DENTAL TRIBUNE

The World's Dental Newspaper · U.S. Edition

Nov. 17–23, 2008 www.dental-tribune.com Vol. 3, No. 41

Help invent the future of informatics in dental care and research

By Titus Schleyer, DMD, PhD

Dentistry is going digital. Computer-based patient records, digital impressions, 3-D models, CAD/CAM, personal dental records, online scheduling and teledentistry are some of the technologies that only recently have seen the light of day. But have you ever wondered how these innovations are created? Where are the people who have these ideas and make them real? How are they trained?

You'd be surprised to hear that innovators are found nearly everywhere in dentistry — in the corporate R&D departments of industry, public and private research institutes, universities and dental practices. Engineers, computer scientists, cognitive and quantitative psychologists, information technology specialists and computer-savvy dentists all contribute to the technological revolution of dentistry. Should you be one of them?

Some of us are quite happy observing the steady stream of new technologies, and picking and choosing what appears useful and usable to us. Others take a more conservative approach and adopt few or none of the newfangled gadgets and technologies. Still others are not happy with just watching the revolution occur — they want to shape it.

It is for these individuals this column is written. We want you! Through our training program in dental informatics (see *di.dental.pitt.edu/postgrad.php*), we educate tomorrow's leaders of the technological revolution in dental care and research. The program is targeted at people with bright ideas who want to change the practice of dentistry.

Gaining the expertise and knowledge to help lead the technological revolution in dentistry requires some work. Our program offers a master's or PhD degree in biomedical informatics with a concentration in dental informatics; a postgraduate program is available (see Table, Page 6). Degree programs are composed of a rigorous didactic component and in-depth research training, beginning in the first semester. Trainees are expected to fully immerse themselves into the science of biomedical informatics, and to present and publish their work frequently.

The University of Pittsburgh Biomedical Informatics Training Program provides a unique setting and environment for future dental informatics researchers. More than 25 core faculty interact with and teach the approximately 35 trainees enrolled at any one time. Trainees come from a variety of backgrounds — medicine, dentistry, nursing, psychology, computer science, infor-

See HELP, Page 6

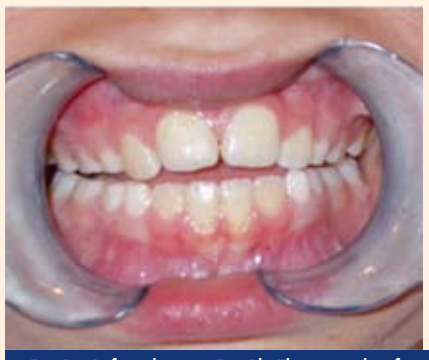
Inside this week

The critical missing element to complete care: where dentistry and orofacial myofunctional therapy meet (*Part 2 of 2*)

By Joy L. Moeller, RDH, BS, COM

Types of therapy programs offered

I have been practicing orofacial myofunctional therapy for 30 years and have treated thousands of patients. My son had this problem when he was 7 years old and I witnessed the positive change in his teeth, headache pain, and attention deficit disorder (ADD) and temporal mandibular dysfunction (TMD) issues. The dramatic results motivated me to study everything available in OMT. I began a private practice in OMT in addition to my dental hygiene practice in 1978. I love the challenge of helping improve the quality of my patients' lives. I have five different programs I offer to my patients:



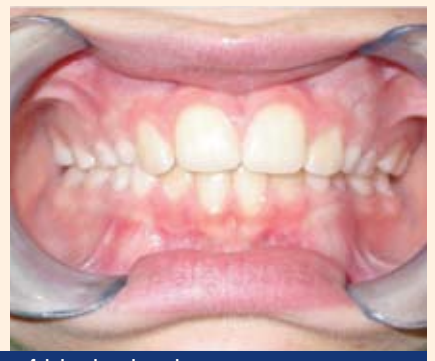


Fig. 1a: Before therapy. Fig. 1b: Three months after successful thumb sucking therapy.

