannot survive on its own without a dental therapeutic component that allows it to function as a long-term, excellent dental restoration.

Soft tissue esthetics and therapeutics

In recent years, botulinum toxin (BOTOX®, Dysport®, Xeomin®) and dermal fillers (Juvéderm®, Restylane®, Belotero®, Expression®) have made their way into dentistry for both esthetic and therapeutic uses in the oral and maxillofacial areas. Some of the same controversies from the past have resurfaced, and just like in the days of old, most of the comments come from dental professionals who have not yet been trained in these nonsurgical, minimally invasive techniques—they have no idea what these techniques are and what can be accomplished by using them.

Botulinum toxin has a more than 20-year history in the treatment of temporomandibular joint (TMJ) syndrome and myofascial pain. Because botulinum toxin affects head and neck muscles and their relationship to the dentition, it is now a common adjunctive treatment for many dental cases, whether it's used for esthetics or therapeutics. I routinely use botulinum toxin for TMJ syndrome, myofascial pain, maxillary gingival excess (gummy smile), bruxism, differential diagnosis, orthodontic relapse, retention of removable prostheses, and treatment of angular cheilitis.

Dermal fillers are used commonly to add volume to the midface and supporting soft tissue structures around the mouth so that the patient's smile actually shows porcelain veneers, implants, or any other dental work from molar to molar. We also use dermal fillers to establish proper lip lines, smile lines, and phonetics, as well as to eliminate deficient interdental papilla (commonly referred to as black triangles), completely changing the way we look at this most frustrating challenge.

The integration of esthetics and therapeutics

Botulinum toxin is used whenever there is a muscular component to myofascial pain, which occurs 85 percent of the time, according to some studies. When a patient is properly evaluated and properly treated, botulinum toxin is highly effective in relieving TMJ syndrome and myofascial pain in a comprehensive treatment plan.

Botulinum toxin is well-known to the general public as a wrinkle remover in the areas between the eyes, in the forehead, and around the eyes. Whether utilized for dental therapeutics or esthetic purposes, the injections are administered in the exact same muscles, in the exact same pattern in each muscle, and at the exact same dosages. Of course, the patient will have smooth skin in these areas when the treatment is completed. In fact, we often use this as a differential

Figure 1. Patient with chronic myofascial pain. Notice intense frontalis action contributing to the pain.

Figure 2. After botulinum toxin injections, smooth skin indicates that the treatment is working and the pain is gone.

diagnostic tool to determine if the treatment has helped the patient's facial pain and if that facial pain is indeed based in the muscle.

If the treatment plan determines that the patient's myofascial pain is coming from the forehead muscle, the frontalis, botulinum toxin is injected into that muscle. If the patient's pain diminishes and the patient returns with smooth skin in the treated area, then we have confirmed the relationship between the facial pain and the muscle; we know the botulinum toxin is working because the skin is smooth (see figures 1 and 2).

However, if the pain still exists and the skin still has wrinkles when the patient returns to the office for evaluation, then we know that the botulinum toxin may not be working or an incorrect dosage was administered. From there, we can begin to increase the dosage and monitor the results. If the patient returns with smooth skin but still has some facial pain, then we know the botulinum toxin is working but that this particular muscle may have no relationship or a limited relationship to the patient's condition, which will require further diagnostic testing or a referral.

Some dental professionals have commented to me that the use of botulinum toxin in dentistry should be limited to therapeutics only—and not be used for esthetics (as if it were possible to actually separate the two). But as we have seen, you cannot separate the therapeutic from the esthetic and vice versa, whether you're dealing with porcelain restorations or botulinum toxin. With proper pharmacological and anatomical training in their use, botulinum toxin and dermal fillers have become well integrated into dentistry now, for both esthetics and therapeutics. Just ask any patient who could not find relief with numerous other dental therapies, especially in the area of facial pain, and whose dental esthetics now include both the oral cavity and the area around it. ◆

Louis Malcmacher, DDS, MAGD

Artificial Joint Claims

Interpreting Premedication Guidelines

As astute clinicians interested in serving their patients effectively, Academy of General Dentistry (AGD) members should all be aware of the new recommendations for premedication of artificial joint patients. An article published in the Jan. 7, 2013, edition of *ADA News* describes the results of the recent scientific review by representatives from the American Dental Association (ADA) and American Academy of Orthopaedic Surgeons (AAOS), "Prevention of Orthopaedic Implant Infection in Patients Under-going Dental Procedures."

The new guidelines were relatively vague as compared to prior versions, and they did not contain the lists that have been characteristic of prior guidelines. In essence, the new guidelines leave more discretion up to the treating dentist. According to the new guidelines:

1. The practitioner might consider discontinuing the practice of routinely prescribing prophylactic antibiotics for patients with hip and knee prosthetic joint implants undergoing dental procedures.

2. The ADA and AAOS are unable to recommend for or against the use of topical oral antimicrobials in patients with prosthetic joint implants or other orthopedic implants undergoing dental procedures.

3. In the absence of reliable evidence linking poor oral health to prosthetic joint infection, it is the opinion of the work group that patients with prosthetic joint implants or other orthopedic implants maintain appropriate oral hygiene.

Read more about the new ADA and AAOS premedication guidelines.

So, where do you go from here? Do you or don't you premedicate? I would like to present some recommendations that may help you handle this situation in the future:

1. You should strongly communicate to all of your patients with artificial joints the need to maintain appropriate oral hygiene. This means a minimum six-month recall and shorter intervals if the patient needs help.

2. There is no need to routinely recommend oral rinses to artificial joint patients prior to treatment unless they have other factors that indicate the use of these rinses.

3. Every patient in your practice with artificial joints should be part of a discussion concerning these new guidelines. Forms with a checklist have been recommended by the ADA, and a sample is included with this article. You should have a discussion with your patients regarding the points covered in the checklist and have each patient sign the form once they have made a decision regarding their treatment. Some situations may require a consultation with the orthopedic surgeon before a decision is made and before the patient is ready to sign the form.

4. If a patient insists that his or her physician mandates the continued use of antibiotics prior to dental procedures despite the new recommendations, and if the antibiotic suggested is not one of the three on prior recommendation lists (cephalexin, cephradine, or amoxicillin), then the patient should be instructed to have the physician prescribe and manage antibiotics administration. The dentist should contact the patient's physician to discuss medication management.

5. If the patient requests that you, the dentist, have a consultation with his or her physician, complete the consultation and document the results in your patient's chart.

Download a sample premedication checklist

6. If a patient has had an artificial joint placed within the last six months and is immunocompromised due to diabetes, rheumatoid arthritis, cancer, chemotherapy, or chronic steroid use, it may be prudent to consider the use of premedication through the first six months that the joint is in place. Otherwise, if the patient has any concerns based on his or her review of the information sheet, a consultation with the treating orthopedic surgeon is indicated.

7. The only procedures that would require any antibiotic coverage remain as follows:
   - Extractions
   - Periodontal procedures that include surgery, scaling, root planing, probing, and recall maintenance
   - Implant placement
   - Replacement of avulsed teeth
   - Conventional endodontic procedures that involve instrumentation beyond the apex or any apical surgery

- Subgingival placement of antibiotic fibers or strips
- Initial placement of orthodontic bands (not brackets)
- Intraligamentary local anesthetic injections.
- Prophylactic cleaning of teeth or implants in which bleeding is anticipated
- Crown and bridge procedures in which bleeding is expected during preparation or cord placement

8. Patients with artificial joints who have objected to antibiotic coverage previously due to allergies or expected complications can be classified more easily as noncandidates for premedication.

