



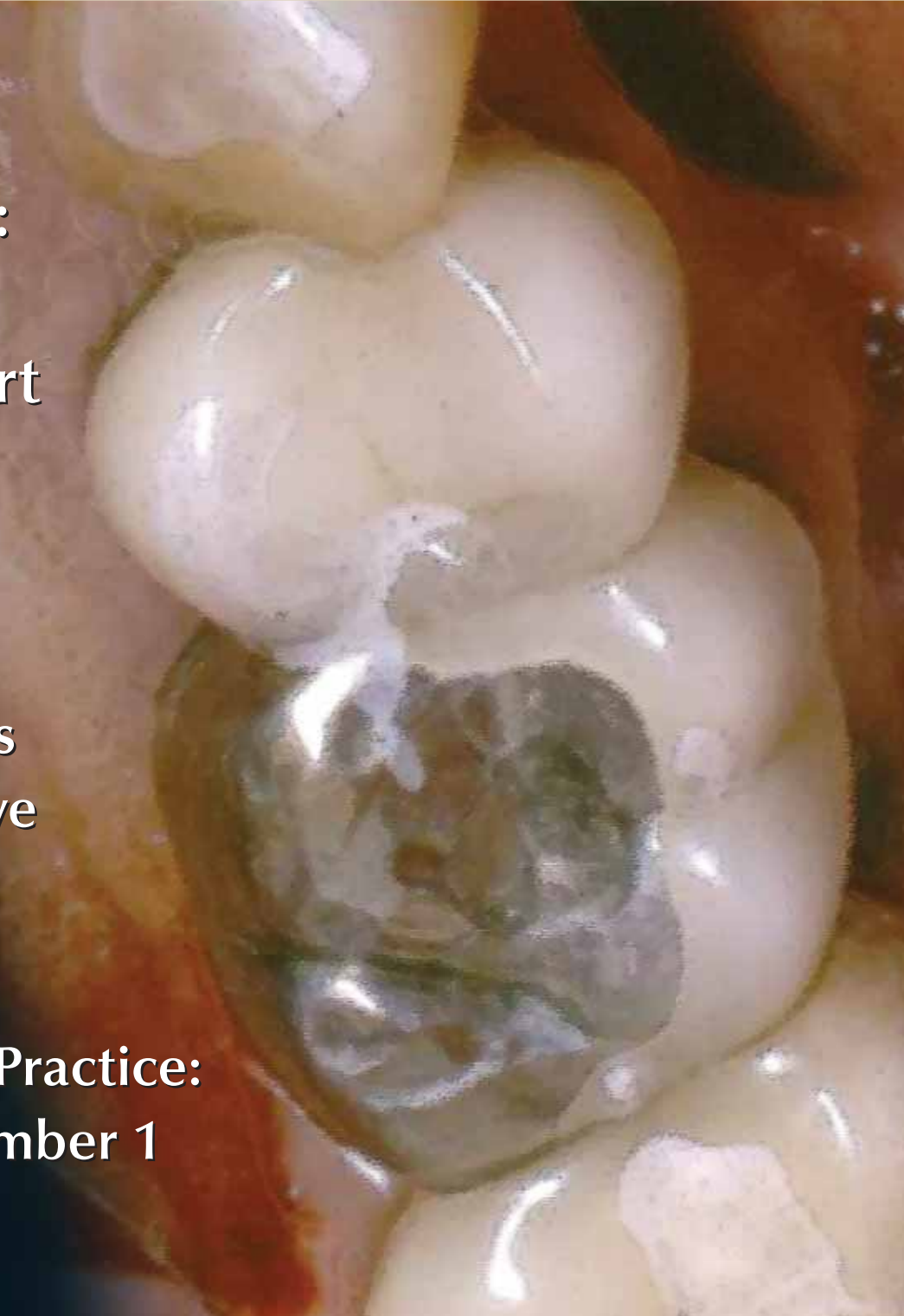
Fall 2007 • Volume 4 • Number 4

wisdom

**Periodontal
Technique Tip:
Maintaining
Palatal Comfort
Following a
Gingival Graft**

**The Seven Habits
of Highly Effective
Dental Teams**

**New Jersey Fast Practice:
Making Staff Number 1**



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Fall 2007 • Vol. 4 • No. 4

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President's message



*Joseph Sandberg,
DMD, MAGD
NJAGD President*

New leadership ... same commitment to excellence

I recently returned from this year's annual AGD meeting in San Diego. We enjoyed record attendance as New Jersey's own Dr. Vinny Mayher took the helm as President of the AGD. As you might imagine, the weather was spectacular. This year's convocation for our new Fellows (FAGD), Masters (MAGD), and Lifelong Learning and Service Recognition awardees (LLSR) was held on the Flight Deck of the USS Midway. The Midway is a highly commemorated aircraft carrier that served in WWII. The Celebrity Premier that followed was a party that featured a great live band, dancing, and fireworks all under a full moon. I would like to congratulate our 8 new Fellows, 8 new Masters, and our first 3 LLSR awardees. I would also like to thank all the NJ members and Delegates that attended.