- Habit Elimination Therapy
- Mini-Myo Program for the young

See CRITICAL, Page 4

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Trade news

- 3M Co. in Minnesota increased third quarter sales of oral care products 15 percent.
- GlaxosSmithKline in the UK agreed to pay $170 million to purchase Biotene for the treatment of dry mouth syndrome from Laclede in California.
- Zimmer Holdings in Indiana increased third quarter sales in its dental implant business 3 percent to $52 million.
- According to a P&G survey, a third of people in the United States believe that a little gum bleeding is normal when they brush their teeth.
- American Dental Supply in Pennsylvania agreed to acquire Leach & Dillon Products in Rhode Island for an undisclosed sum.
- Dale Dental in Texas introduced an online case entry Web site for dental labs that automatically prints air bills to ship cases and prints unique PanTags™ to aid in production planning.
- Two investment firms acquired Dental One Inc., a privately owned practice management firm in Texas. Dental One generated annual revenues of $55 million from its approximately 60 dental offices in the southwestern United States.
- The state of Arkansas is considering opening a new dental school at the University of Arkansas. If approved, this would be the only dental school in the state.
- Great Expressions Dental Centers in Michigan purchased ConsoliDent Inc., a dental chain with 41 affiliated practices in Florida and Michigan.
- Kettenbach in Germany is launching its line of impression materials in the United States. through its newly formed California subsidiary. The firm will market these products directly to dentists.
- Zila Inc. in Arizona engaged the investment-banking firm William Blair & Company in Chicago to shore up the company's capital structure and further evaluate opportunities for growth.
- Researchers at the UCLA School of Dentistry are developing a test to detect oral cancer by measuring protein levels in saliva.
- D4D Technologies Inc. in Texas announced that its E4D Dentist system can now make restorations with Ivoclar Vivadent's high-strength IPS e.max CAD LT material.
- Infinity Medical Group Inc. in Canada contracted with Kerry Associates to develop a franchise strategy for its dental implant and cosmetic medical laser clinics.
- Nobel Biocare North America in California announced that it is offering dentists who purchase a minimum of 15 dental implants a free Web site with one year of free hosting.
- Dr. Jane Grover, vice president of the American Dental Association, testified before the United States Congress urging members to get more dentists to participate in Medicaid for low-income children.
- CMP Industries in Albany, N. Y. reported that its Nobilium/Ticonium division opened a new distribution center in central Florida to serve the southeastern United States.
- Internet Dental Alliance in Tiburon, Calif. is now providing its Nine Truths dental office marketing program online.
- Turnkey Opportunities Inc. in Exton, Pa. is now marketing the TKO™ Dental Assisting School Program, which allows dentists to use their existing facilities to train assistants and generate significant new revenue.
- Dental, medical and other biomedical sites created more than 1.5 billion pounds [0.68 billion Kg] of biomedical waste in 2006.
- 3M ESPE donated $45,000 to Oral Health America's Smiles Across America program.
- Aspen Dental in New York opened a new dental office in Flint, Mich.
- Bright Now! Dental in California reported that all of its offices in Oregon and Washington state are now offering Lumineers veneers at $1,200 per tooth.
- Turku University's Institute for Dentistry in Finland developed a baby pacifier that releases xylitol and probiotics to boost children's immune systems.
- Henry Schein Inc. sponsored its 11th annual Back to School program that provided more than 1,500 children with back to school clothing and supplies.
- National Dentex Inc. purchased Dental Art Laboratories in Michigan. This adds more than $7.5 million in additional revenues.
- Philips Oral Care launched the Philips Sonicare HealthWhite power toothbrush that can whiten teeth two shades after two weeks of use.
- Sales of mouthwash products in the United States increased 4.7 percent last year to $3.45 billion.

Fight oral cancer!

Did you know that dentists are one of the most trusted professionals to give advice? Thus, no other medical professionals are in a better position to show patients that they are committed to detecting and treating oral cancer.

Prove to your patients just how committed you are to fighting this disease by signing up to be listed at *www.oralcancerselfexam.com*. This new Web site was developed for consumers in order to show them how to do self-examinations for oral cancer.

Self-examination can help your patients to detect abnormalities or incipient oral cancer lesions early. Early detection in the fight against cancer is crucial and a primary benefit in encouraging your patients to engage in self-examinations. Secondly, as dental patients become more familiar with their oral cavity, it will stimulate them to receive treatment much faster.