The bottom line is that the research conducted by the scientific panel showed that invasive dental procedures—with or without antibiotics—did not increase the odds of developing a prosthetic joint infection. Hopefully this explanation will help you understand how to handle your patients from now on. You can tell your patients that the new guidelines took effect in January 2013. Most of them, especially those prone to candidiasis infections, will be relieved that they do not need to take the antibiotics anymore.

In the past 20 years, we only have had to deal with two claims regarding failure to premedicate due to the presence of artificial joints or other joint-related issues. A description of each of these cases follows. At the time of the first incident, no guidelines were in place. At the time of the second, the most stringent guidelines were not in place yet.

Case 1

In 1994, an 82-year-old male retained the services of a lawyer and threatened to sue our insured based on "problems which occurred as a result of a root canal performed." The allegations stemmed from root canal therapy performed on tooth No. 4 over two appointments in September and October 1994. There were no complications during the procedure, and no antibiotics were prescribed.

Ten days after the root canal was completed, the patient's daughter called the dentist to inform him that the patient was in the hospital. She asked the dentist if he knew that the patient had a prosthetic knee joint. The daughter was informed that the patient had never disclosed such important information on any health history that he filled out in the office, nor was that issue ever brought up during any conversation about the patient's health. Next, the patient's wife called the dentist in November 1994 and asked him "what type of compensation he had

planned." This caught the dentist off guard, and he told the wife that he would get back to her. The dentist called me, and we discussed the treatment. Although antibiotics had been prescribed in the past as part of root canal therapy based on presenting symptoms, the procedure completed most recently did not dictate antibiotic use. No guidelines for premedication of artificial joint patients were in place at that time.

The dentist was advised to call the patient's wife to assess her feelings and expectations. As these had been longtime patients whom the dentist considered to be friends, he mentioned to the wife in a subsequent conversation that if it would help with any out-of-pocket expenses, he might be willing to provide them with $1,000. To that the wife answered, "Oh no, that is not even close. I was looking more at $50,000!"

Bone images disclosed that the patient's right knee showed septic arthritis associated with the artificial joint. The patient's lawyer sent a letter to us claiming that the knee infection was related to the root canal treatment and had caused the patient severe problems. The lawyer further claimed that a hospital physician had advised the patient's wife that the root canal was most likely the cause of the knee infection. Surgery had to be performed to clean out the knee area of the patient, who also had a "heart condition which increased the risk." The lawyer went on to claim that "had the dentist prescribed antibiotics in conjunction with the root canal therapy and premedicated the patient, the infection would not have happened."

We responded to the lawyer's letter by stating that the patient had never disclosed the presence of an artificial knee joint and had undergone several root canals since 1989 without antibiotics and without any problems. Furthermore, the medical records showed that the patient had complained of knee problems for a long time prior to the root canal in question.

The pathology report following the surgery stated that there were conditions in the knee related to inflammation rather than infection, and that bacterial cultures taken at the time of surgery showed no organisms that could be traced to the mouth. Furthermore, we determined that this patient was not a candidate for premedication or post-medication at the time of the endodontic procedure. At that time, the ADA advised against routine antibiotic prophylaxis on dental procedures for patients with prosthetic joints. In a brief article published in the well-read *CRA Newsletter* in July 1995, Michael Wahl, DDS, recommends against antibiotic prophylaxis for late prosthetic joint infections, as well.

The lawyer and patient responded to my letter by providing letters from some orthopedic surgeons claiming that antibiotic premedication for joint patients was necessary, but we were able to produce letters from other orthopedic surgeons denouncing the necessity of such premedication. Of course, prior to the 1997 advisory statement adopted by the ADA and the AAOS, there were no firm guidelines in place regarding premedication for artificial joint patients, so opinions were strictly subjective. We sent the lawyer a follow-up letter restating our position and emphasizing that the patient had a responsibility to disclose the presence of an artificial knee joint to any dentist. Apparently this effort persuaded the attorney and his client to drop the matter, as no lawsuit was ever filed, and the claim file was closed in 1996 after all applicable statutes of limitations had run their course.

Case 2

A 75-year-old male presented to the dentist in December 2008 with what were noted as severe periodontal problems associated with his upper left molars (teeth No. 14 and 15). The teeth were extracted. The patient had a hygiene appointment scheduled two weeks from the date of the extractions, but his wife called to cancel that appointment, saying that the patient was in the hospital.

Upon further questioning, she claimed that his knee started bothering him two days following the extractions and required fluid drainage and ultimately surgery. The patient's son claimed that the patient should have been prescribed antibiotics since "you always give antibiotics following every extraction." The dentist questioned the wife about the knee, as there was nothing on the health history indicating the presence of any artificial joint. The wife claimed that there was no artificial joint but explained that her husband, the patient, had injured his knee in a motorcycle accident 40 years ago.

The dentist contacted the attending physician, who stated that he did not insinuate that the patient should have been premedicated but mentioned that the lab results indicated the presence of a bacteria that does inhabit the mouth. In January 2009, the patient's wife called back to cancel all appointments scheduled.

There was no further contact until September 2009, when the patient's wife requested that the dentist help her with out-of-pocket expenses. Although he agreed to reimburse the patient for a limited amount as a good-faith gesture without admitting any liability, the patient refused to sign a release of all claims

provided by the dentist through us and obtained the services of a lawyer instead.

The lawyer sent a notice of intent to commence action to the dentist on behalf of the patient, dated Nov. 18, 2009, alleging that the patient had informed the dentist of a "pre-existing knee condition which had recently involved the removal of metal hardware." The lawyer went on to claim that former health care providers had given the patient antibiotics "to ensure that there would be no infection complications in the patient's knee." The lawyer accused the subject dentist of not providing the patient with antibiotics despite his receiving the alleged information about the knee. The lawyer further claimed that "blood work done at the time of surgery revealed that the origin of the knee infection was the extraction of the infected tooth performed on Dec. 3, 2008." He went on to demand a settlement of $55,000.

I discussed the case at length with the dentist, who insisted that he had never been told about any knee problem or injury sustained by the patient. The question on the health history read: "Check any of the following which you have had or have at present," and the patient did not put a check mark by "Artificial joints (hip, knee)." Furthermore, the patient refused the dentist's offer to provide a prescription for pain medication after removal of the teeth, one of which required sectioning and a surgical approach, and the patient did not ask for antibiotics.

We requested and obtained a complete set of the patient's medical records from the hospital and providers involved, and contacted our defense lawyers to have an infectious disease specialist review the records as a potential expert witness. The expert determined that although the bacteria cultured from the knee can, indeed, come from the mouth, the patient had a prior history of a staph infection in the knee, and no one could have anticipated a recurrence of the infection. Furthermore, the patient was not a candidate for premedication under the 1997 guidelines in place at the time.

A letter to the patient's attorney dated May 25, 2010, stated that after careful review of the records, the malpractice carrier determined that there had been no breach of the standard of care and that the prior knee injury did not fall under the guidelines that required antibiotic premedication or post-medication as outlined by the AAOS. The letter mentioned that we had retained as expert witness an infectious disease specialist who supported our position that the care rendered by our insured was proper

and appropriate. As in the prior claim, the position outlined in our letter persuaded the lawyer to convince his client (and the angry wife) to drop the claim against the dentist. The claim file was closed in January 2012 after all applicable statutes of limitations had run their course.

