THE RISE OF HPV-RELATED ORAL CANCER

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The Rise of HPV-Related Oral Cancer

By Kelly Rehan

Cases of human papillomavirus (HPV)-related oral cancer are rising. While the reason is unclear, according to the American Cancer Society, some think it could be due to changes in sexual practices in recent decades. The increase in incidence is only half the story — the other being whom HPV-related oral cancers are affecting.

Delivering a Five-Star Patient Experience

By Duke Aldridge

Most companies share one common goal: to gain and retain customers through best practices that encourage brand loyalty, while earning the respect of their customers. Consider these hospitality industry lessons that can be applied to dental practice.
I have honed my communication skills over the years through my interactions with many patients. I have learned over time that it’s important to choose your words wisely. Professor Erwin G. Hall said it best: “Poorly chosen words can stifle enthusiasm, dampen spirits, and be offensive and hurtful.”

If we made a list of all the things we underestimate, words could be at the top of it. We sometimes take them for granted, blurt things out without thinking about the impact our words might have on others, ourselves and our environments. As they say, once toothpaste is squeezed out of the tube, it is impossible to put it back in. The same is true for words; once harmful words are spoken, they can’t be taken back.

As they say, once toothpaste is squeezed out of the tube, it is impossible to put it back in. The same is true for words.

Specifically, parents and teachers should constantly remind themselves that their words and the way they say them have enormous power in shaping the lives of children.

Robert Fulghum, author of the best-selling book, “All I Really Need to Know I Learned in Kindergarten: Uncommon Thoughts on Common Things,” has been quoted as saying: “Sticks and stones can break my bones, but words can break my heart.” The traditional saying goes: “But words can never hurt me.” On the contrary, words can hurt more than sticks and stones do, whether they’re said via text message or posted to the internet.

Unfortunately, nowadays, it’s common for children to either bully or be the victims of bullying, the latter of which can have long-lasting, harmful effects on well-being and self-esteem.

Toxic words have no place in our children’s vocabularies or in ours. We must make our homes, schools and offices better places by banning all toxic language.

In my office, we do not tolerate the following: swearing or using offensive language; complaining, whining, moaning and groaning; putting each other down with mean-spirited and hurtful words; using rude and inconsiderate language; and gossiping.

In our offices, we must practice the art of encouragement. Author William Arthur Ward wrote: “Flatter me, and I may not believe you. Criticize me, and I may not like you. Ignore me, and I may not forgive you. Encourage me, and I will not forget you.”

Dentists who are “picker-upper” professionals have happier and more effective staffs. We should all know that the smallest positive gesture, a kind, genuine word of encouragement, compliments or praise can make a lasting difference. And yet, we don’t always take the time to let people know our heartfelt thoughts and give them a small gift of happiness. We can be heroes in our offices by becoming “picker-upper” professionals, and we can make giving encouragement a way of life, rather than a one-time event.

I implore you to take the time to set an example for your staff members and patients by speaking kindly to everyone with whom you interact.
Balancing Treatment Recommendations with Patient Realities

By Larry Stanleigh, BSc, MSc, DDS, FICD, FADI, FACD, FPFA

A patient whom I’ll call “Mary” came to see me many years ago for emergency care. She had fallen on an uneven sidewalk and did a proverbial face-plant onto the cement. Her front teeth were broken, and with her dentist being away on holiday, she was referred to me by one of her friends, a patient of mine.

We worked to restore her smile and her confidence. We also worked to help her negotiate the quagmire of paperwork required for insurance and other legal matters. My team and I provided the care, service and treatment she needed. She complimented how she was cared for and ended up remaining a patient of ours until she moved from Calgary, Alberta, Canada, for work-related reasons.

Many years later, Mary returned to Calgary but began visiting another dental office that was close to her new home. Since she’d last sought dental care in Calgary, she had been diagnosed with and treated for breast cancer. But then, nine years after her final treatment, it was discovered that her cancer had returned and metastasized to multiple sites in her body. The prognosis was poor, and she accepted this and began chemotherapy.

This treatment altered her saliva quantity and quality, as well as her immune responses, and she rapidly developed caries and periodontal infections. Her dentist recommended comprehensive, high-quality dentistry, including extractions, grafting and implant-retained prosthetics. This colleague was taught to present ideal comprehensive care to every patient because you never know who can and will say “yes.”

But it was estimated that Mary only has about one year to live. The treatment plan her dentist presented was sound and comprehensive, but was it the best one for her at that time? Did she want or need this kind of comprehensive dental care?

She came to me for a second opinion. It was wonderful to see her again, even under the challenging circumstances, and I spent time listening to her story. After reviewing her symptoms (she was completely asymptomatic except for one tooth in her lower right quadrant), and evaluating her radiographs and a clinical exam, we decided to remove the lower right first molar (tooth No. 30). We recommended maintaining comfort and function and addressing oral health issues as they arose, offering minimally invasive treatment (with minimal cost).

In his book, “Making it Easy for Patients to Say Yes,” Dr. Paul Homoly discusses how our treatment recommendations have to “fit” into patients’ lives. Otherwise, there is no case acceptance.

According to the Canadian Cancer Society, about two out of every five people in Canada will develop cancer in their lifetimes. As front-line health care providers, we need to stop, listen and learn about our patients so that we can provide the best care, as well as recommendations for care, that fits who they are and their needs at that moment in time.

We need to take time to discover what is going on in our patients’ lives, so that we can tailor-make treatment plans that best fit their oral health needs and desires now and in the future.

After decades of generous financial support and innovative research, we have found a way to prevent, detect and treat cancer and improve survival rates dramatically for many people with cancer. Now, when I see patients who have cancer diagnoses, more often than not, I tell them that when they are cancer-free or in remission, we should look at more comprehensive dentistry to ensure they remain healthy.

We need to take our time to discover what is going on in our patients’ lives, so that we can tailor-make treatment plans to best fit their oral health needs and desires now and in the future.

Larry Stanleigh, BSc, MSc, DDS, FICD, FADI, FACD, FPFA, is a private practice dentist based in Calgary, Alberta, Canada. To comment on this article, email impact@agd.org.
2017 Midlevel Provider Legislation

In 2016, Vermont joined Maine and Minnesota in passing a law establishing the licensure and practice of dental therapists in the state. Efforts to establish dental therapists have continued in several state legislatures across the country in 2017.

As of Feb. 13, six states have seen bills introduced that seek to establish the licensure and practice of dental therapists, which would allow them to perform numerous procedures under the general supervision of a dentist:

Connecticut S.B. 40
Pending before the Joint Committee on Public Health

Kansas H.B. 2139
Pending before the Committee on Health and Human Services

Maryland S.B. 1013
Pending before the Education, Health, and Environmental Affairs Committee

Maryland H.B. 1214
Pending before the Health and Government Operations Committee

New Mexico H.B. 264
Pending

Massachusetts S.D. 1005
Introduced by Maryland Sen. Harriette L. Chandler (D-First Worcester)

North Dakota H.B. 1256
Failed to pass following a floor vote (59-32) on Feb. 8

Based on legislative activity in 2016, it is likely that dental therapist bills will be introduced in several more states as 2017 state legislative sessions move forward. For more information on the midlevel provider issue, visit AGD’s Key Issues webpage at: www.agd.org/advocacy/key-issues/midlevel-providers.aspx.

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Scientific Session CE Spotlights

**Differential Diagnosis of Oral Lesions**
*Speaker: John L. Alonge, MS, DDS*

The development of a working differential diagnosis is one of the most difficult tasks in the diagnostic sequence. During this course, attendees will have the opportunity to build their confidence with the diagnosis of oral lesions. Clinical case presentations focusing on a variety of pathological conditions and the use of an audience response polling system will help engage attendees in the decision-making process. Attendees will leave this program with a fresh perspective on oral pathology and understand the information needed to identify and diagnose oral lesions that are encountered in daily practice.