As I start my term as President of the NJAGD, I am excited about our future. We have an excellent line up of CE courses for the coming year, including several participation courses. I would like to thank our CE Committee Chair Dr. Max Ahtau for his efforts in making it all possible. We also have NJ's own AIM Mastership Track program run by Drs. Navin Bogg and Beth Clemente. Dr. Gordon Christensen in the June issue of *Dentaltown* said that he considered a Mastership from the Academy of General Dentistry "to be as valuable as the formal master's degree I received in my specialty many years ago". Please see NJAGD.org for a listing of all of our upcoming courses.

The AGD offers more than top notch CE and highly respected awards. It provides advocacy and a voice for you, the general dentist. The ADA is an essential organization for Dentistry and I am both a member and supporter but it represents the profession as a whole. Only the AGD is looking out solely for the general dentist. It is critical to recognize and appreciate that distinction.

One example of how the AGD represents our interests in providing care to our patients was the American Academy of Periodontics referral guidelines that were recently introduced. Several of the provisions in the guidelines could set a standard of when referrals are required, including some procedures and management protocols that are a part of many general dentists who have been properly trained through residency and continuing education. AGD responded swiftly on behalf of the general dentist. Remember that the AGD is your voice.

I would like to thank our Immediate Past President, Dr. Melvin Pierson for his contribution and leadership last year. I would also like to recognize Dr. Manny Cordero, our National Trustee and Dr. Beth Clemente, our Regional Director for their dedication and commitment.

I am proud and excited about being an integral part of the AGD organization. On a local level, the NJAGD is in need of your ideas, concerns, and passion to keep our organization strong and growing. At the Board level, we invite your participation. You can contact any of our Board members through NJAGD.org or 1-888-GO-NJAGD.



Why would anyone want to be a dentist?



*Evan Spivack,
DDS, FAGD
NJAGD Editor*

“Why would anyone want to be a dentist?” I was recently asked. Not an uncommon question, and one that I am sure all of my colleagues have been asked countless times. The questioner raised all of the usual points — how “everyone” hates going to the dentist, how dentists are always causing pain and, of course, how dentists have such a high suicide rate. Any dentist can add to the list of negatives: increased paperwork and governmental involvement, increased pressures from DMOs, PPOs and other insurers, increasing incidence of lawsuits, increasing difficulty in finding and retaining high-quality staff. Not a pretty picture, is it?

The other side of the argument, however, offers a strong counterbalance. Ours is a well-respected, independent profession, with many dentists outearning many of our physician colleagues. The need for dental care is strong, and the desire for esthetic procedures has never been greater. We have at our disposal technology and materials undreamed of by our predecessors, and the educational resources to learn how to wield them.

We all have our own mental “highlights reel” of our careers. For many, the cases that stand out are those that were the most technically complex. Sometimes, however, it is the little things that help us remember why we went into dentistry in the first place, and why we continue in our profession despite the challenges. I am certain that all of those reading this have had experiences similar to those below, experiences that reside inside of us as surely as they do in our charts.

Patient Lisa R., whose hopelessly deteriorated dentition was evidence of a life lived on the streets, drugs and alcohol her constant companions. She presented for extraction of her remaining teeth and fabrication of complete dentures. The case was straightforward and routine. At her second adjustment appointment, our staff noticed a tremendous change in Lisa: she was smiling, something we had never seen her do before. Her hair was done, she was wearing makeup, and was ready to look for a job. A simple set of dentures had made all the difference in her world.

Patient Patrick D., a young man who was getting engaged prior to joining the Marines. He wanted crowns on his upper central incisors to replace the discolored composites before getting engaged to his high-school sweetheart. Several weeks after delivery, however, Patrick was killed in a devastating accident that stunned the neighborhood. At the wake, Patrick’s mother recalled how much those improved teeth meant to him.