Conducting your own inspection of patients' oral cavities provides the perfect opportunity to mention that this is something they can easily do themselves as well. You can explain the procedure in brief and then let them know about the Web site, *www.oralcancerselfexam.com*, that can provide them with all the details they need.

If dental professionals do not take the lead in the fight against oral cancer, who will? And in the eyes of our patients, they likely would not expect anyone else to do so — would you?

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The World's Dental Newspaper · US Edition

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CRITICAL

From Page 3

child
- Orofacial Myofunctional Therapy
- Special Needs Therapy
- Cosmetic Muscle Toning for facial fitness

Habit elimination therapy

My program for habit elimination treatment is three to five visits. I work with thumb and finger sucking, nail biting, hair chewing, tongue and lip sucking and/or chewing, and many other oral habits with a 95 percent success rate.

Rosemarie A. Van Norman , an expert in the field of thumb sucking, has determined:
- 60 percent of malocclusion is caused by prolonged digit sucking;
- 10 percent of 6–11 year olds suck their digits;
- 85 percent of digit suckers exhibit an open bite;
- many times, open bites lead to TMD due to lateral movements of the jaw in order to chew food;
- 49.9 percent of orthognathic surgery patients with open bite relapse;
- 59 percent of digit suckers experience atypical root resorption;
- 40 percent of digit suckers have learning and behavior problems in school.

Figs. 2a, 2b: Patient presented with TMD, many oral habits, headaches and depression. After eight months of myofunctional therapy, all symptoms have subsided. Note the change of facial symmetry.

Infants are born with only a suckling skill, which enables them to survive. Usually, at 9 months to 3.5 years, the child starts drinking from a cup and eating more solid foods and transitions from suckling to sucking, which is supposed to be used in only a few situations, such as using a straw. However, many times a pacifier is used or the child finds his or her thumb or another object, and the suckling habit is extended and continued. At this point, the tongue is unable to rest and swallow correctly, leading to an open bite, cross bite or some other type of malocclusion.

The program that I follow uses behavior modification and positive reinforcement. The patient feels so proud to have ceased the habit once and for all. The success of this program will empower patients to control many choices in their lives that feel good, but that they know is wrong for them. As a dental hygienist, I have learned that the value of pro-active therapy is to minimize or eliminate problems by treating early.

The Mini-Myo Program for the young child

Many times young children can benefit from doing exercises to develop positive growth factors and eliminate negative growth pressures. The young child program has to be fun and fast in order to achieve success. Because the bones are soft, the changes can be remarkably fast. I use a variety of rewards and behavior modification techniques. Parental support at home is essential. The young child program lasts from three to six months and can make a major life enhancing change.

The goals of the Mini-Myo Program include:
- encourage nasal breathing,
- develop a lip seal,
- implement a palatal tongue rest posture,
- encourage bilateral chewing,
- work on proper sleep posture as well as eating posture,
- introduce the “bite, sip, and swallow back” motion,
- keep hands and objects away from the face.

Orofacial Myofunctional Therapy

This is my standard program for those ages 7 to 97. It consists of a yearlong program of therapy exercises for creating proper patterning of the tongue and facial muscles and includes:

a) noxious habit elimination;
b) many different therapy exercises to stretch, tone and develop proper neuromuscular proprioception of the facial muscles;
c) introducing the proper chewing and swallowing patterns;
d) development of proper head and neck posture;
e) habituation of the new patterns.

The first eight weeks of treatment is the intensive period, followed by habituation of the new pattern.

Special needs patients

These patients need an individual program based on their physical limitations, pain factors and ability to cooperate. The treatment plan always needs to be individualized for the best result possible. The goals would be the same as the other programs, but the methods are customized to meet the needs of the patients. The patients really appreciate this help that no other specialty has been able to provide. Some patients with special needs afflicted with incorrect muscle patterns would present:
- TMD
- Autism
- Cerebral palsy
- Down syndrome
- Attention deficit disorder
- Bells’ palsy
- orthognathic surgery
- trauma-induced muscle abnormalities
- Sturge Weber syndrome

Cosmetic muscle toning for facial fitness

With age, orofacial posture changes. There are about 40 facial muscles that work in group function. This allows for facial expression. If the patient presents with chronic non-nutritive facial muscle habit patterns, inadequate orofacial postural patterns, orofacial muscle function patterns or orofacial muscle integration patterns, then the overall cosmetic appearance will be compromised in spite of cosmetic surgery or orthodontics.