**The Top 10 Secrets to Make Your Practice Thrive**
*Speaker: Kirk Behrendt, BS*

Some dentists and team members are working harder than ever for the same result. At this session, you’ll see 10 powerful secrets you and your team can use to create more opportunities to produce more dentistry and reduce the amount of open chairs in your office today.

**Successfully Treating All Patients with Anxiety or Special Needs**
*Speaker: Harvey Levy, DMD, MAGD*

This course will provide attendees with the knowledge and tools necessary to treat difficult or unmanageable patients. Discussion will include examples of complicated cases involving medically or mentally compromised patients, from the apprehensive to the combative, from infancy to old age. These cases will illustrate criteria for case selection, protocols for pre- and postoperative care and practical clinical tips for greater intraoperative efficiency.

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**INSIDE GENERAL DENTISTRY**

**The Effect of Microwave Radiation on Stone Surfaces**

Look for the following article in the March/April 2017 issue of AGD’s peer-reviewed journal, *General Dentistry*.

**Microwave radiation is effective at disinfecting dental stone surfaces without changing their physical properties (Bona et al)**

Type IV stone surfaces exposed to three, five or seven minutes of microwave radiation showed no significant differences in dimension or roughness. All regimens sterilized *Escherichia coli* and *Candida albicans* specimens, but only five- and seven-minute exposures sterilized all *Staphylococcus aureus* specimens.

To view past issues of *General Dentistry*, visit www.agd.org/generaldentistry.
IN MEMORIAM

Peter G. Sturm, DDS, MAGD

Past AGD Associate Editor Peter G. Sturm, DDS, MAGD, of Lavallette, New Jersey, died Feb. 14 at age 71.

He received his undergraduate degree in sociology from Rutgers University in New Brunswick, New Jersey, and was a 1972 graduate of New York University Dental School. He maintained a private practice in Fort Lee, New Jersey, from 1973 to 1985.


Sturm served as AGD’s associate editor from 1996 through 2011, contributing editorials to both AGD Impact and General Dentistry and a regular column to AGD Impact addressing dental insurance issues. He received his AGD Mastership Award in 1984, as well as AGD’s Distinguished Service Award in 2011. He served as a member of the AGD Council on Group Benefits and was instrumental in coordinating AGD’s constituent editors’ program.

Sturm was a past president of New Jersey AGD and the New Jersey Society of Dentistry for Children. He was a member of the New Jersey AGD Board of Directors from 1977 through 2001, serving in many positions, including as New Jersey AGD editor for 10 years.

He was active with the New Jersey Emergency (Forensic) Dental Identification Team (1990 through 2001), including being part of the 9/11 victim identification team in New York City. He also served with Washington’s forensic team.

Sturm was a charter member of the Northeast Chapter of the American Society for Geriatric Dentistry. He served as a regional cable television dental adviser, coordinated children’s dental health programs, co-chaired a regional continuing education program for the University of Pennsylvania, and lectured at national and local dental meetings. Sturm’s love of magic led him to lecture to dental students in a way that combined magic and dental education.

He is survived by his wife of 46 years, Paula; daughter, Paige Morabito; son-in-law, Mark Morabito; and two granddaughters, Siena and Gianna.

Remembering My Friend Peter G. Sturm

My Valentine’s Day this year will stand out as one of the saddest of my life. In February, we lost one of the most dedicated AGD members whom I have had the privilege to have been associated with, especially while working on our professional publications. Peter G. Sturm, DDS, MAGD, my first associate editor for 15 years, died at his beloved New Jersey shore.

From 2002 to 2008, Peter and his wife, Paula, lived in Spokane, Washington, but their true love was New Jersey and their friends. He practiced there in Fort Lee from 1973 to 1985, and resided in Lavallette, New Jersey.

Peter was New Jersey AGD’s editor for 10 years and was very competitive with me, Ohio AGD’s editor, in pursuing the yearly constituent editorial award early in our careers. But when AGD’s national editor position came up for vote, Peter supported my candidacy, and our friendship began — one of my greatest blessings.

Appointing Peter as my associate editor and his acceptance were outstanding for AGD’s publications, AGD Impact and General Dentistry. Peter had a mannerism that made me constantly appreciate his professional approach to our collaboration. As we worked on a project, he would say, “How can I help, boss?” Or, “Yes, boss.” We knew we were equals, but his dedication to our cooperation was refreshing.

Peter and Paula would always update my wife, Debra, and me on their daughter, Paige, as she was growing up. Their dedication and love for their daughter was an example everyone who knew them tried to emulate. I always pulled Peter’s chain because he had to balance Paula’s and Paige’s visions of ecology with my hunting conservatism viewpoint. I would tease him about hunting penguins (Paige’s favorite animal) in Antarctica, which I never did — it’s unlawful. We both enjoyed our teasing banter.

The past few years have been difficult for Paula and Paige as they dealt with the devastating progression of Peter’s Alzheimer’s disease. Their courage was outstanding, and I hope they can now take some comfort in their memories of Peter.

Peter was one-of-a-kind: husband, father, dentist, editor, writer and one of the best friends I could have ever asked for. I will miss him very much, and I pray someday we can resume our collaboration.

Roger D. Winland, DDS, MS, MAGD
Editor
By Amy Kinnamon, RDH, EFDA, BAS

As dental professionals, we cannot escape expectations, even though many a literary figure has warned against it. Our patients rely on our knowledge and expertise and expect us to provide excellent treatment. Without expectations, there is a potential for a breakdown in communication, treatment acceptance, outcomes and, ultimately, the health of our patients.

As patients have expectations of the dentist, so do the dentist’s team members of the dentist, and vice versa. For example, a dentist employing a hygienist or a team of hygienists has unavoidable expectations; the dental hygienist is a licensed member of the team and as such is expected to be competent to perform the delegable duties under his or her respective state dental board. Conversely, the hygienist or team of hygienists has expectations of his or her employer; they expect the dentist to be competent in performing the duties that he or she has been licensed to perform as well. Unfortunately, competency under licensure is not enough to have a successful team relationship.

Expectations are the cornerstone of the practice philosophy. Effectively managing those expectations in a dental practice is equally important as clearly verbalizing those expectations that may seem superfluous. Mismanagement of expectations can lead to an unhealthy relationship that can negatively affect not only the dentist/dental hygienist relationship, but also the entire team dynamic.

Expect Your Dental Hygienist to Align with Your Clinical Philosophy

Every expectation in the dental practice begins with a clinical philosophy. Having a team in place whose members’ clinical philosophy aligns with yours is crucial to the success of the practice.

During the job interview process, too many times, the focus is on hours, salary and clinical skill. What the hiring dentist may not realize is that this is the time to get an in-depth view of a dental hygienist’s ideal practice environment and his or her own philosophy about patient care. A quick-to-hire, slow-to-fire approach may leave the dentist with a hygienist who is averse to the expectations that the dentist has in place to achieve optimum treatment, or the dental hygienist may have a completely different view of what acceptable treatment may be.

When clinical philosophies are aligned, the dental hygienist will anticipate your diagnosis and recommendations for a seamless conversation among the patient, dentist and him or herself. The patient will hear and see the same message presented from both professionals. This will solidify the patient’s trust with the dental team and increase case acceptance. In return, the dental hygienist will expect the dentist to support his or her clinical findings and recommendations.

Expect Standardization of Care

Dental hygienists come from a multitude of backgrounds and may have varying bases in research, education, knowledge and experience. For example, some perform a cancer screening at every recare appointment, while others do this yearly or not at all; some only use an ultrasonic scaler, while others selectively polish. Employing more than one hygienist in a practice requires a standardization of care.