These types of case are not pleasant, but they do occur. It's important that dentists understand the newly released ADA and AAOS guidelines and are able to determine whether nor not their patients are candidates for premedication prior to treatment. ◆

Points to Ponder

1. It turned out that neither of these patients were candidates for premedication under the status of no guidelines for Case 1 or existing guidelines for Case 2. Interestingly, some may argue that Case 1 might have fallen under requirements for premedication under the most stringent guidelines in place from February 2009 to January 2013 if the endodontic procedure performed had involved any expected manipulation of bone beyond the apex of the tooth treated.

2. Unfortunately, not all physicians, including orthopedic surgeons, are aware of current guidelines and may make recommendations "outside the box," especially since the new guidelines are more dependent on a consensus decision by the dentist and the patient. If a physician insists on premedication under a unique regimen, the patient should be managed as mentioned in this article.

3. In Case 2, the dentist was willing to give a refund to the patient to cover some out-of-pocket expenses and wisely provided a release of claims form from the malpractice insurance carrier for the patient to sign. The patient refused to sign and, as the claim was ultimately closed with no settlement, essentially walked away from more than $400. We have mentioned these release of claims forms before. No money should ever be refunded to a disgruntled patient unless he or she signs one of these forms, which should be made available to you by your own malpractice insurance carrier.

4. The most recent ADA and American Heart Association guidelines for premedication pertaining to heart issues were published in April 2007 and have not been revised or modified to date. Nevertheless, AGD members should keep abreast of changes or new developments pertaining to cardiac conditions as well.

Richard C. Engar, DDS, FAGD

Navigating the World of CE

Events Offer Education, Learning Opportunities

I attended my first meeting as a "real dentist" this past March. My co-residents and I packed up and headed to my home state of Georgia for the 101st Thomas P. Hinman Dental Meeting in Atlanta. In addition to its excellent reputation and great educational opportunities, this annual meeting was a mere three-hour jaunt from my current location of Columbia, S.C.

For a recent dental school graduate, one of the biggest contrasts from dental school to real-world practice is the learning process. Instead of required classes with regular testing intervals, we now navigate the world of continuing education (CE)—one of the major pillars of the Academy of General Dentistry (AGD).

The CE process still feels funny to me. I halfway expect a pop quiz during the middle of the CE course, just to confirm we've perused our handouts ahead of time. The lecture process that could feel like a chore in dental school now stands as a way for us to stay current on the latest in clinical skills and dental technology.

Unfortunately, after being out of the dental school academic loop for even a few months, it's hard to pay attention for an extended period of time. Sitting still for hours on end is definitely a practiced art. One day at Hinman, my co-residents and I all took the same 8 a.m. to 4 p.m. class. The lecture was fabulous and engaging, but the speaker failed to follow the unwritten "must-give-a-break-after-one-and-a-half-hours" rule. I looked to my left and right and was tickled to see I wasn't the only one who needed some practice in the art of sitting still.

Besides the CE, my favorite part about the meeting was networking with other dentists. With five co-residents and three attendings in my residency, there is no shortage of dialogue among dentists, but my friends who went straight into private practice told me that it can be isolating at times. So, at the meeting, I took advantage of talking to people and vendors outside my usual professional bubble.

There was a perpetual buzz on the exhibit floor and in the hallways as attendees discussed new materials, big cases, and practice pearls. It's astounding to see literally hundreds of dentists outside the office pursuing more education. You can't help but leave a big meeting feeling fired up about the profession.

Another type of meeting I've loved as a resident is our monthly Greater Columbia Dental Association meeting, which allows us residents to plug in locally. Professionally, it's been my first time interacting with our surrounding specialists, and I've enjoyed putting faces with names.

I recently had my third molars extracted by a local oral surgeon. He finished my general practice residency program many years ago, and our office often refers to him. At a recent dental society meeting, I had the pleasure of sitting with him at dinner and chatting nonclinically. As I continue to refer patients to him for the remainder of my residency, I will be able to sing his praises both personally and professionally because of our interactions at the dental society meeting.

Kallie Law, DMD

Due to my residency graduation, I can't attend the AGD 2013 Annual Meeting & Exhibits in Nashville, Tenn. I can only imagine how much fun (and learning) will happen. If you're in Nashville, please go honky-tonking for me. If you're not in Nashville, I hope you've been able to get in some meeting time of your own and improve yourself professionally. ◆

Learn more about upcoming AGD meetings and events.

Granting Opportunities

Apply for the AGD Foundation Grant Program

Academy of General Dentistry™ FOUNDATION

The mission of the Academy of General Dentistry (AGD) Foundation, the philanthropic arm of the AGD, is to passionately support the efforts of general dentistry toward improving the oral health of the public. The AGD Foundation Grant Program offers financial support to community-based programs that provide quality oral health care for underserved populations. By encouraging these efforts through financial grants, the AGD Foundation can enhance the ability of AGD constituents and nonprofit organizations to help underserved populations across the U.S.

The AGD Foundation Grant Program is supported by generous donations from members, individuals, and corporate supporters who help the foundation respond to those in need. To learn more about the program, visit the AGD Foundation booth outside Exhibit Hall A1 during the AGD 2013 Annual Meeting & Exhibits, which runs June 27 to 30 at the brand-new Music City Center in Nashville, Tenn.

To download a grant application and guidelines, visit *www.agd.org/agd-foundation/our-programs/agd-foundation-grant-program.aspx.* Applications must be postmarked no later than Oct. 31, 2013. Grants will not exceed $5,000 each. Final grant decisions will be announced and monies will be disbursed in the first quarter of 2014.

In 2013, the program was able to award $25,000 to the following eight organizations and their access to care programs:

- Community Smiles (Miami)—A community-based nonprofit dental clinic using a holistic approach to provide oral health treatment and education to the underserved.
- Dentists Delivering Service (Corona, Calif.)—A global nonprofit organization composed of volunteers that travel to underdeveloped and designated areas within the U.S., providing dental treatment, education, and training to people in need.

The AGD Foundation is a 501(c)(3) charity; gifts to the AGD Foundation are fully deductible for United States federal income tax purposes, subject to the limitations placed on charitable gifts by the Internal Revenue Service. Be sure to check with your tax professional or attorney for specific, allowable deductions in your state.

- Gulf Coast Dental Outreach (Dunedin, Fla.)—An organization dedicated to providing low-cost access to dental care through education, prevention, and treatment of oral health diseases.

- Hope Clinic (Ypsilanti, Mich.)—A nonprofit that provides general preventive and restorative care with compassion and dignity to those without the ability to pay for dental care.

- Lane County Dental Care (Eugene, Ore.)—A local grassroots group of volunteers who work with AGD members in their county to combine resources and give back to their local communities.

- Mission of Mercy Pennsylvania (Shippensburg, Pa.)—Co-founded by an AGD member, this grassroots group of volunteers reaches out to people in local counties who have dental needs and are unable to afford care.

- Mississippi Dental Association Foundation (Flowood, Miss.)—A nonprofit that hosts dental missions for the needy and underserved throughout the state of Mississippi.

- Practice Without Pressure Inc. (Newark, Del.)—A group that focuses on helping children and adults with disabilities to overcome their fears of medical and dental procedures so that they may receive quality dental care with dignity and respect.