Plastic surgery patients are tired of having their face cut, burned, injected, creamed and acid etched only to have gravity pull the muscles down again. The more effective way to achieve desired results would be to develop tone and fitness in the facial muscles by changing muscle patterns, habits and postures by a trained orofacial myofunctional therapist and work with the surgeon and orthodontist both before and after surgery. A personal trainer will tell you that you have to stretch, lift weights and do cardio three to four times a week in order to be fit. Why not exercise your face as well? I feel that this type of treatment will be the way of the future for orofacial myofunctional therapists.

In Brazil, plastic surgeons would not think of doing surgery without having a trained orofacial myofunctional therapist to work with them. The field of cosmetic orthodontics is growing. It is only natural that cosmetic orofacial myofunctional therapy will follow.

Orofacial myofunctional courses and certification

For speech and language pathologists, dental hygienists, physical therapists, registered nurses, and other allied health care profession-

Figs. 3a, b: This 61-year-old female exhibits low muscle tone, digestive disorders, short lingual frenum and anterior tongue thrust. After two months of therapy, patient feels better and her friends are commenting on how much younger she looks. She is now ready to pursue orthodontic and restorative treatment.

als there are currently four or five post-graduate courses available to help you become an orofacial myofunctional therapist. Certification is available through the International Association of Orofacial Myology.

After taking an approved IAOM course and becoming a member of the IAOM, one can apply to take a written exam and an on-site practical evaluation. The courses are usually five intensive days with a recommendation to follow up with an internship and other courses of study in the field. For more information, check out the IAOM Web site, *www.IAOM.com*.

Practicing OMT guides patients toward making major life enhancing changes that affect their entire body. After 30 years of practicing and teaching courses in OMT, I view the profession of OMT as a specialty of its own, working parallel with orthodontic treatment, and one that is the critical missing element to complete care.

The author would like to thank Karen Macedonio, a certified Life coach (and patient), Barbara J. Greene, COM, and Licia Coceani-Paskay, MS, CCC-SLP, COM for their assistance with writing this article. A complete list of references is available from the publisher.

To find a therapist near you, go to www.iaom.com *and look at the directory.*

Study OMT!

Joy Moeller will teach a seven-day IAOM-approved course on orofacial myofunctional therapy (which includes two days of internship) on Feb. 11–17 and June 24–30, 2009 in Los Angeles with Barbara J. Greene, COM, and Licia Coceani-Paskay, MS, CCC-SLP, COM. For more information contact Greene at bgreene@tonguethrust.com or call (805) 985-6779.

Contact info

Joy Moeller, BS, RDH, COM, is a certified orofacial myofunctional therapist and a licensed registered dental hygienist. She is in the exclusive private practice of OMT in Pacific Palisades and Beverly Hills, Calif. She is currently an elected member of the Board of Directors of the IAOM and is the hygiene liaison. Joy is also a former associate professor at Indiana University School of Dentistry and an on-going guest lecturer at USC and UCLA to ortho, perio and pedo dental residents, and at Cerritos College to hygiene students.

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HELP

From Page 1

mation science and biology, just to name a few. Taken together, these individuals create an intellectually stimulating and rewarding environment dedicated to the pursuit of science and discovery.

Dental informatics students take most of the same courses as other trainees, but have a track of nine didactic credits for their specialty. All of them participate in dental informatics research from the first day in the program. Early research experiences typically occur as part of a group mentored by one or more faculty members, while subsequent research, such as the MS project or PhD thesis, becomes increasingly independent.

Program	Duration	Credits	
		didactic	*research*
MS	2 years	28	11
PhD	3-5 years	54	18
Postdoc	2 years	non-credit research	

Table: Summary of degree and postdoctoral programs

Research projects are chosen from a broad range of topics. Most of our research involves clinical informatics and thus is focused on the application of computers in patient care. PhD student Jeannie Irwin is currently working on a grant-funded project to develop a natural language interface to electronic dental records, which will make it possible for dentists to record findings and planned treatment without using complex computer commands. Dr. Humberto Torres-Urquidy is working on reference terminology for dental findings and diagnoses, while Dr. Amit Acharya is developing an information model for patient records in general dentistry.