Patients should receive the exact same preventive treatment in the exact same way in accordance with the most up-to-date protocols that suit the practice. Patients notice when treatment varies. The evaluation and maintenance appointment that is guided by clear protocols (expectations) provides a calibrated experience and establishes treatment standards that are met for every patient every time.

In exchange, the hygienist will expect up-to-date equipment and consideration when exploring the addition of technology to benefit the dental practice. Standardizing care across the hygiene department can eliminate confusion about processes and elevate the patient experience.

Expect Participation in Lifelong Learning

Dentistry is changing, and advanced knowledge is necessary to competently treat patients. Successfully addressing oral-systemic considerations requires knowledge of not only dental health, but whole-body health as well. In order for dentists to differentiate the practice, highly educated dental hygienists are needed.

I am not suggesting advanced degrees; rather, the expectation of constant learning to increase critical-thinking skills and optimize patient education and preventive treatment. Hygienists who are vested in their education provide competent case presentation with the verbal skills to accurately educate the patient and increase acceptance. Openness to change is an added benefit of relying on research in today’s constantly changing health care environment. In accordance with expecting the dental hygienist to evolve his or her education, the dental hygienist will expect an investment in that education that may not necessarily be monetary. Looking for ways to encourage dental hygienists to increase their knowledge base is a win for the practice.

Managing expectations is an undervalued leadership skill. In order to manage expectations, there has to be concrete expectations in place. Do not presume that your team knows what is expected beyond clinical competency. Have the expectations of your practice been clearly verbalized? ✪
TREATMENT PLANNING

Occlusion May Not Be Causing Your Patient’s Orofacial Pain

By Louis Malcmacher, DDS, MAGD

General dentists have typically been trained to think that occlusion is the starting point for treating bruxism, temporomandibular joint (TMJ) disorders and orofacial pain. As a restorative dentist, occlusion is important to the success of the long-term prognosis of restorative dental care for everything from basic restorative to complex, full-mouth dentistry. However, when it comes to TMJ and orofacial pain cases, occlusion shouldn’t always be the starting point and, in truth, it may never even come into play in treating these cases.

That being said, it is important to understand that the approximately 10 orofacial pain dental residencies in the United States (and more, internationally) do not teach occlusion as the starting point of treating these cases. These programs teach proper evaluation and diagnosis of orofacial pain conditions and extraoral treatments first before teeth are treated. I know dentists who have gone through their entire two-year orofacial pain dental residency and never even picked up a high-speed handpiece. This tells you that the most successful treatment for TMJ and orofacial pain does not begin in the mouth and may actually have nothing to do with the occlusion. Perhaps this explains the frustration most dentists have when treating bruxism and TMJ cases; many dentists have not been properly trained in evaluating these patients. Proper evaluation of TMJ/orofacial pain patients includes, but is not limited to, a detailed medical history, cranial nerve examination, TMJ examination and head/neck muscle trigger-point examination.

The following is a case presentation that illustrates an orofacial pain case and the above points.

Reevaluating a Patient in Pain

The first time I saw “Sally,” she described a medical and dental history of severe orofacial pain, along with migraines and TMJ pain that she’d had since a relatively young age. She already had seen numerous dental professionals who had adjusted her bite and had been given a few bruxism appliances — none of which really helped her — but she wore them in the desperate hope that someday they would. If you have been trained in facial esthetics, you’ll likely guess that most of her pain was occurring on the left side of her face; as you can see in Fig. 1, her face has an asymmetry, with the musculature being larger on her left side.

She also reported a bump when she opened her mouth, as you can see in Fig. 2. This is associated with loud and painful cracking of her left temporomandibular joint. This bump had gotten larger over time, as the pain increased.

Fig. 1: Sally’s facial esthetic appearance is the clue to recognizing her orofacial pain.

Fig. 2: A “bump” (see arrow) is a facial muscle in painful spasm upon mouth opening, which was also causing cracking in the temporomandibular joint.
When the evidence shows that up to 85 percent of TMJ and orofacial pain cases are muscle-related, why start with appliance and irreversible occlusal changes when most of these cases have nothing to do with the occlusion?

After a thorough medical and dental history, we gave Sally a home bruxism and sleep monitor overnight test, and suggested that she wear her full-coverage bruxism appliance during the test as a baseline. The results were a high bruxism episodes index (BEI) of 13.2 (a BEI over five is considered destructive bruxism). And this was with wearing the bruxism appliance!

We then asked her to repeat the bruxism and sleep test without wearing the appliance and found that her BEI was cut in half, to 7.4. It was apparent that she needed to stop using the appliance immediately, as it was obviously making her condition worse.

Our treatment plan for Sally consisted of trigger-point injections using botulinum toxin (such as Botox or Xeomin) on the affected muscles determined by a head and neck trigger-point examination. Approximately 86 units of botulinum toxin were used for her trigger-point injections in the trapezius, splenius capitis, masseter, temporalis, glabellar area and frontalis muscles.

Here’s how this treatment protocol works: Imagine that a trigger point in the trapezius muscle is a button that when pushed will send pain signals up to the side of the head near the temporomandibular joint, thus mimicking TMJ pain. While the site of the pain is in the TMJ, there is actually nothing wrong with the joint, so any treatment such as bruxism appliances or occlusal therapy will give no relief at all. The trigger point in the trapezius muscle is treated with an injection where the needle tip of the syringe is used as a mini-scalpel to physically break up the trigger point in the muscle, after which botulinum toxin is injected into the muscle for longer-term relief. Breaking up the actual trigger point will cause the body to heal the muscle, and the botulinum toxin will provide relief by relaxing the muscle over time. This was the treatment used in Sally’s case.

Long-Awaited Relief

While sitting in the dental chair for the first time in a few years, Sally started exhibiting some relief from her long-running TMJ and orofacial pain. At a follow-up appointment, another 20 units of botulinum toxin and trigger-point injections were delivered. Approximately two weeks later, all of her orofacial pain and migraine symptoms had been resolved, with her BEI eventually decreasing to 0.8, well within the normal range of nondestructive masseter activity.

Oh, and that bump that appeared when she opened her mouth? That disappeared as well, along with the cracking in her left temporomandibular joint. All of her symptoms were muscle-related and had absolutely nothing to do with her occlusion.

The point here is simply this: When the evidence shows that up to 85 percent of TMJ and orofacial pain cases are muscle-related, why start with appliance and irreversible occlusal changes when most of these cases have nothing to do with the occlusion? Every dentist should learn front-line TMJ and orofacial pain trigger-point techniques, which are nonsurgical, minimally invasive and highly effective in treating facial esthetics, TMJ/orofacial pain and bruxism, in order to successfully treat their patients.

Louis Malcmacher, DDS, MAGD, is a practicing general dentist, lecturer and author and is president of the American Academy of Facial Esthetics. To comment on this article, email impact@agd.org.

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PRACTICE MANAGEMENT

How to Respond to a Procrastinating Patient

By Don Deems, DDS, FAGD

How many times does your scheduling coordinator hear the response, “I will schedule treatment later” after asking a patient, “Do you prefer a morning or afternoon appointment?” Probably enough times to notice. Do patients who say this when they’re checking out at the front desk actually call later to schedule follow-up treatment? I doubt it.

When a patient says, “I will schedule treatment later,” it used to mean that he or she didn’t understand the need for treatment, for the most part. But is this the only thing that “I will schedule treatment later” means? Absolutely not. It might also mean:

1. “I’m concerned about paying for treatment.”
2. “I’m not sure what my condition is or why I need treatment.”
3. “I want to do more research before I commit to treatment, and even get a second opinion.”
4. “I need to check my schedule. (And it’s difficult for me to get time away from work.)”
5. “Now’s not a good time for me to be receiving care.”
6. “I don’t want treatment.”
7. “I need to think about it.”