Paula S. Jones, DDS, FAGD

For more information or questions, contact the AGD Foundation at 888.AGD.DENT (888.243.3368), ext. 4329, or *foundation@agd.org*. We appreciate your support of the AGD Foundation Grant Program and all our efforts to provide oral health care for those in need. ◆

Grant Application Mailing Information

Academy of General Dentistry Foundation
Attn: Grants Committee
211 E. Chicago Ave., Suite 900
Chicago, IL 60611
foundation@agd.org

Learning and Looking Back

Reflecting on the AGD PACE Council's Work

Learn more about AGD PACE and PACE-approved courses.

It's true—time flies. I simply cannot believe that my time on the Academy of General Dentistry (AGD) Program Approval for Continuing Education (PACE) Council is coming to an end.

I am honored to have worked with so many fine dentists who have dedicated many hours to keeping the 60-year-old dream of eight extraordinary dentists alive. The AGD founders' mission is as important today as it was back in 1952—maybe even more so. If we want general dentistry to continue to flourish and really serve our communities, then we all need to work together to deliver high-quality patient care. But, in order to do that, we need to keep learning. And in order to keep learning, we need to find the right educators. That's why we need PACE. I feel truly honored to be a part of such a strong institution, which helps dentists identify quality dental education providers.

Looking back, I am pleased with the work the PACE Council has done. Since 2007, the number of nationally approved PACE providers has increased by more than 25 percent, which means there are more opportunities to attend CE courses from well-organized, high-quality organizations. The council has worked very hard to ensure that these courses are independent of commercial influence. We've also reconfirmed that nearly all of the U.S licensing jurisdictions that have CE requirements for licensure renewal accept credits from AGD PACE-approved providers.

As I leave this post, I want to encourage you once more to look for the AGD PACE logo and approval statement every time you consider registering for a CE course. When you see it, you can be confident that your colleagues on the PACE Council have done their best to ensure you will have a valuable educational experience.

I want to thank the PACE Council, my fellow AGD members, and the AGD staff for this awesome opportunity. It truly has been an honor and a privilege. Onward and upward—education first! ◆

Otice "Z" Helmer, DDS, MAGD

What's Hot and What's Getting Hotter

BY HOWARD S. GLAZER, DDS, FAGD

MATERIAL

Telio CS Desensitizer

Ivoclar Vivadent Inc.
175 Pineview Drive
Amherst, NY 14228
800.533.6825
www.ivoclarvivadent.us

There are many desensitizing agents on the market, and in a lot of those products is the essential component glutaraldehyde. And while many of the products out there have been quite effective, Ivoclar Vivadent's new Telio CS Desensitizer seems to be the most potent one to hit the market. Dentinal hypersensitivity is a symptom that we, as practicing dentists, face every day, and patients look to us for relief. Telio CS Desensitizer can provide that relief.

There are two essential components within Telio CS: polyethylene glyrol dimethacrylate (PEG-DMA) and glutaraldehyde. The former precipitates protein and the latter serves as a bonding agent. Together, they create "plugs" that seal dental tubules, reducing tooth permeability and decreasing sensitivity. According to company research, Telio CS Desensitizer precipitates more proteins than many of the other leading brands, making this a highly valuable product in treating dentinal hypersensitivity.

Application is simple and easy, and you can use this product with adhesive resin procedures without affecting bond strength. Telio CS Desensitizer is a clear liquid that is gently brushed into the dentin (safe on enamel too), thinned out with a gentle stream of air, and allowed to air dry for 10 to 20 seconds. Once dry, you can proceed with your restorative treatment. You also can safely use this product prior to cementation of a temporary crown, bridge, or inlay/onlay, as well as prior to final cementation to reduce the dentinal hypersensitivity often associated with cementation procedures. There is no doubt that dentinal hypersensitivity is a problem we face almost daily, and it is nice to know we have a good solution with Telio CS Desensitizer.

PRODUCT

FIT CHECKER™ ADVANCED and FIT CHECKER ADVANCED BLUE

GC America Inc.
3737 W. 127th St.
Alsip, IL 60803
800.323.7063
www.gcamerica.com

About eight years ago, I wrote the following description about FIT CHECKER™ II: "It may be 'fit for a king' but does it fit your patient?" Well, the king back then—FIT CHECKER II—has been replaced by FIT CHECKER ADVANCED, and the FIT CHECKER BLACK has been replaced by FIT CHECKER ADVANCED BLUE. GC America has improved these two "princes" of a product (Sorry, I couldn't resist.), and they are both invaluable in making sure the internal fit for the cast post, crown, partial, or denture is correct, as well as making sure the occlusion is making precise and correct contact.

Both are automix "no fuss-no muss" syringable VPES materials that are odorless and tasteless. FIT CHECKER ADVANCED, used for dentures and partials, is a white VPES material that you syringe into the appliance (has a 1 minute working time) and then seat in the patient's mouth and let set for about 1 minute. Upon removal from the patient's mouth, you can make any necessary adjustments and then simply peel out the material and reseat. Of course, you can repeat as necessary. This material has a minimal film thickness so that it is not a factor in seating the prosthesis, and once removed it leaves no residue.

FIT CHECKER ADVANCED BLUE can be used in the same way as FIT CHECKER ADVANCED, and also can be used to check the occlusal contacts. Again, the material has the same working and setting times, flows easily, and has a minimal film thickness so as not to offer any interference. Detail is excellent, and it too peels away easily without any residue. GC's new and improved FIT CHECKER products once again have made it easy to check the fit without having a fit!

MATERIAL

EndoSequence® BC Sealer™

Brasseler USA
One Brasseler Blvd.
Savannah, GA 31419
800.841.4522
www.brasselerusa.com

I am a big fan of the single master point and warm gutta percha technique for filling and sealing an endodontically treated tooth. In order to facilitate this technique, I am always looking for a better and easier way to ensure a complete seal. Brasseler USA's new EndoSequence® BC Sealer™ seems to be the answer.

The "BC" in the name stands for bioceramic, and it is delivered via an easy-to-use, syringable sealer paste material that is biocompatible, hydrophilic, and highly radiopaque. It also has antibacterial and anti-inflammatory properties. It uses the moisture naturally present in the dentinal tubules (even after paper point drying) to initiate the setting reaction. Once it's set, the EndoSequence BC Sealer forms a hydroxyapatite, chemically bonding to both the dentin and the specially formulated EndoSequence BC Points—which have been impregnated and coated with bioceramic particles. The result is a perfectly integrated seal without any gaps for microbes to inhabit. This actually may improve the tooth's fracture resistance, according to a September 2011 *Journal of Endodontics* study, "Resistance to Fracture of Roots Obturated With Novel Canal-filling Systems." This entire system is available in the EndoSequence BC Obturation Kit, which is neatly packaged and ready to use. A truly invaluable product, EndoSequence BC Sealer can help ensure successful root canal therapy.

PRODUCT

GUM® EasyThread™ Floss

Sunstar Americas Inc.
4635 W. Foster Ave.
Chicago, IL 60630
888.528.8537
www.us-professional.gumbrand.com

Cleaning in, around, and under bridges, implants, and orthodontic appliances is a must for maintaining good oral hygiene. We preach it daily, but some patients are lax in practicing what we preach, in part because it's difficult and time-consuming. There are many flossing devices on the market, but to my knowledge, no one has released a floss threader in an easy-to-use floss dispenser—until now.