Other research projects include the design of an electronic dental record centered on the cognitive requirements of clinicians, 3-D visualizations, the development of a virtual community for people interested in dental informatics, and systems to help biomedical researchers find the most appropriate and qualified collaborators.

The program prepares individuals primarily for research and teaching careers in dental informatics; other career options include positions within larger dental care delivery organizations, such as group practices and independent practice associations to support the application of computer technology. Dental software developers, such as dental practice management system vendors, also require the expertise offered by dental informatics specialists.

Trainees come from a wide variety of backgrounds. While some are dentists, that is not a precondition for admission. The mix of individuals from different backgrounds ensures that many different ideas and viewpoints come to bear on solving scientific problems.

For U.S. citizens and permanent residents, financial support from the National Institute of Dental and Craniofacial Research (NIDCR) is available. The NIDCR funds provide a stipend, tuition, fees and health insurance support, travel subsidies, and a state-of-the-art computer. These positions are highly sought after and admission is very competitive. The program also offers a limited number of positions for self-funded trainees. Typically, we have approximately three to five dental informatics trainees in the program at any one time.

So how do you decide whether this program is for you? If you like to innovate, be in control of technology (rather than being controlled by it), and would like to contribute to improving dentistry and dental care using technology, this program is for you. You should have good analytical skills, and either quantitative or qualitative abilities. A background in programming and/or information technology is a plus because although informatics is not just about computers, we use them a lot in our day-to-day work.

Additional information about the program is available at *di.dental.pitt.edu/postgrad.php*. We are currently looking to fill several trainee positions. For any questions, please contact the program director, Dr. Titus Schleyer, at titus@pitt.edu.

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Family business or family feud?

By Sally McKenzie, CMC

> 'Too often family members won't question one another's decisions or actions.'

Certainly, when it comes to *the family*, the ties that bind can also fray. What is supposed to be a source of strength is often the cause of stress and anxiety. And maintaining family harmony in the face of workplace challenges can be no small undertaking for any business, particularly dental practices. Although everyone may be related, clearly everyone is not alike. Families, as we know, are composed of varying personalities, opinions, styles, problems and issues, all of which can wreak havoc on efforts to simply get along, let alone work together.

The family has a profound impact in shaping our decisions, our values and our culture. It also has a huge effect on the economy at large. In fact, family businesses encompass 80–90 percent of all enterprises in North America. In the United States alone, family businesses account for 50 percent of U.S. gross domestic product. They generate 60 percent of the country's employment and 78 percent of all new job creation according to the University of Southern Maine's Institute for Family-Owned Business. Certainly, the family business is an economic powerhouse, but for those working in the trenches of the "blood-born" unit, it's the emotional toll that packs the bigger punch.

Family businesses can be very complex, to say the least. And navigating through the potential minefields is no small challenge for many. After all, when it comes to working with family there is a lot to gain — and a lot to lose. In dentistry, family-run practices are common with fathers and sons, husbands and wives, mothers and daughters, siblings, in-laws, aunts, uncles, etc. working under the same roof.

Some function very effectively together and, typically, those that are the most successful are able to deal with business issues as partners, not as husband-wife, father-son, mother-daughter, etc. However, without clearly defined roles and detailed practice systems, emotion and family "issues" can quickly take over.

Family communication and trust are essential. Clearly defined management systems and accountability are absolutely critical. Maybe the practitioner's spouse has been doing things "that way" since 1999, but asking prospective patients whether they have insurance immediately after a caller indicates that she or he would like to schedule an appointment simply isn't good for the office — no matter how long she's been doing it "that way." Perhaps brother Joe, the financial coordinator, is allowing his friends and neighbors to carry balances indefinitely, sending accounts receivables over the top. And Aunt Carol is habitually late. Joe, Carol and yes, even the practitioner's spouse, must be educated and held accountable for their systems, their actions and their results.