Of course, the patient is not actually telling you any of these things. It would be much simpler if the true reason was provided up-front, wouldn’t it? However, for most people, it is hard to tell their truth. Maybe it’s embarrassing. Maybe they don’t want to appear foolish. Maybe they just don’t care (although, I bet they do). Whatever the reason, it’s legitimate for them, whether we agree with them or not.

How can we proactively take action to ensure that patients are scheduling follow-up care and treatment? Let’s discuss how best to respond to each response a patient could give while delaying the scheduling of treatment.

1. “I’m concerned about paying for treatment.” Rarely will a person tell you he or she has no money to spend on dental care. Consider scheduling the patient’s treatment in phases, if possible. You could ask, “Would it help to schedule just a portion of your treatment at this time?” Or, “We offer financing options.” If the patient still declines scheduling an appointment, a note should be made to contact him or her within a one- to two-week window following the date of diagnosis, with a reminder of the next steps in the treatment plan.

2. “I’m not sure what my condition is or why I need treatment.” This is a failure to communicate while the patient was in the chair. What can be done when treatment is diagnosed? For one, during the appointment, the patient’s condition and treatment options should be clearly explained to them. Use educational handouts, either in the form of brochures, customized handouts, photos, radiographs, models or any number of informational aids. Don’t just give these things to them; review the materials with them each and every time to ensure understanding. Don’t assume that just because a patient has been with your practice for 20 years that he or she will take your word at face value and schedule an appointment for the placement of those crowns. Review the problem...
In a dental scenario, it is morally and ethically advisable to make sure the patient understands the consequences of lack of treatment.

and the solutions, and address the patient’s concerns, questions and objections. Keep the conversation going until the patient feels he or she truly understands.

Here are some questions you can ask while you are talking with the patient: “What questions do you have about the treatment needs that have been diagnosed?” “Before we proceed, what questions do you have about your condition?” Whenever asking a question, pause afterward to allow time for the patient to formulate a response.

3. “I want to do more research before I commit to treatment, and even get a second opinion.” The proactive approach to this is much like in No. 2 — ensure understanding. As you are reviewing a patient’s condition and treatment needs, check in with him or her along the way to ensure understanding. Ask: “Mrs. Smith, does this make sense to you?” Again, pause after asking the question, and give the patient time to respond. Much like a person who is reading a sentence and comes across a word he or she doesn’t understand, if a patient encounters something that’s confusing and doesn’t gain clarification, one may not understand anything after that.

4. “I need to check my schedule.” It is true that most people’s lives are busy. To proactively deal with this so the patient doesn’t “slip through the cracks,” simply state, “Mr. Jones, we’ll call you in two weeks if we haven’t heard from you. What is the best number to call?” Notice I am not asking for their approval or permission. If the patient says, “Do not call me,” well, do not call! Make sure that a note is immediately made somewhere where it will not get lost, so that the patient is called as promised.

5. “Now’s not a good time for me to be receiving care.” What proactive step can you take here? Try saying: “Mrs. Jones, it sounds like now is not the right time for you to schedule necessary treatment. When would be a better time?” Remember, then be silent. Let the patient answer. Then, determine the next step.

6. “I don’t want treatment.” This is an interesting one, since the patient came to your office for care and obviously has shown interest in self-care. As we know, some patients put off care — unless they hurt — for years. Personally, I have done more endo in my practice over the past few years than ever before, for people who have simply neglected to receive care or did not follow through with receiving a simple filling. How can you get someone to progress? One effective way is to draw from your own life experiences when talking with a patient. What is something you knew you should do, but procrastinated on doing? Consider talking with your patient about your own experiences with things such as exercising, dieting or servicing your vehicle, for example. As dentists, we know the risks of leaving an infection untreated, and we should be even more cognizant of the impact that it makes on our general health. Does your patient understand that, too? If not, take the time to help him or her understand.

7. “I need to think about it.” At the core of this is mostly a lack of knowledge; thus, the reason the patient may seek out information on the internet, from friends or even from other dentists. You can avoid this by striving to never let the patient leave the treatment or consult room without ensuring the patient has all the information needed to make an informed decision about care. You don’t want the patient feeling like a second opinion or more details are needed.

In a dental scenario, it is morally and ethically advisable to make sure the patient understands the consequences of lack of treatment. Do your part by taking all the time that is necessary to ensure patients understand the prescribed course of action and elect to follow it on their path to dental wellness. ✴
Behind the Product Review with Dr. Howard S. Glazer

Academy of General Dentistry (AGD) emeritus member Howard S. Glazer, DDS, FAGD, of Fort Lee, New Jersey, says it was AGD’s continuing education (CE) model that drew him to the association in 1975.

“I was impressed by the dedication and the professionalism of my colleagues toward CE, and so I joined and never looked back,” says Glazer, a practice owner, former associate clinical professor of dentistry, and internationally known writer and speaker.

Since he joined AGD, Glazer has had many roles within the organization, most notably as AGD past president (1995–96). Currently, he’s chair of AGD’s International Membership Committee.

Glazer’s professional background is extensive: He has been an attending dentist at Englewood Hospital in New Jersey since 1989 and the deputy chief forensic odontology consultant to the Office of Chief Medical Examiner, city of New York, since 1982. He’s also worked as assistant clinical professor at the Albert Einstein College of Medicine Department of Dentistry from 1978 to 1999. Dentistry Today recently named him a 2017 CE Leader.

Glazer also has been published extensively and worldwide, including in AGD’s scientific, peer-reviewed journal, General Dentistry, and newsmagazine, AGD Impact, for which he has written the products review column, “What’s Hot and What’s Getting Hotter,” since 2004. Here, Glazer further discusses how he reviews products and more.

AGD Impact: Why did you join AGD?

Glazer: The camaraderie is terrific. The one thing I’ve always felt we could never put into a brochure is the concept of camaraderie that you have with colleagues with whom you share passion and interests. That’s a key selling point, but yet, one you can’t really sell.

Also, my father, Dr. Jack Glazer, was a member of AGD, and he got his AGD Fellowship in the mid-1970s. I was impressed with what he had to do to get that and his devotion to CE, not only as a student, but as an instructor.

Growing up, did you always want to be a dentist?

Yes and no. My parents wanted me to become a dentist. I started out in college pre-dent and hated it. I ended up taking all my electives as pre-dental, and after college, I actually worked for the television networks.

What exactly did you do, working in TV?

I have a Bachelor of Arts in political science, with minors in English, chemistry and international relations from Fairleigh Dickinson University in Teaneck, New Jersey. I went on to help produce election night coverage.

I worked for a pool operation, News Election Service, which combined the three major news networks (ABC, CBS and NBC) and the two wires at the time (The Associated Press and United Press International). We reported top-of-the-ticket races, so within six minutes of the poll closing, we collected, tabulated and distributed the vote returns around the world. It was pretty impressive. I was assistant director of operations at that organization.

Then, my wife said, let’s apply to dental school. So, totally out of left field, I did it. I got accepted to New York University College of Dentistry and graduated in 1975 with a Doctor of Dental Surgery degree. It was the first three-year program class, so I completed dental school in 33-straight months. That was a blur! And I fell in love with dentistry. I really did fall in love with it, as can be witnessed by the lecturing I do, the amount of teaching I do and the amount of writing I do.

After graduation, I went on to complete a one-year general practice residency at the Bronx Municipal Hospital Center/Albert Einstein College of Medicine. Afterward, I had the wonderful opportunity to practice with my dad for almost 14 years. Then he retired, and I took the practice over. In 1992, I bought a practice in Fort Lee, New Jersey. So, I ran two practices for a while and, ultimately, sold one.

How did your experience in journalism help you in your dentistry career?