GUM® EasyThread™ Floss, from Sunstar Americas Inc., comes in an easy-to-use package that allows patients to employ its built-in cutter. Patients simply pull out the green threader, which is followed by "puffy" floss, until they reach the middle of the next green threader. Patients are more likely to comply with simple oral hygiene procedures, and GUM EasyThread Floss makes flossing that much simpler. Thanks and tip of the threader cap to Sunstar for a much-needed and easy-to-use product.

Howard S. Glazer, DDS, FAGD

BEFORE YOU BUY...

The AGD has compiled all of Dr. Glazer's reviews in the online Product Review Directory. Access the directory at *www.agd.org/2/practicemanagement/productreview.* Search the reviews by product type or product category. If you have questions about the directory, email *impact@agd.org* or call 888.AGD.DENT (888.243.3368), ext. 4353.

The Financial Pinch

Coping With the Rising Pressure of Dental School Debt

By Eric K. Curtis, DDS, MA, MAGD

Thirty years ago, I struggled with the cost of dental school. My alma mater, a wonderful institution with which I still maintain warm ties, offers one of the most expensive private educations, in one of the most expensive cities, in the world. I wrote a check for $10,000—the entirety of my personal savings—on my first day of class. To keep myself in the program, I borrowed the maximum possible: $15,000 in guaranteed student loans, backed by the federal government at 8 percent interest.

Yet even on an impoverished budget of $400 per month, sharing a rent-controlled apartment with a bohemian industrial designer whose previous residence had been a homeless shelter, I didn't have

nearly enough. Steering clear of the terrifyingly usurious Health Education Assistance Loan Program (a 1980s government-supported funding option running credit card-like 20 percent interest rates), I applied for every scholarship I could identify, without luck. Recruiters for the military, caught in post-Vietnam budget cuts, told my class they weren't hiring.

So I panhandled friends and relatives. My maternal grand-mother advanced me $5,000, and my father's uncle, who had helped my dad through dental school a generation earlier, loaned me another $5,000, interest-free. Even my college roommate—who, by the way, still gets complimentary care at my office for his wise investment in my future—lent me $1,000. I graduated $75,000 in hock, a crushing burden that sent me to live in my parents' basement for three years after my residency while I scrimped to pay the albatross down.

The high cost of education

According to a U.S. Bureau of Labor Statistics Consumer Price Index-based inflation calculator (*www.bls.gov/data/inflation_calculator.htm*), that $75,000 tab today would equal about $162,000—no small sum. But to Darren Brower, DMD, MPH, a newly minted dentist in Mesa, Ariz., my debt is a pittance.

A 2011 ADEA survey of graduating seniors indicated that the average student debt among new dentists was almost $246,000 at private schools and $178,000 at public schools.

Dr. Brower began undergraduate college already married and with one child. By the time he was in his third year of dental school, he had three children. He attended a private dental school without state subsidies, where he earned not only his dental degree but also a master's in public health. At graduation, Dr. Brower's portfolio of 34 loans totaled $379,338 in principal and $43,461 in interest. And he is not an outlier. Official budgets generated by Dr. Brower's school—Arizona School of Dentistry and Oral Health, in Mesa, Ariz.—show annual student expenses hovering around $100,000. "Many in my class," he says, "are in the same boat."

Though the question of rising student debt has fueled a national buzz in recent years, student loans actually date back to 1958. The history of student loans continued when in 1965 the government

began removing risk to lenders by guaranteeing such loans. And by 2008, the government was actually issuing most student loans. According to a March 29, 2013, data report from the Federal Reserve Bank of New York, the total national student debt load at the end of 2012 was $966 billion—more than either auto loans or credit card debt, and an 11 percent jump from the previous year. While debt levels reflect increasing numbers of students, other variables have emerged, including growing numbers of higher learning institutions, decreasing real incomes of students' families, easy credit, and inflation.

But observers argue that the numbers also speak to the fact that runaway prices of education far outstrip inflationary effects. In his Feb. 12, 2013, *The Wall Street Journal* article "America's Baby Bust," Jonathan V. Last writes, "If you don't know that the economics of the university system are broken, consider this: Since 1960, the real cost of goods in nearly every other sector of American life has dropped. Meanwhile, the real cost of college has increased by more than 1,000 percent."

Some of that debt is unsustainable. According to recent U.S. Department of Education statistics, the three-year student loan default rate was 13.4 percent in 2012. These figures are of concern to both educational and financial experts; pundits worry that rising student debt could be the next financial bubble to collapse. A Jan. 13, 2013, report in *The Wall Street Journal*, "Risky Student Debt Is Starting to Sour," by Ruth Simon and Rachel Louise Ensign, cautions that high debt loads and rising defaults could drag a recovering economy back down. Simon and Ensign quote Moody's Analytics Senior Director Cristian de Ritis, who warns, "The taxpayer is going to be on the hook for losses."

In an April 6, 2013, *Salon* article analyzing the high cost of law school, "Law School Is a Sham," author Steven J. Harper warns that student loan costs may have reached the point of exceeding their benefits: "As one recent graduate observed, a federally guaranteed student loan may be 'the closest thing to debtor prison that there is on this earth.'"

The financial impact of dental school debt seems just as daunting. According to data on the American Dental Education Association (ADEA) website (*www.adea.org/publications/tde/Pages/Students.aspx*), average U.S. dental school tuition and fees for resident first-year dental students rose 50 percent from 2000 to 2010. (Average nonresident first-year dental student costs increased 45 percent.) A 2011 ADEA survey of graduating seniors indicated that the average student debt among new dentists was almost $246,000 at private schools and $178,000 at public schools.

Try out the U.S. Bureau of Labor Statistics' inflation calculator:

"The reality is that the average person who wants to become a dentist needs to take on hundreds of thousands of dollars in debt to accomplish that goal," says Martin Smallidge, a student at the University of Pittsburgh School of Dental Medicine and vice president of the American Student Dental Association (ASDA). "For students who are struggling financially, this level of debt poses a significant risk to their future, particularly when combined with their undergraduate or other education."

Why dental education costs increase

The causes of the dizzying spiral in the price of dental education remain fuzzy. "When you ask dental deans what drives up their costs, the reasons vary among institutions," says AGD Immediate Past President Jeffrey M. Cole, DDS, MBA, FAGD, of Wilmington, Del. He thinks that the effect of salaries on tuition is a nonfactor. "The faculty and staff in dental schools are certainly not overpaid," he says, pointing out that many schools still have vacancies for their funded positions.

But one likely factor is the precipitous decline of state and federal funding for dental schools in recent years. Fewer subsidies mean that schools must increasingly sustain themselves through tuition and fees. "As funding declines from year to year," Smallidge says, "deans and school administrations have to look to quickly replace those revenue losses. Increases in tuition are a quick fix."

According to Dr. Cole, another element that could be adding to dental schools' expenses is competition, including efforts to attract top candidates. "One of the highest costs of higher education is recruitment," he says. "Everyone is trying to recruit the best and brightest students." These university recruitment costs may be passed on to its dental school even if the dental school doesn't benefit. "Many dental school expenses involve paying overhead costs back to the universities," Dr. Cole says.

Students also are competing for spots in dental school programs. "The demand for dental school is extremely high," Dr. Cole says. "The joke on the street is that now students say, 'I couldn't get into dental school, so I have to go to medical school.' When demand goes up, usually marketing costs go down, but in dental education, the marketing costs of institutions are increasing—even with high demand."