The bottom line is: Just because you are the spouse, the sister, the brother, or dear old dad doesn't mean you can do as you please. The practice is a business first and a family operation second. What's in the best interest of the business comes before anything else. And that is where things can get complicated.

Conflict and control

While conflict may seem to be an obvious area for family strain, trying to avoid it can be far worse. Too often family members won't question one another's decisions or actions. They won't address problems. They refuse to buck the status quo and push for necessary change because they are afraid to start an argument within the family. Families that attempt to dodge conflict open the door for much bigger problems because the issues only grow and fester. And if family members won't confront family members, where does that leave the rest of the staff? Most likely searching for employment elsewhere.

Then there's the issue of control. Countless dentists or their spouses are running dental offices but don't understand what it takes to manage the business side of a practice. They are incapable of reading and understanding practice reports and business statements. They don't comprehend the impact of overhead or how something so seemingly innocuous as a little pay raise can cause salaries to spiral off the charts. Yet because they "own the practice" they make decisions based on what they think is *right* that affect their own long-term financial health as well as the fiscal health of the practice.

For the lucky ones, the family members settle into their roles and are able to understand and compensate for each other's strengths and weaknesses. You may have one family member who is more technology oriented and handles those aspects of the practice. Another may be the human resources "guru" and still another who is the recognized "financial expert." If the individuals take responsibility for their roles and the rest of the family can let them do their jobs, these informal arrangements become formal without the practice ever having to spell them out. What typically makes these situations work, however, is that the family members all have the same philosophy of care and business. However, the success of such informal arrangements can be rare.

Structural guidelines

Most successful business arrangements require a more formal organization. Dental practices are no different. There needs to be a clear designation of exactly who is responsible for what and what the family wants to get out of the practice.

Do you want it to grow? Do you want to keep it where it is? What's more important to you, giving up some control and growing or keeping control and staying where you are? What's your vision of the practice? What if it's different than your spouse's or your brother's or your dad's? Whose vision gets priority? What steps will the practice take to achieve that vision and those goals? Who will be responsible for which areas? How will the practice measure its success? It's those issues — where you want to take the practice — that require open and honest communication, but can cause significant friction. Yet all the players in the family practice must be on the same page. If not, it's grounds for a family meeting, probably several.

Ultimately, there may be those on the "family" team that would rather strike out on their own. In some cases, that is the best alternative. Maybe Chuck the dad and Brian the son work well together in their general practice, but Dave the brother and periodontist, wants his own office, separate and away from dad and his brother. Although it may be hard to reject the family, doing so early on will be much easier for

See FAMILY, Page 8

FAMILY

From Page 7

everyone, and Dave will be far less likely to feel that he sacrificed his own vision and goals for the sake of "the family practice."

In other cases, family members are in the wrong jobs and would be much more effective in another position. For example, Ellen the wife is working as the office manager but would make a much better financial coordinator. The dentist must have the courage to make the change and Ellen must have the courage to accept it, a tall order for both. And oftentimes, it's necessary to bring in outside help to navigate the players through the process of developing job descriptions and identifying who will work best in which positions. The fact is that family members are simply too close to the issue — literally.

Things to consider

Certainly, there are those families that sincerely enjoy working together and are successful in doing so. But it's not for everyone. Before you decide to partner with your spouse, sister, brother, mother, father, uncle, cousin or whomever, evaluate the decision carefully. We all have family members whose company we enjoy, but we wouldn't necessarily want to spend 40 hours a week with them. We've all made excuses for that eccentric relative who made a poor financial or professional decision here or there, but we wouldn't want to have to do it on a regular basis, no matter how good hearted he is or hard working she is.

Consider whether this arrangement is consistent with your personal practice philosophy of care and business management approach. Carefully evaluate whether you will have the opportunity to grow as a professional and fulfill your personal goals. Is this the career move you've dreamed of or dreaded? Will you be given the opportunity to use your strengths in making a contribution or pigeonholed into a particular role? If you believe you can contribute your expertise, abilities and know-how to the practice, your chances of success increase exponentially. They decrease significantly, however, if you make the move because of family pressure or a sense of entitlement.