Patient Ashley S., a seven-year-old girl who was terrified of the dentist and of an impending primary tooth extraction. After the tooth was safely in the gauze her tears stopped, and she said: “It’s out? That was so easy! Let’s put it back and do it again!” She was a model patient from that point on.

In the course of a pressure-filled day, it is often easy to lose sight of why we do what we do. When ever that happens, just stop for a moment and play some clips from your own “highlights reel” before stepping back into the operator. There’s nothing better.

Q & A

Dr. Vincent Mayher, DMD, MAGD

was installed as president of the Academy of General Dentistry during the annual session held in San Diego this summer. A long-time member of the Academy, Dr. Mayher lives and maintains a private practice in New Jersey. We are pleased to present a “question and answer” session with this homegrown leader of our organization.

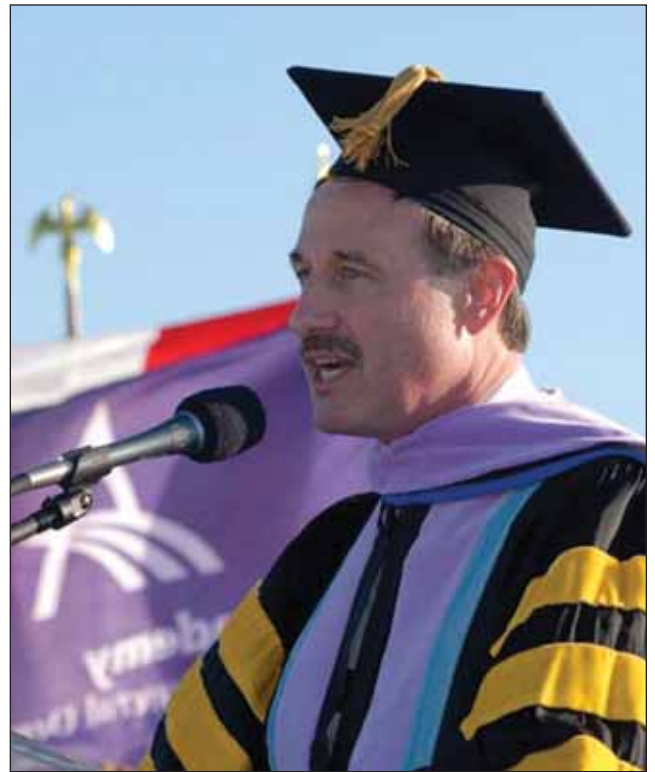
Q: What are the primary goals that you have set for your administration?

Dr. Mayher: The major initiative for the upcoming year is to “set the record” in improving membership recruitment and retention efforts. When I addressed the House of Delegates on July 1st, I outlined a program that will kick off at the August Board meeting where a large number of AGD leaders will spend a good part of a day brainstorming membership issues with a professional marketing facilitator. We will look at our membership policies and initiatives from top to bottom. And, we will not take anything off the table. This year’s theme is “MEMBERSHIP IS EVERYTHING!”

Q: What do you see as the greatest challenges facing dentistry and the Academy in the coming years?

Dr. Mayher: Dentistry is changing faster than many can adapt to. It’s like drinking out of a fire hose! Not only is the clinical aspect changing at light speed pace, but so is the business of dentistry. As we discover and embrace new techniques, we have to be cognizant of the patient’s ability to pay for these techniques and an increasingly skeptical dental third party presence. There needs to be a way to harness these new techniques so that an affordable version is available to those people of limited means in order to address the access to care problem that the US Surgeon General alluded to a few years ago.

Unfortunately, during this past year, there was a heightened degree of division within the dental profession as evidenced by the issue that the AGD had with the proposed AAP Guidelines. Other issues regarding implant treatment and the scope of practice for generalists, specialists and hygienists all seem to create divisions.



The parameters of "who does what" appear to be getting fuzzier and fuzzier.

It saddens me that there appears to be considerable dissatisfaction among some of the leadership in a few organizations within organized dentistry with respect to their role in the delivery of dental services and in their perception of the role that general dentists should play. Lately, the services that the general dentist provides seem to be the center of attention, whether it be limiting those services, or encroaching upon them. And sometimes, unfortunately, this is done in the name of access to care.

General dentistry is so very rewarding because, by its very definition, it allows the GP to treat whatever he or she chooses to treat as long as sufficient continuing education is attained. What has to be understood is that all dental professionals play an important part in the health of our patients. And, those who are not general practitioners need to have a clear vision of their role as providers and be proud of that role instead of seeking to limit, or infringe upon, that of the general dentist. And, the AGD needs to remain THE voice of general dentistry and a strong advocate for the general practitioner and the patients whom we treat. We can only do this if our membership roles are strong and we remain vigilant in observing trends that affect our profession.