A further complication in the supply and demand equation is the fact that new dental schools are continuing to open. "We are producing a glut of dentists," Dr. Cole says. "The problem of high demand will go down." The ripple effects of such fluctuations, he points out, can be calamitous: "Remember what happened in the 1970s,

when the government funded increased class sizes? Managed care appeared. Then federal funding stopped. Some dental schools closed. Others contracted."

Dr. Cole also worries that dental education, like other segments of higher education, is trapped in a financial bubble. "Jack Brown, [*Journal of Dental Education* editor and former American Dental Association policy analyst], says that now it's not a policy bubble. It's market driven. Dental schools are becoming profit centers. But the bubble will burst eventually. Who will be left? The best institutions, or just the most profitable?" Dr. Cole asks.

Federal grants, such as Pell Grants, non-repayable funds the federal government ladles out based on student need, also may be nudging price tags north. Sources of free, unrestricted money, grants remove schools' pressure to contain costs. "People in Congress have told me that grants become, in essence, a blank check for institutions," Dr. Cole notes.

Yet another factor that raises costs is increased student loan interest rates. Smallidge explains that interest costs generally aren't reflected in the numbers that measure current student debt because the data reflect debt loads at graduation rather than across the period of loan repayment. He cites the effects of Congress' Budget Control Act of 2011, which abolished Subsidized Federal Stafford Loans (the upgraded version of my old guaranteed student loans) for graduate students, doubled dental students' interest rates to 6.8 percent, and imposed a system of interest accrual beginning at loan origination. "This has occurred," Smallidge says, "during a time in which the Federal Reserve has held interest rates at nearly zero."

The limitations of loans

Loan options may seem abundant, but the rules are perplexing. Alternatives include subsidized loans, in which the government pays interest that accrues while students are in school. There also are unsubsidized loans that make the borrower responsible for all interest, and that interest accrues as soon as the loan is disbursed. Students select from Federal Student Aid, Federal Family Education Loans, Federal Direct Loans, PLUS Loans, Direct PLUS Loans, and Federal Perkins Loans.

Current options for managing student debt repayment also encompass a bewildering array of financial programs. The U.S. Department of Education offers a range of plans. Try to absorb the following—gleaned from "Navigating Your Dental School Debt," by Todd Balsley, in the Summer 2012 issue of the ASDA publication *Mouth*—and then imagine a 26-year-old without financial planning experience attempting to understand it, too:

- Income-based repayment (IBR), for new dentists entering a practice after graduation, limits monthly loan payments to 15 percent of the borrower's discretionary income. Pay As You Earn, now renamed Income-Contingent Repayment, is a variation of IBR that allows borrowers who show "partial financial hardship" to limit monthly loan payments to 10 percent of discretionary income; full loan forgiveness is available after 20 years.

- Additionally, the Public Service Loan Forgiveness program allows borrowers working for a public service entity such as a nonprofit agency or university to claim loan forgiveness after making 120 qualifying payments. Federal Direct Loan consolidation programs allow eligible borrowers to extend their repayment term or lock in a fixed rate on a variable rate loan. Students who have taken out various loans at different interest rates also may be able to refinance into lower interest rates.

- High-debt graduates may find relief through career choices, too. The National Health Service Corps, funded by the federal Health Resources and Services Administration (HRSA), offers loan repayment programs for dentists who practice in underserved areas. HRSA also makes scholarships available to health professions students from disadvantaged backgrounds.

- The Health Professions Scholarship Program offers a paid education, including tuition, fees, money for books, and a stipend (currently more than $2,000 per month), in exchange for active duty service—at least three years for dentists—in one of the branches of the United States military.

- The U.S. Public Health Service (USPHS) also provides loan repayment programs, monetary bonuses, and a $75,000 signing bonus for students who take a commission. USPHS officers may be assigned to federal agencies such as the Indian Health Services, Bureau of Prisons, Department of Homeland Security, Coast Guard, and Immigration and Customs Enforcement. The U.S. Department of Veterans Affairs offers its own student loan repayment program of up to $10,000 per year with a minimum three-year employment.

- Individual states also may provide loan repayment programs of up to $35,000 per year for a minimum two years of service in designated health professional shortage areas.

- Former students with insufficient income can select from several alternative strategies. Deferment options allow borrowers who enter residencies to suspend payments temporarily and receive full

subsidies, without interest accruing. Borrowers who don't qualify for deferment but also can't pay on their loans may be granted a forbearance, in which they can reduce or stop payments for up to 12 months—though interest continues to accrue.

Maneuvering all these options and their fine print and caveats can be complicated; close inspection of any given opportunity may reveal serious limitations. Dr. Brower, for example, recognizes particular irony in his situation. "While my school is very public health-oriented," he says, "it straps us with so much debt that the decision to work within public health is tricky." He explains that loan repayment opportunities through the public health sector typically won't pay the full amount on a 15-year repayment schedule. Many public health positions pay a capped salary, which means that, as part of making the right decision, a potential employee must balance the potential loss of income against the loan repayment.

Young dentists also may distrust the system itself. "While there are plans and promises of loan forgiveness after 10 years in the public health arena—if the minimum payments are made through that time period—my classmates and I hesitate," Dr. Brower says. "Because what are the guarantees that eight years into this, the program won't get scrapped?" he asks. Meanwhile, he notes, the minimum payment requirements won't even pay for the interest on the loans.

The effects of ballooning school expenses

While debt does affect many dental students, it's important to note that not every dental student takes on debt—and not all debt is debilitating. "One segment of students—maybe about 20 percent—has no debt," Dr. Cole estimates. Another 20 percent, he says, carries extreme debt. Then there is everyone in the middle. "Some in dental education have concluded that the only problem is the top 20 percent," he says. "But the problem is much bigger than that."

Learn more about the impact of dental school debt.

What constitutes extreme debt may be a matter of mind-set. Students who take on debt at any level may experience denial, depression, stress, and fear. Their idealism may erode. Their dreams may fade. But because not all students suffer equally, legislators and scholastic institutions tend to downplay debt's consequences—not only economically, but also professionally, personally, and psychologically. "People in Washington don't look at dental school debt as a problem because dentists will make money," Dr. Cole says.

Dr. Cole believes that decision-makers in the educational community similarly tend to understate the weight of student financial liability. According to the March 2013 report "A Report of the ADEA

Presidential Task Force on the Cost of Higher Education and Student Borrowing," there isn't evidence to conclude that high student debt—defined as more than $200,000—affects career choices.

Dr. Cole disagrees with that assessment. "When students carry a high amount of debt, their decisions are limited," he says. For one thing, potential students from rural and inner city areas tend to see dental school as unattainable. For another, dental students avoid practicing in rural areas once they graduate; they feel inhibited from seeking employment with academic institutions, federally funded health clinics, "or anything that might be satisfying that they can't afford to pursue," he says.

Regardless of institutional perceived evidence, Dr. Cole says that common sense "can tell you when numbers are out of whack." He believes that high debt levels create access problems—that curbing access to education is tantamount to limiting access to care. "I don't think that dentistry should be the province of the privileged few," he says.

The issue of dental student debt also may be important because indebtedness potentially alters practice ownership patterns and participation in organized dentistry. "New grads are not starting their own practices," observes Fares M. Elias, DDS, JD, FAGD, of Royal Oak, Mich., president of the University of Detroit Mercy School of Dentistry Alumni Board. "They are becoming associates, either of other dentists, large group practices, or corporations."