Realistically consider if you can work with your family. Being honest with yourself from the beginning will potentially save you years of frustration and discontent. Remember, a "good son," "good daughter," or "supportive spouse" is far different from being an effective business partner. It will take courage to raise issues that may put you at odds with your family. And serious problems can arise if communication is weak or if the relationships in general tend to be strained. Be sure that you are emotionally and economically prepared to leave if frustrations become too great.

Certainly, for some, working with your spouse, mom, dad, brother, sister, etc. can feel more like a life sentence than the opportunity of a lifetime. However, for many who choose this road it can and does work *if* the systems are in place, the roles are clearly defined and communication is open. And if, most importantly, everyone understands that when it comes to the family practice, it's business first and family second.

About the author

Sally McKenzie, certified management consultant, is a nationally known lecturer and author. She is CEO of McKenzie Management, which provides highly successful and proven management services to dentistry, and has since 1980. McKenzie Management offers a full line of educational and management products, which are available on its Web site, *www.mckenziemgmt.com*. In addition, the company offers a vast array of Practice Enrichment Programs and team training. McKenzie is the editor of the e-Management newsletter and The Dentist's Network newsletter sent complimentary to practices nationwide. To subscribe visit *www.mckenziemgmt.com* and *www.thedentistsnetwork.net*. McKenzie welcomes specific practice questions and can be reached toll free at (877) 777-6151 or at sallymck@mckenziemgmt.com.

Bone preservation: one of the keys to esthetic success in immediate implant therapy

Don't miss Dr. Levin's lecture at the Dental Tribune Symposia during the Greater N.Y. Dental Meeting at 3–4 p.m. on Dec. 2.

Clinicians and researchers have developed recommendations regarding implant position, dimensions and numbers, but the area of surgical technique and instrumentation to preserve native bone has been under emphasized.

Instrumentation designed to remove teeth without damaging or eliminating pre-existing osseous tissue is mandatory. The era of using large cumbersome elevators and forceps is dwindling. Surgeons must now appreciate the importance of preserving surrounding bone and maintenance of soft tissue and understand the necessity of modern instruments designed to facilitate, if not enable, esthetically pleasing results.

The advent of Periotomes, X-Trac forceps and now X-otomes by A. Titan Instruments has simplified these procedures. The presentation will demonstrate the role of these instruments in immediate implant surgery.

A.TITAN INSTRUMENTS

Enhancing your dentistry: Get out of dentistry alive!

Don't miss Randy Donahoo's lecture at the Dental Tribune Symposia during the Greater N.Y. Dental Meeting at 1:30–2:30 pm. on Dec. 2.

This course will provide you with an opportunity to see for yourself how the benefits of "heads-up" dentistry can enhance your practice. Experience first hand the Dental Procedure Scope, a life-changing device that provides increased magnification, superior lighting and improved ergonomics all in one device. The lecture will provide an overview of how Dental Procedure Scopes work, their capabilities and the ease of which they can be incorporated into your daily routine. Learn how they can enhance your practice and put the fun back into dentistry. It's just a wonderful way to spend your day!

MagnaVu Magnified Video Dentistry

Earn C.E. credits! Attendance is free for all GNYDM visitors!

For more information and registration, please contact Julia Wehkamp: j.wehkamp@dtamerica.com.

High-resolution cone beam with PreXion 3-D

PreXion 3D

Don't miss Dr. McEowen's lecture at the Dental Tribune Symposia during the Greater N.Y. Dental Meeting at 3–4 p.m. on Nov. 30.

Cone beam computed tomography (CBCT) offers a whole new paradigm to dental radiography. From what were conventional 2-D images, dentists now have the ability to look at the maxillofacial region in any direction, and at any thickness, as well as in 3-D. With the introduction of CBCT the specialist and general dentist alike can now afford to own and enjoy the benefits of this fantastic diagnostic tool. This symposium will cover the basics of CBCT, field of view (FOV), focal spot, flat panel types, processing time and gray scale, and how these affect resolution and image quality. PreXion 3-D high resolution images will be discussed and time spent with real scans showing how these images can be used in planning periodontal treatment, implants, oral surgery, complex endodontic diagnosis, and treatment planning for the general dentist.