It’s easy to say working on a deadline is akin to staying on schedule. I’ve got a list of patients; you’ve got to know how to budget your time so that you can tell the front desk how to appoint people. Being meticulous in detail in journalism is akin to being meticulous in detail when you’re doing dental procedures. And I think being articulate in
writing helps you be articulate in speech. The trick I had to learn was not to write like I speak because it’s a little different. I try to keep my column, “What’s Hot and What’s Getting Hotter,” tongue-in-cheek, as if I’m talking with my colleagues.

When you are reviewing products, what exactly are you looking for?
I review a product based on four elements: It’s got to be faster; it’s got to be easier; and it’s got to be better for me and for the patient, who is the ultimate end user. The quasi-fourth one is it’s got to be reasonably priced — but I try to explain that one away. You should never shop for price; shop for something that’s better for the patients in the long run.

Do you test all of the products that you review?
Absolutely! Nothing makes it to the column or my lectures unless I actually use or have used it. Now, obviously, some products have been replaced over the years because newer and better versions have come out. I get asked fairly routinely: “What does it cost for me to get a mention in your column?” And I say, “It costs you nothing, but if I don’t like it, it’s not going in my column. So, you can send me the product, but that’s it. It doesn’t guarantee anything.”

What’s your strategy for reaching people through your lectures and your column?
My philosophy is to keep it easy, keep it simple, keep it folksy and keep it fun, in a sense. The way that I’m talking to you is the way that I’d sit and talk to my audience. I have a humorous, interactive style. During my lectures, I work with a wireless microphone because I want to be “in your face,” [so to speak]. I don’t care if there’s 1,500 people in the audience, which I’ve had, or if there’s 12 people in the audience, which I’ve had — we’re going to make it interactive because I, as well as the entire audience, learn by the questions asked.

When you go to dental meetings, how do you gauge what your fellow attendees are interested in?
I watch the traffic certain products and booths are getting. When I go eyes wide open, it’s not only for me to go look at new stuff, but even existing stuff to see where the fervor is, to see what’s drawing them. Is it a new laser? Is it a new light for their loupes? Is it new bonding material? I look at it from a lot of different perspectives.

It’s interesting, too, when I walk the hall, how many colleagues come up and say, “Hey, what do I need to go look at?” Or, “What’s the thing that you think I should go see right now?” Or, “What are you recommending for a composite; which one should I go look at?” I’m like a living, walking directory.

I review a product based on four elements: It’s got to be faster; it’s got to be easier; and it’s got to be better for me and for the patient, who is the ultimate end user. The quasi-fourth one is it’s got to be reasonably priced.
THE RISE OF
HPV-
RELATED ORAL CANCER

Exploring the Dentist’s Role in Preventing this Emerging Epidemic

By Kelly Rehan

In March 2007, Jeff Blackburn, DDS, FAGD, of Midlothian, Virginia, had all the energy in the world. He was a single dad of four kids, coached multiple baseball teams, completed sprint triathlons and was merging another dental business into his own busy practice. Then, one Sunday morning, he looked in the mirror and saw a lump the size of a large, unshelled peanut on his neck.

After visiting his physician, Blackburn was prescribed an antibiotic with instructions to call the office if the lump didn’t go away in a week. The lump didn’t go away, so Blackburn returned to his physician for a needle biopsy that revealed malignant cells.

“When you get the news, it hits you, and you go into shock,” Blackburn says. “I always controlled everything in my life. In my egotistical way, I thought, ‘I’m too busy for all this,’ and as the nurse was telling me available appointment times, I realized I wasn’t in control anymore.”

Blackburn had oral cancer, but his doctors didn’t know the cause or the primary source. Five weeks after the diagnosis, doctors discovered the source at the left base of his tongue, and all of the lymph nodes on his left side were infected. There was also a 50 percent chance that the lymph nodes on his right side were infected as well.

Blackburn’s treatment of intense radiation and chemotherapy lasted seven weeks. He underwent 35 treatments of radiation and had chemotherapy once a week.

“The treatment was awful,” he says. “You can’t eat or swallow. You lose your voice and [sense of] taste. You shake from the drugs and cough up blood; ulcers are everywhere in your mouth and throat. Your neck gets raw. You become extremely tired, and you lose a lot of weight. I ended up having to feed myself through a tube inserted into my stomach. I lost 21 pounds.”
Blackburn was expected to miss up to four months of work, but he didn’t miss a day. Six weeks after treatment ended, he completed a sprint triathlon.

Blackburn didn’t have a history of tobacco or alcohol use, which are traditional risk factors for oral cancer. A few months after his diagnosis, his oncologist said new research was showing links between oral cancer and human papillomavirus (HPV) — the most common sexually transmitted infection in the United States today, which has become a major oral cancer risk factor.

**Understanding HPV and Oral Cancer**

Cases of HPV-related oral cancers are rising. The number of oropharyngeal cancers linked to HPV has risen dramatically over the past few decades, according to American Cancer Society. HPV DNA (a sign of HPV infection) is now found in about two out of three oropharyngeal cancers and in a much smaller fraction of oral cavity cancers. A standard for prevention in dentistry is essential to curb this emerging epidemic.

On any given day, approximately 26 million Americans have an oral HPV infection, according to data from an ongoing National Health and Nutrition Examination Survey. Up to 80 percent of Americans will have HPV infections in their lifetime, and 99 percent will clear these infections without consequence or even knowing that they had it, as it produces no noticeable symptoms, according to Centers for Disease Control and Prevention (CDC).

The HPV family contains almost 200 strains, and of all these, nine are associated with cancers. According to The Oral Cancer Foundation, of the nine that are high risk, only one is strongly associated with oropharyngeal cancer: HPV type 16 (HPV-16).

A small percentage of people with oral HPV infections develop oropharyngeal cancer, according to American Cancer Society. CDC reports that each year, on average, 8,000 men and 2,000 women in the United States are diagnosed with cancers of the oropharynx that may be caused by HPV. However, consider that 63 percent of oropharynx cancer cases in women per year is caused by any HPV type, according to CDC, while the percentage in men is 72 percent, making HPV the leading cause of oropharynx cancer.

Also consider the results of the 2011 study in *Journal of Clinical Oncology*, “Human Papillomavirus and Rising Oropharyngeal Cancer Incidence in the United States.” The study found a 225 percent increase in HPV-related oropharyngeal cancers from 1988 through 2004, compared with a 50 percent decline of HPV-negative cancers over the same period.

The increase in incidence is only half the story — the other being whom HPV-related oral cancers are affecting. According to American Cancer Society, cancers of the oral cavity and oropharynx usually take many years to develop, so most patients with these cancers are older than 55 when first diagnosed.

However, people with cancers related to HPV infection now tend to be younger and less likely to be smokers and drinkers. While the American Cancer Society reports that the reason is unclear, some think that it could be because of changes in sexual practices in recent decades — in particular, an increase in oral sex.

To ensure more Americans are protected from cancer, CDC recommends that all adolescents who are 11 or 12 years old get the HPV vaccine. (See “HPV Vaccine Recommendations” sidebar on page 17.) In addition, it’s important for dentists to talk with patients about HPV as a major oral cancer risk factor, as well as screen patients of all ages for oral cancer. Dentists should also be knowledgeable about HPV vaccines and be prepared to discuss them with parents of adolescent patients when the topic arises.