Dr. Elias concedes that generational preferences also may influence new dentist behavior. "Students want things now, and they are more social, so they may be OK being associates," he says. "They are not joiners. They want to work 9 to 5 and be done with it. In a corporation, they can make $80,000 to start paying off loans and buying what they want."

Even as some insist that educational expenses are not out of control, assertions circulate regarding who is at fault. Dr. Cole discerns multilevel finger-pointing. "Are institutions mortgaging their futures on the backs of students?" he asks. "Legislators say schools have to cut costs. Schools say they need more government funding. They blame each other."

Increasingly, Dr. Cole observes, both parties are reframing the argument to deflect responsibility from themselves onto students: "The conversation used to be that the problem was the high cost of education. Then the problem was recast as student debt. Then the problem became student borrowing habits."

Steven Ghareeb, DDS, FAGD, of Charleston, W. Va., acknowledges that a portion of student debt indeed hinges on students' decisions and their lifestyle choices. Ultimately, student encumbrances are tied to personal responsibility and circumspection, he says, and some students are not willing to sacrifice to keep costs down. "Do students request extra money to live a comfortable life?" he asks. "Do they just want to live well?"

Dr. Ghareeb remembers seeing both kinds of students. On one hand, "I had a buddy in dental school who lived in a nice townhome. He had a nice car and a motorcycle. He spent all his loan money and then bummed money from his classmates. He would ask, 'Can I have $100 for the weekend?'" On the other hand, Dr. Ghareeb says, "I had another classmate who lived below his loans and gave money back [to the government]."

Strategies for managing debt

Whether they are living beyond their means or carefully saving for the future, all dental students and recent graduates must eventually learn how to tackle their debt. Alexandra Quiroz, a pre-dental honor student at the University of Arizona, is the first member of her family to go to college. Quiroz has funded her own education thus

far without parental support, working in telecommunications sales jobs, in medical billing, and as a nanny—sometimes several jobs at the same time—while garnering Pell Grants. With one year left until graduation, the ambitious fifth-year microbiology junior is almost out of money and has been considering taking out a loan.

Nevertheless, Quiroz plans to take off a year after college before applying to dental school to save some much-needed cash. The college to dental school break pattern has become common, she says—about half of the students in her pre-dental club plan on sitting out a year. Some use the extra time to earn a master's degree or boost their grade-point average, but most work to accumulate money. Quiroz says her mother wants her to apply to dental school as soon as possible and acknowledges that it's getting more difficult to get accepted the first time around. But Quiroz says her pre-health professions counselor at the university told her that lots of people report feeling burned out and wish they had taken a break before dental school, but that no one regrets taking the extra time.

All those years of delayed gratification can take an emotional toll. Dr. Elias recognizes that new dentists have been living a life of deprivation through college and four years of dental school. "When they get a little money, they want to indulge themselves," he says, "and maybe buy a new car. But there is a difference between a Hyundai and a Mercedes. It's a matter of priorities. Some will immediately add to their debt."

To avoid even more financial pain later, Dr. Ghareeb advises both students and young dentists to embrace a Spartan lifestyle. "I found a shoebox apartment close to school," he says. "I made a conscious decision to limit my debt. I lived on ramen and tuna instead of eating out. I roomed with my brother during my last two years. I tried not to spend what I didn't have."

Dr. Ghareeb, who attended West Virginia University School of Dentistry, graduated in 2004 with $125,000 in debt—a lot of money, he says, "but not exorbitant." He cut costs when he got out of school, too. "I lived with my parents while I figured out my situation," he says. "Later I bought a modest home at a great price. At this point, my house is paid for and my loans are almost paid off."

Dr. Ghareeb cautions young dentists to pay close attention to their loan interest rates. "I locked in my student loans at a low rate by applying early," he says. "I paid attention to incentives for on-time payments and signed up for automatic deductions," which ensured a reduced interest rate and eliminated possible penalties for a late or missed payment. To melt away the loan faster, Dr. Ghareeb also doubled up on monthly payments.

Dr. Elias points out that debt risk is not limited to new dentists. Lots of established dentists, he says, even specialists, went bankrupt during the recession. They remodeled offices and bought new technology. They got married and divorced. They built bigger houses. And they subsequently discovered that their patient flow was slower than they anticipated. "As long as banks and other lending agencies will give them loans because of their degrees, dentists of any age may be tempted to borrow beyond what they can afford," Dr. Elias says.

While some student loans can be forgiven, Dr. Elias cautions that the only completely predictable way for dentists to reduce their debt is to pay it. To pay down debt, they must have money, and there are only two ways to get money—increase production or decrease expenses. "We don't emphasize the second part as much as we should," he says.

"To assess their needs," Smallidge says, "students should reflect on their career goals and family situations. Dental students need to understand what level of debt they can undertake." He says that ASDA also provides benefits and resources to help students manage debt, including free debt assessments and information on loan repayment plans.

Further, Dr. Elias counsels that debt structuring should be part of a comprehensive financial plan. "The day you walk out of school, set up goals, and then let professionals guide you," he says. "I tell students that if they plan it right, save right, and get a good accountant, attorney, and/or money manager, they can still live comfortably. But starting out without a plan can lead to devastating results."

And for some, the best plan may be one that generates no liabilities in the first place. For example, Dr. Elias' son, a senior dental student at the University of Detroit Mercy, will graduate with zero debt. He was accepted into the Army Health Professional Scholarship Program, which covered his school expenses and gave him a salary, to be paid back in service.

Is dental school worth the debt?

Free schooling is one thing. But when the balance sheet shifts the other way, how much debt can a dental student manage reasonably? "It's getting to that gray area where we don't know what's affordable," Dr. Elias says. "A $400,000 debt at 6 or 7 percent interest—which is more right now than real estate—will take 30 years to pay off. Will students be able to service that debt and still live as comfortably as they would like? It is very difficult to predict the economy. There are too many moving parts." But the questions many are asking are: Will the future of dental student debt improve? Is the cost truly worth it?

House Bill 6674, the Earnings Contingent Education Loans (ExCEL) Act of 2012, aims to reduce student debt burdens by helping prevent default. Introduced on Dec. 17, 2012, by Rep. Thomas Petri (R-Wis.), the bill calls for loans to be fixed on origination and paid back automatically, with a percentage deducted from paychecks. Non-compounding interest would be capped at 50 percent of the principal, at which point the rest of the loan would become interest free. "This idea at least encourages a manageable payback," Dr. Cole says.

Whether this bill succeeds, or whether other repayment mechanisms are used, Dr. Cole believes even very high debt won't discourage students from pursuing a career in dentistry. "Dental students will do anything because they are already committed," he says. "They feel they are so far in debt that they have no choice but to keep borrowing and spending."

Dr. Elias, who believes that students generally understand the enormity of their loans, perceives more hope than desperation. "Will high debt deter students from applying to dental school?" he asks. "So far, no. The number of applicants is still rising. But at the same time, is it worth it? My conclusion is yes, it is worth it."

Smallidge argues that while the sustained rise in educational costs is making dentistry less accessible, especially to those who would dedicate their careers to underserved areas, debt is still a useful tool for fulfilling student dreams. "It is difficult to put a price on the ability to provide patients with a perfect smile or to aid them in achieving oral health," he says.