By reaching out to the dental community, my goal will be to enhance communication with other groups and, therefore, foster collective initiatives that will address our responsibilities to the public. After all, isn't that what we should all be thinking about? In a time where there are fewer and fewer dollars available to be spent on dental care for those truly in need of it, if the dental community is to address the access to care issue, shouldn't we all do so in a coordinated manner?

Q: What are the most important lessons that you have learned on your path to the presidency over the years of your involvement with the Academy?

Dr. Mayher: Leadership is a privilege and, not a right. When you assume any leadership position, you must be confident, creative, open minded, and, above all else, humble. In observing the talent and dedication so very evident within our membership roles, it is very motivating. Knowing that you are the leader of such an accomplished group, compels you to want to serve these individuals at very highest level possible.

In addition, you have to understand that people who become involved in service to organized dentistry, whether it is the AGD, ADA, New Jersey Dental Association, or any other body, are offering their time and talent because they derive satisfaction in these efforts. Therefore, taking the time to praise a colleague who serves the profession and the public through volunteer activities goes a long way. People want to be appreciated for what they do. I encourage anybody in leadership to take a little time to extend their appreciation to their colleagues equally engaged in organized dentistry.

Q: How do you foresee the relationship between general dentistry and the dental specialties, and between dentistry and medicine, changing in the coming years?

Dr. Mayher: General dentistry will always enjoy a good relationship with the specialties as long as there is a strong advocate for general dentistry. This will only be possible if the AGD enjoys a

strong market share. And, it s the reason why membership is everything.

As general practitioners, most of us enjoy great working relationships with the specialists whom we refer to and work with. However, turf is turf. And, while we enjoy great one-on-one relationships with our specialist colleagues, the specialty organizations, in their zeal to serve their members, will be looking for ways to fill the chairs in their members' waiting rooms. And, sometimes, as we discovered last year, this methodology involves an attempt to limit the services that the general dentist provides.

In the upcoming year, I intend to extend the hand of friendship to the specialty organizations and look forward to fostering collaborative and mutually constructive relationships with them. But this can only be accomplished if we can communicate from a position of strength.

Fortunately, our medical colleagues and the Surgeon General now understand that the mouth is, in fact, connected to the rest of the body. The AGD must continue to be in a position where we can educate the medical profession and be a major source on information as both medicine and dentistry discover all that we have in common.

Q: How much does personality play a role in the leadership of the Academy? What are the greatest strengths you bring to this position?

Dr. Mayher: There is no single personality profile that guarantees success in leadership of the AGD. I have seen great leaders who are outgoing and those who are more introverted. However, it is very important that you are perceived as "genuine."



For this to occur, you need to be able to communicate. And, to a good leader, the major element in successful communication is listening. Over the years, you learn that you do not have to always express your opinions, unless asked. But, it is very important to allow others to express theirs.

Loyalty, enthusiasm in addressing leadership responsibilities and, a good sense of humor will improve your chances of success in any leadership position.

Q: The Academy has evolved dramatically in the past few years. Please comment on the changes that have occurred, and on major evolutionary changes that you see in our future.

Dr. Mayher: The AGD has undergone a “facelift” these past several years with an engaged new Executive Director and many new, enthusiastic staff members to compliment the dedicated ones that have served the AGD over time. In addition, our leadership has created a new strategic plan and, as a result, reorganized our governance structures. We have all been spending plenty of time in the “think tank” these past few years. Now, it is time to roll up our sleeves and put these plans into action in order to bear the fruit of this planning.



In addition, we must continue to be a “member centered” organization. Our membership deserves prompt, courteous and knowledgeable treatment when they contact their Academy. It is all about value. Once a member loses his or her perception of value, they quickly drop from the membership roles. This has to be prevented.

I am pleased to announce that our staff is now taking continuing education in customer service techniques. This is crucial. Every phone call, every email inquiry to the AGD, either at a national or local level, is an opportunity.