**TIPS FOR TALKING WITH PATIENTS ABOUT HPV AND ORAL CANCER**

Consider these tips to improve dentist-patient communication about HPV and oral cancer:

- Make brochures or other educational literature on HPV-related oral cancers available in your practice’s reception area. Visit www.agd.org/factsheets to download AGD’s latest oral health fact sheet on oral cancer to distribute to patients or use during your discussion.
- Establish your practice’s philosophy on how to approach HPV and oral cancer, and make sure your team is comfortable broaching the subject with patients.
- Add a section to patient questionnaires that indicates whether the patient would like to speak with the provider in private about oral cancer concerns.
This is why, as an oral surgeon, John Alonge, MS, DDS, of Erie, Pennsylvania, performs oral cancer exams on every patient. Early detection is critical. “We’re taught how to do an oral cancer screen, but I’m not sure how many dentists do it on every patient or how thorough they are,” he says. “I get a tongue blade and mirror, and I tell the patient what I’m doing. I can see more than what we’d be normally looking for. Dentists should put that in their repertoire; it only takes 20 seconds at best.”

The gold-standard screening tools, at least currently, are a dentist’s eyes and hands, Alonge says. He notes the emergence of systems such as VELscope® and ViziLite®, which have a role in detection but shouldn’t be viewed as “magic wands.”

“The newer adjuncts shouldn’t be your sole screening source because they’re not foolproof,” he says. “They are not substitutes for your eyes and hands, which provide the best possible screen.”

Alonge says the advantage of such screening devices is they may detect changes in the basement membrane, where HPV-related oral cancers start, so those who advocate for the tools say they can catch the cancer earlier. However, Alonge questions the validity of the results, as reports of lesions being “detected” by the devices have turned out to be noncancerous.

“Collectively, along with the gynecological and ear, nose and throat (ENT) communities, we will come up with an adjunct that could help with early detection,” he says. “We’re not there yet.”

Alonge says when performing an oral cancer screening, dentists should look behind the tongue and tonsil area — sites beyond where dentists are typically trained to look for oral cancer. The infection typically manifests itself in the posterior third of tongue, tonsils and lateral pharyngeal walls, he notes, adding, “If you see something abnormal, you have to test, biopsy and refer.”

Linda Miles, CSP, cofounder of Oral Cancer Cause, says first and foremost, patients and providers both need to be aware of the initial signs of oral cancer: a lump on their neck; a persistent sore throat; hoarseness; or a spot on the roof of their mouth, cheek or gums that won’t heal.

The reasons many oral cancers aren’t discovered until the late stage are because dentists are not recommending biopsies on early indicators, or patients are not following through by going to an oral surgeon or ENT doctor for a biopsy, she says.

“Doing complete oral cancer screenings is standard of care for all dentists, but sadly, fewer than 20 percent of all practices are doing an advanced two- to three-minute screening,” says Miles, who adds that salivary testing is gaining popularity as a diagnostic tool.

“The real paradigm shift is that with salivary diagnostic testing, we can now determine who carries the HPV-16 and HPV-18 strains, which cause oral cancer,” Miles says. “The salivary testing has been termed ‘the liquid biopsy’ by some.”

Because more than 90 percent of HPV infections will go away within two years, the role of salivary testing is to identify patients who should be followed closely to determine if their immune system has cleared the infection, Miles says. Outside of screening every patient at every exam, she adds that dentists can prevent HPV-induced oral cancers and save lives by educating patients.

Desexualizing HPV: The Patient Education Approach
Because HPV is transmitted through sexual contact, dentists may find themselves in a challenging position when it comes to preventive discussions with patients. Striking a balance between maintaining a comfortable, professional relationship with patients and educating them about the disease can be difficult.

Jacquelyn L. Fried, RDH, BA, MS, of University of Maryland School of Dentistry, Baltimore, suggests reframing the conversation. HPV should be desexualized and instead viewed as an infection that could lead to head and neck cancer, she recommends.

The three HPV vaccines approved by the FDA have been recommended for children as young as 9 years old. Fried says many health care professionals consider early adolescence, such as 11 to 12 years old, a more appropriate time to broach the subject with patients and parents.

“There are no data to suggest that addressing the topic early encourages high-risk sexual activity among young

**HPV VACCINE RECOMMENDATIONS**
Three vaccines are approved by the FDA to prevent HPV: Gardasil®, Gardasil 9 and Cervarix®. All three vaccines prevent infections with HPV-16 and HPV-18, though some formulations are approved for females only.

- **All children — girls and boys — ages 11 or 12 should be routinely vaccinated for HPV. The vaccines may be started as early as age 9.**
- **All children and adults (males and females) ages 13 to 26 should be vaccinated if they haven’t received the vaccine already.**
- **The vaccines are most effective when given before they become sexually active. CDC recommends 11- and 12-year-olds receive two doses of HPV vaccine at least six months apart rather than the previously recommended three doses. Those who start the series later, at ages 15 through 26, will still need three doses of the vaccine to protect against cancer-causing HPV. For more information about CDC’s “Pre-teen Vaccine” campaign, visit [www.cdc.gov/vaccines/who/teens/index.html](http://www.cdc.gov/vaccines/who/teens/index.html).**

Sources: American Cancer Society, CDC and National Cancer Institute
adults,” says Fried, who has spoken nationally and internationally on HPV and oral cancer. “Dentists and dental hygienists are ethically obligated to bring up the subject of vaccination.”

Fried says each practice needs to establish its own philosophy on how to approach HPV and oral cancer with patients. For instance, as providers conduct their head and neck cancer screenings, they can address the subject. Another opportunity could be during a general conversation about wellness. Providers may feel more comfortable having the HPV conversation with longtime patients, or they may want to discuss the topic with parents of young adults, she suggests.

**Roughly one person every hour of every day is expected to die from oral cancer.**

— The Oral Cancer Foundation

“Telling a young person that high-risk sexual behaviors can lead to head and neck cancer is within the oral health professional’s purview,” Fried says. “One is not asking a patient what he or she did last Saturday night. The issue of transmission is a fact. Prying into a patient’s private life is unnecessary. It is an educational discussion.”

In her home state of Maryland, Fried says all dentists and dental hygienists received a letter from the Maryland Department of Health and Mental Hygiene, strongly recommending their involvement in encouraging the HPV vaccine. Such widespread statements from government and professional associations may encourage more providers to be proactive about HPV, she says.

As with any sensitive topic, with some practice, providers will become more comfortable discussing it with patients, she says.

“There was a time when helping patients refrain from tobacco use was almost taboo, yet today it is and/or should be a standard of practice,” Fried says. “I liken the normalization of tobacco interventions to what I hope will occur with patient-provider discussions about HPV.”

**Providing Support for Patients with Oral Cancer**

Nearly 10 years after his diagnosis, Blackburn is cancer-free and now uses his experience to give back to those who are fighting the disease.

Radiation oncologists in the Richmond, Virginia, area send patients his way. He makes sure each patient’s mouth is “in incredible condition” prior to starting cancer treatment, as gum disease, tooth decay and other diseases can cause severe consequences during radiation, such as oral mucositis and difficulty

**ON-DEMAND WEBINAR:**

**HUMAN PAPILLOMAVIRUS (HPV) AND HEAD AND NECK CANCER**

Visit [www.agd.org/olc](http://www.agd.org/olc) to view AGD’s on-demand webinar, “Human Papillomavirus (HPV) and Head and Neck Cancer,” presented by Eric R. Carlson, DMD, MD, FACS. After viewing this webinar, attendees will be able to describe:

- The increasing incidence of oral cancer in young people
- The molecular events involved in carcinogenesis associated with HPV, particularly with regard to the early proteins E6 and E7
- The social habits associated with tongue cancer
- The public health initiatives associated with HPV vaccination

This webinar is part of the members-only Free CE Program and was presented in collaboration with American Association of Oral and Maxillofacial Surgeons.