Quiroz dreams the dream and vows to find a way to finance it. "The cost of dental school is something I can't hide from," she says. "I want to become a dentist. I will become a dentist." ◆

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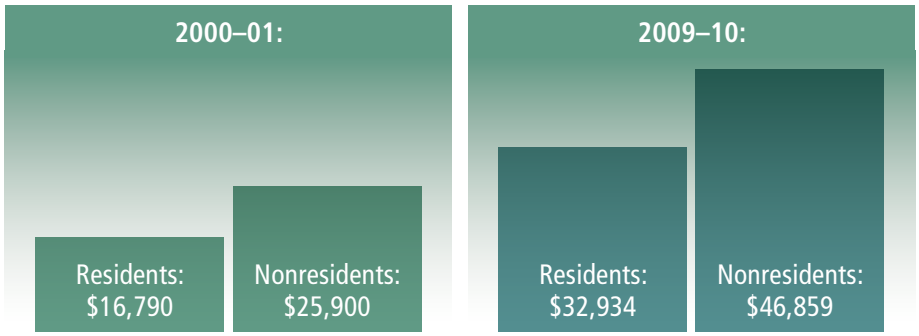
Dental School Debt by the Numbers

Average graduating debt for dental students in 1996

Average graduating debt for dental students in 2011

Source: American Dental Association, Survey Center, Surveys of Dental Education, 2010–11.

Average U.S. dental school first-year tuition and fees



Source: American Dental Association, Survey Center, Surveys of Dental Education, 2010–11.

Medical School/ Primary Care Physicians	Dental School/ General Dentists	Law School/ Attorneys
Average total of educational debt **$161,300**	Average total of educational debt **$203,374**	Average total of educational debt **$100,300**
Average starting salary **$49,394***	Average starting salary **$80,853–$117,103**	Average starting salary **$78,653**
Average salary **$177,330**	Average salary **$194,000**	Average salary **$104,000**

*Salary for first-year residency, average 80-hour work week

Sources: American Bar Association, American Dental Association, Association of American Medical Colleges, Association for Legal Career Professionals, Bureau of Labor Statistics, Payscale.com

The Best Foods and Drinks for Kids' Oral Health

A child's diet can have a direct effect on his or her health, particularly oral health. Learn more about which foods and drinks are good for your child's oral health—and which aren't so great.

Which foods and drinks promote good oral health?

There are many healthy, nutrient-rich foods and drinks that children can eat to help with their oral and overall health. These foods and drinks contain vitamins and minerals that help kids stay healthy and strong—and keep their teeth and mouths in great shape, too!

Calcium

Teeth and jaws are made mostly of calcium, and they need lots of it to stay healthy. If children don't eat or drink enough calcium, they risk developing gum disease and tooth decay. Calcium-rich foods and drinks include: milk (soy milk and cow's milk); yogurt and cheese; cooking greens (collards, spinach, kale, okra); and beans (soy beans, white beans).

Iron

Iron helps improves you child's brain development, and fights against anemia. It also helps prevent tongue inflammation and sores that may form inside the mouth. Great iron-rich food choices include: red meat (beef, pork, lamb); beans (chickpeas, lentils, soy beans); and iron-fortified, low-sugar cereal.

Vitamin C

Consuming foods and drinks with vitamin C is essential for children—and adults, too. Too little makes it harder for wounds and cuts to heal. It also can affect oral health, causing bleeding gums. Provide your children with fresh fruits and vegetables to ensure they are consuming enough vitamin C. Opt for these healthy food choices: oranges, sweet potatoes, red peppers, strawberries, kiwi, and broccoli.

Which foods and drinks should my children avoid?

There are a few foods and drinks that you should try to avoid giving your children because they have harmful effects on their oral health.

Sugar

Consuming too many sugary snacks can cause tooth decay. Your children should avoid, or sparingly consume, the following: cookies, cakes, candy, gum, sports drinks, and fruit juices.

Carbohydrates

It's sometimes surprising that carbohydrates are harmful to teeth, but eating them causes bacteria to stay on the teeth, which produces acid and may cause decay. Avoid these foods, or feed them to your children in moderation: chips, bread, pasta, crackers, and pretzels.

Carbonated drinks

Both regular (sugar-added) and diet sodas are very harmful to teeth. The carbonation in soft drinks wears away the enamel on the teeth, causing them to become weak and susceptible to staining. Offer your children milk or water instead of carbonated drinks.

It can be difficult to help children learn the best foods and drinks to keep their mouths healthy, but starting early is the best way to ensure your children have great oral and overall health. Talk to your dentist and pediatrician about the best ways to incorporate healthy foods and drinks into your child's diet.

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New Jersey, Brick—Established general practice seeking motivated, part-time associate, leading to full-time and eventual purchase of practice. Fax CV to 732.477.9514 or email to *JPBDMD@aol.com.*

New York, Buffalo—University Pediatric Dentistry (UPD) seeks pediatric dentists and a second OMS–Academic Appointment. UPD, a progressive and well-established practice, is scheduling interviews for pediatric dentists and an oral and maxillofacial surgeon due to rapid growth and expansion. Our goal: to be the best practice in the country. Our mission: that every child in western New York has a dental home. Our collegial group offers you a busy practice from the start, opportunities for community outreach, tremendous support from our exceptional clinical staff, and state-of-the-art facilities. We are clinical educators for the residents and dental students at the University at Buffalo School of Dental Medicine Department of Pediatric and Community Dentistry. We pride ourselves on offering "best practices," which include sedation and safety measures that are second to none. We work with a triple-boarded pediatric anesthetist. The ideal candidates will have a high level of integrity, a desire to care for the underserved, and a passion for teaching. We treat kids as if they are our own. Affordable housing, excellent schools, and, yes, a benign and hospitable climate. It's no wonder Buffalo was rated the 10th best place to raise a family by Forbes in 2010. Located on the eastern shore of Lake Erie and with a population second only to New York City in the state of New York, Buffalo boasts a strong economy, professional sports teams, a rich history, universities, and an abundance of outdoor activities, including skiing, boating, hiking, and biking. Contact Kim DeBlasi at 800.678.7858, ext. 64558; *kdeblasi@cejkasearch.com*; or visit *wwwcejkasearch.com,* ID No. 150351E26.

South Carolina, Myrtle Beach—Experienced associate dentist needed; minimum three years experience. Have a stake in our team by July 2013. Opportunity to become a stakeholder for a future in our practice. Tuesday-Friday work week, 8 a.m. to 5 p.m. Email résumé to *batodddmd@aol.com.*

Texas, Austin—Progressive, patient-centric Austin office is seeking an experienced dentist; must be friendly, caring, and professional. Opportunity available (if desired) for practice ownership. Serious inquiries email: *fahoosha@gmail.com* or *mike@miloinc.com.*

PRACTICE FOR SALE

Connecticut, central—For sale: General practice providing comprehensive fee-for-service dentistry; 2,200 square feet, expandable to 3,000; five operatories, expandable to 10. Average gross in five-plus years—$1.6 million. Office fully computerized and digital; highly trained staff. Send inquiry to *ctdentpract@gmail.com.*

Florida, Key West—Live and practice dentistry in paradise! Well-established, four-operatory dental practice with 1,850-square-foot, stand-alone building for sale. Great office layout, high-quality staff, room for growth. Great opportunity! Call 305.394.2874 for details.

Minnesota, Minneapolis—Practice and building for sale; 900-square-foot stand-alone building, three operatories. Remodeled six years ago; fully digital, paperless. Contact *dwightdemaine@comcast.net* or 612.729.5104.

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