**GET INVOLVED DURING ORAL CANCER AWARENESS MONTH**

April is Oral Cancer Awareness Month, and it’s an opportunity for your dental practice to participate in community-wide education and prevention. “Educating communities can spread the knowledge faster and attract new patients to a practice,” says Linda Miles, CPS, cofounder of Oral Cancer Cause. Here are some ideas to consider:

- Host cancer screening events at your office throughout the month.
- Sponsor a “fun run” to boost awareness and fundraise.
- Offer stickers for each patient to wear after they receive their oral cancer screening.
- If you’re an AGD dentist in Nevada, volunteer to provide oral cancer screenings during AGD2017 in Las Vegas. Volunteer forms, which can be found at [www.agd2017.org/the-agd-foundation.aspx](http://www.agd2017.org/the-agd-foundation.aspx), must be submitted to AGD by June 15.
Blackburn’s involvement in these patients’ lives doesn’t end with the pre-treatment dental exam. He mentors patients throughout the entire cancer treatment process by talking with them on the phone, sharing what they might expect from therapy and simply listening.

“We are in the business to cure disease and educate people so they have a better life — that’s dentistry,” Blackburn says. “In treating cancer patients, they may receive a lot from me, but I get far more out of it than they do because of the difference I’ve made in their lives.”

The Importance of Early Oral Cancer Detection

By Linda J. Edgar, DDS, MEd, MAGD, AGD Foundation Vice President, AGD Past President

About a year and a half ago, I was experiencing one of the most stressful periods in my life. I had been caring for my mother and was traveling back and forth from Seattle to Portsmouth, Virginia, every two weeks to organize and provide care, as I was her medical power of attorney. I was also practicing dentistry during this time and really felt as if I had a 24/7 job with everything combined.

In September 2015, I developed a fever blister on my inner lower lip. I thought it was probably due to stress, poor diet from traveling and lack of sleep. I purchased over-the-counter medications that did not help and then went to a dermatologist in December. She gave me a cream that was painful to use and made no difference. The sore would ulcerate, then crust and fall off, and then ulcerate again. The area never fully healed. My husband, who is also a dentist, examined the sore and recommended a biopsy, which I had done in January 2016. The oral surgeon was a friend and rushed the report, which came back a week later with a diagnosis of squamous cell carcinoma of the lower lip. This diagnosis left me feeling very anxious because the determination of how much lip, face or jaw would have to be removed is not made until the surgery actually occurs. I left the oral surgeon’s office shaking and called my office to cancel my afternoon appointments with patients.

I met with a well-known head and neck surgeon at the University of Washington, as well as the head of the oral medicine department, Dr. Edmond Truelove. He looked at the lesion and determined that a Mohs surgery could be done if it hadn’t spread, and it hadn’t. In March, the Mohs surgery was done, and the cancer cells were removed with two cuts. The second cut removed most of the lower lip, but they were able to save most of the vermillion border.

The next day was the reconstruction surgery, which took about five hours. Forty-two stitches later, I woke up in the recovery room with a large bandage across my whole lower lip that I had to wear for 10 days.

After the surgery, I wore a surgical mask at work and at home. I took about a week off from work. My lower lip remained swollen for about six weeks. My diet consisted of Jell-O, pudding, lukewarm soup and ice cream for about a month. My lower lip is still numb; it was painful to brush my teeth for about six months, and I often used a cotton swab. It still hurts to touch the area and apply lipstick. The area also is very sensitive to spices and sugar. I am constantly aware of the tingling in my lower lip.

So, why did this happen to me? The biggest reason probably was because I was a serious competitive runner and triathlete from ages 28 to 38, often running 120 miles a week and biking several 100-mile rides out in the sun. I have never smoked, rarely drink alcohol and have been with the same marriage partner for more than 50 years. I have never had Botox or anything injected into my lips or face.

I have been encouraged to tell my story as a reminder for dentists to screen more often and refer for biopsies for areas that are not healing in our patients’ mouths. I also want to show how scary this positive diagnosis can be and the importance of early diagnosis.

The Academy of General Dentistry (AGD) Foundation’s mission is to promote oral cancer awareness and education, as well as provide screenings. Of course, this mission has become much more personal for me. It would be my vision to see AGD take the lead in the country and have proactive action and education in every state to help prevent this disease. If each member donated $25 to the foundation, we could accomplish this vision.


Kelly Rehan is a freelance journalist based in Des Moines, Iowa. To comment on this article, email impact@agd.org.
Today, most of us are familiar with what is commonly referred to in the hospitality industry as “five-star customer service.” But what exactly is it? According to seasoned service expert Bryan K. Williams: “[Five stars] is not an award; it’s a declaration to your team that good is not good enough and only excellence will do.”

Five-star service is easy to talk about. However, it’s much more difficult to deliver, and this is something I know firsthand. Long before I became a dentist, I worked for American hotelier Barron Hilton and other executives at Hilton Hotels Corporation (HHC). During my 13-year tenure at HHC, I experienced some of the greatest professional training in the world — training that incorporated leadership, accountability, the value of human capital and “customer service like no other.” This type of world-class service was at the core of HHC’s existence — a service woven into the fabric of the culture in which every team member’s livelihood was dependent upon how well they treat their guests.

As Norm Merritt, business expert and CEO of point-of-sale platform ShopKeep, wrote in Entrepreneur.com: “An exemplary customer care experience can completely redefine how someone feels about a brand. It can turn a one-off purchase into a lifetime of loyalty and transform an average consumer into a passionate brand advocate.” In the case of your dental practice, what type of experience are you providing your patients? Will they be loyal to your “brand” of dentistry, or will they look for another provider after one or two visits? Here’s where providing five-star customer service can differentiate your business from the competition.

Provide an Above-Average Patient Experience

Start today by redirecting your focus to “customer service first,” or “do unto others as you would have done to you.” It is a powerful credo that produces tremendous results, including a lifetime of patients built upon long-term
There is no external marketing piece, discount dental plan, PPO, secret sauce or magic bullet that will ever replace service with a smile, a “be my guest” attitude and a sincere commitment to a culture of caring for others.

relationships. As Bill Quiseng, award-winning writer in the area of customer service, says: “Nobody raves about average.” In clinical dentistry, average is considered the best of the worst and worst of the best. I don’t know about you, but I have never met a patient who recommended their friends, family or colleagues to the “average” dentist.

So what can you and your team do to provide an above-average experience? Review the patient’s records the night before his or her appointment and make note of something unique about the person. Maybe it is an upcoming anniversary, graduation, birthday or vacation. Show your patients how much you care by taking an interest in their lives. Learn to build rapport that leads to trust and long-term relationships.

There is no better way to promote your business than through your existing clientele. It is estimated that it costs five to seven times as much to acquire new patients than to keep your existing ones.

A poor customer service experience can result in catastrophic outcomes for the dental business. Considering 77 percent of patients consult online reviews as a first step to selecting their doctor, it is critical to protect your business reputation. Today, the disgruntled, frustrated or unhappy patient has a seat at the table and will not hesitate to take his or her complaint to the internet for the world to read on Yelp, social media, etc. How are your reviews? Do you have a quality management program in place? Are you measuring key performance indicators, such as the number of new patients, attrition rate, patient satisfaction, efficiency and on-time performance?

Patient complaints and poor reviews should never be ignored or overlooked. To the contrary, employees should be empowered to make decisions so every patient feels heard and cared for. Immediate resolution without escalation should be the norm.

**Prepare Your Team for Optimal ‘Customer Relations’**

Dentistry is a customer service-based industry. As David O. Willis, DMD, MBA, CFP, wrote in “Business Basics for Dentists” (2013), “Dentists market a service, not a product.” Patients can see it, feel it and hear it. Unfortunately, this means that our diagnostic and clinical skillsets are no longer the sole determinant of whether we succeed or fail. In addition to being proficient in the operations of the business, we also have to hire and provide comprehensive training to the right people, as they will ultimately be responsible for our practice’s customer relations. How can you prepare your staff to anticipate and fulfill each patient’s needs? Think Ritz-Carlton style.

The Ritz-Carlton is known for its legendary customer service. So what are the secrets to its success? According to a PSA Financial Services Inc. “PSA Perspective” blog post — which summarized a recent seminar presented by Joseph Quitoni, The Ritz-Carlton’s corporate director for culture transformation — The Ritz-Carlton strives to ensure sufficient training is provided. For instance, it offers new employees a lengthy orientation, during which staff are told they should be making eye contact, smiling, remembering guests’ names and consistently providing exceptional service. Also, every morning at every Ritz-Carlton location, the staff holds a 15-minute “Daily Line-Up” to discuss the plan for the day, talk about special events and important guests and share an inspiring quote. “This is our answer to sustained culture,” Quitoni told his audience. The emotional connection you make with your patients is just as important as the service you provide. Remember, as dentists, that is what we sell — quality services, not products. While patients’ needs may vary, their bias for quality never does. The delivery of legendary service begins by anticipating and delivering the unexpected. Enthusiasm, compassion, charisma and empathy are all attributes of high-quality employees who possess excellent customer service skills.

**Create a Culture of Caring for Others**

Operating a flagship hotel such as the Hilton is a demanding responsibility where guest services, life safety systems and attention to detail are paramount to success. Analogous to the hotel industry, today’s successful dental practice is built upon a philosophy of caring for others. The dental business whose culture embraces the patient’s emotional and social needs while valuing interpersonal relationships will seldom experience a problem with patient retention. A culture that welcomes every patient as if they were the last. A culture that implores the patient to “be my guest.”

There is no external marketing piece, discount dental plan, PPO, secret sauce or magic bullet that will ever replace service with a smile, a “be my guest” attitude and a sincere commitment to a culture of caring for others. As the great Walt Disney once said: “Whatever you do, do it well … [so] when people see you do it, they will want to come back and see you do it again and bring others …” ✨
TESTING THE TOOLS

What’s Hot and What’s Getting Hotter

By Howard S. Glazer, DDS, FAGD

FitStrip™ Interproximal Finishing and Contouring System
Garrison Dental Solutions LLC
www.garrison dental.com

Interproximal finishing and polishing is a must whenever restoring a class II, III or IV. However, it is often difficult to achieve. Garrison’s new FitStrip device is ideal for interproximal trimming (even light orthodontic interproximal reduction) and composite finishing. Regarding the product name, “Fit” actually stands for “Flexible Interproximal finishers — with a Twist.” This novel system has a handle that will attach to a variety of FitStrips that have a twistable top that locks, letting you use them curved, to fit the curvature of the tooth, or rigid for interproximal separation and/or finishing. The handle makes it quite easy to position and hold the FitStrip in place while contouring and finishing, with full visibility. The starter kit has everything you will need, including two handles, four each of multiple diamond grits (both single- and double-sided strips) and two serrated strips, neatly packed and color-coded for easy reordering. The strips are durable and can be autoclaved multiple times without losing their effectiveness. FitStrip is inexpensive and invaluable, which makes this an “in” product to have for providing a perfect restoration.

CASI Instrument
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www.cosmedent.com

Cosmedent provides excellent composite resins that we can use in both posterior and anterior restorations; it has also developed instruments that can help us place the composites to achieve a better result. CASI (Composite Anterior Sculpting Instrument) is a wonderful tool for shaping and contouring anterior composites. There are actually two instruments: one for cuspids and central, which has a wider blade (3C), and one that is more universal and ideal for laterals, called a universal blade (3L). You can quickly and easily shape and contour anterior class III, IV and V restorations, as well as direct resin veneers with these efficient, curved instruments. Both instruments have a titanium, nonstick surface and a sharp tail end for “tucking” into the interproximal areas and/or removing excess composite. The titanium surface allows you to easily spread, shape and smooth the composite. Bravo to Dr. “Buddy” Mopper and his creative team for a great instrument to help us achieve a great esthetic result.
Howard S. Glazer, DDS, FAGD, practices in New Jersey. For more than 24 years, he has lectured and published articles on various areas of dentistry. To comment on this article, email impact@agd.org. Glazer has not received any remuneration for the products mentioned. All reviews are the opinions of the author and are not shared or endorsed by AGD Impact or the Academy of General Dentistry.

TheraCem™ Self-Adhesive Resin Cement
BISCO Inc.
www.bisco.com

It was only a matter of time before the company that gave us TheraCal LC®, a super product for indirect and direct pulp-capping, would develop a bioactive-type cement that would also help protect the pulp. Bisco’s TheraCem is a self-adhesive resin cement that is ideal for cementing crowns, bridges, inlays, onlays and all types of endodontic posts. This dual-barrel, automix syringe can be used with zirconia (no priming or etching required), as well as other material substrates such as lithium disilicate, titanium and stainless steel. With zirconia restorations, TheraCem demonstrated a high shear bond strength when compared with other brands. TheraCem offers continuous fluoride and calcium release over a nearly two-month period. It is radiopaque and easy to clean up. TheraCem transitions from an acidic state to an alkaline pH in minutes for maximum patient comfort. This is a great, easy-to-use, reliable cement for ensuring a high bond to zirconia, as this indirect restorative material continues to grow in popularity. It can also be used reliably with our other restorative crown and bridge materials for long-term, healthy cementation.


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Describe a memorable mentorship experience you’ve had in your career.

Steven A. Ghareeb
My father, Dr. Sami Ghareeb, has been the best mentor not only in life, but also in dentistry. I had the opportunity to work with him directly out of dental school in what we call the “Dr. Ghareeb residency.” During that year, we worked side-by-side, and I learned a wealth of information.

One of the more memorable situations was when he was elbow-deep in a surgical extraction and something went wrong. I don’t recall exactly what happened, but there was suddenly significant bleeding, and the scene made me flinch and break into a sweat. My mind started racing through all the emergency scenarios they taught us in dental school, and I wondered how my dad was going to respond. As I was standing there, freaking out in my mind, I watched my dad continue with the procedure as if nothing had happened. He pressed on and removed the rest of the splintering tooth, and after observing my reaction, he pulled me aside for a discussion. That day, I was taught to never lose my cool no matter how intense things get. My father explained to me how our reactions as doctors can strongly influence the patients’ and staff members’ reactions (and blood pressures) as well.

Steven A. Ghareeb, DDS, FAGD, is based in South Charleston, West Virginia.

Jennifer S. Bell
One summer, I came home from college and scheduled my routine dental checkup and cleaning. My dentist was asking questions about my future plans and my major. I answered that I was considering medical school and finishing my requirements. He said, “Oh, you [should] go to dental school. Our field needs more people just like you.” And then he offered me a job for the summer. That summer, I cleaned rooms, sterilized instruments, assisted chairside and so much more. I left that summer job ready to become a dentist. Had he not taken the time to get to know me, or taken the even bigger leap of offering me an opportunity to learn, I would not be a dentist today. I am so thankful for Dr. Keith Phillips and his mentorship throughout my career.

Jennifer S. Bell, DDS, FAGD, is based in Holly Springs, North Carolina.

Mai-Ly Duong
A memorable experience I had was with an instructor, Dr. Tannaz Malek, at an Arizona AGD MasterTrack® periodontal course. She taught us how to perform connective tissue grafts. A couple months after the course, I finally found an ideal patient who needed a minimal connective tissue graft in an unaesthetic area. I contacted Dr. Malek, and she reviewed key concepts with me over the phone multiple times before the “big day.” She even spent time the night before the procedure listening to me talk through every step I was going to perform and giving me words of encouragement. I took images throughout the procedure, and afterward, she provided constructive feedback on each step I completed. It meant so much to me that she took time out of her busy schedule to genuinely mentor me and help me succeed.

Mai-Ly Duong, DMD, FAGD, is based in Gilbert, Arizona.
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