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Friday, October 12 [08D0210]

**ADHESIVE & RESTORATIVE
MATERIALS UPDATE**
Friday, October 12 [08D0211]
• JEFF J. BRUCIA, DDS of San Francisco, CA

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HYGIENE 2007 & BEYOND
Wednesday, October 17 [08D0217]

Parts 2 & 3 of a Hands-on Continuum
THE ESSENTIALS OF ESTHETIC DENTISTRY
Fridays, Oct. 19 & Dec. 7 [08D0201]
• STEPHEN D. POSS, DDS of Brentwood, TN

ADHESIVE DENTISTRY 2K7
Wednesday, October 24 [08D0213]
• JOHN KANCA III, DMD of Middlebury, CT

**PERIODONTAL SURGERY FOR THE
GENERAL PRACTITIONER:**
Free Gingival Grafts and Crown Lengthening
Friday, October 26 [08D0214]
• JON SUZUKI, DDS, PhD of Philadelphia, PA

**CONTEMPORARY REMOVABLE
PROSTHODONTICS:**
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James Kohner,
DDS

Periodontal Technique Tip:

Maintaining Palatal Comfort Following a Gingival Graft

Have you ever done a gingival graft from the palate and had patients complain of pain from the donor site? Have you tried to keep a periodontal dressing on the palate and failed, leaving the palate sore and the patient not so happy?

Rather than attempt the surgery yourself, have you referred patients to a periodontist for the grafting procedure and had the same patient complaints? As a periodontist I can tell you that 50% of grafting patients report knowing someone who had a painful experience with a graft donor site, and the other 50% usually remark: “*That sounds painful*” when the graft procedure is explained.

I have also, more often than I would like to admit, heard patients report that their previous grafting procedure was “The worst dental experience of my life.” That response looks bad for our profession and is embarrassing. Worse, when patients feel that way it is often difficult to gain their acceptance for more grafting, even when it is clearly indicated and I know it will help.

It is for this reason that Acellular Dermal Matrix (ADM), a human donor skin product that has been treated to remove all cellular activity, has gained popularity with some clinicians. One of the stated benefits is that it eliminates the acknowledged palatal issues of an autogenous graft. It is my experience, however, that using ADM is very technique sensitive, and can present its own set of difficulties. Furthermore, I prefer the firm fibrous tissue that results from autogenous palatal grafts over the non-keratinized thinner appearing result from the ADM.

The good news is that my clinical experience has shown that the technique described here will predictably eliminate those issues of donor site morbidity, so why not use autogenous tissue? And, I might add, autogenous tissue is free.

Autogenous gingival grafts have been used for over 50 years, and are clearly shown to be predictable in stopping or preventing gingival recession.¹ (Fig. 1-2) They also allow for more effective



Fig. 1: Recession starting on cuspid and bicuspid on a 22 year old.



Fig. 2: Early treatment has resulted in a fiber defense system with reattachment and some root coverage.



Fig. 3: Recent recession complicated by frenum pull making plaque removal difficult and painful.



Fig. 4: Graft at 2 years showing stable keratinized result. Plaque removal is facilitated since soreness is gone.

plaque removal in situations where patients have discomfort brushing around teeth with thin and receded gum tissues.² (Fig. 3-4) A gingival graft is one of the most predictable surgical procedures that Periodontics has to offer,³ and it is my opinion that more patients would be agreeable to this procedure if their fear of palatal discomfort could be allayed.

If you have patients with these concerns, or if you shy away from recommending the procedure due to your own concerns over palatal discomfort, here is a technique tip that is a sure fired way to change all that!

Simply making a palatal stent out of a thin *plastic vacuform material* is the answer.



Fig. 5: Model and palatal stent.



Fig. 6: Note buccal overlap stays on teeth and away from soft tissue.

The technique is:

1. Assure patients of the benefits (increased comfort and diminished chance of post-op bleeding problems) derived from the palatal stent.
2. Take a maxillary impression at the consultation appointment and pour a model.
3. Make a vacuform stent with .20 thick vacuform material prior to the surgical appointment.
4. Trim the plastic to avoid the soft palate, as with a denture, and trim to overlap on the buccal surfaces 2-3mm. (Fig. 5-6)

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— Vinny Mayher, DMD, AGD President





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Fig. 7: Stent in place over the collagen. Note minimal bleeding through the collagen. This indicates the bleeding is controlled.

5. At the surgical appointment check the fit before starting as another vacuform can be made from the model if for some reason the first one does not fit. This is a rare situation, but it has happened.
6. After surgery simply place two layers of the collagen material of your choosing over the donor site, then cover it with the stent. Make certain that the stent contacts and gently holds the collagen in place. (Fig. 7)

One remarkable benefit, besides significantly less pain, is that the collagen creates almost immediate clotting. Consequently, since the stent holds the collagen against the donor site, bleeding is visibly under control before the patient leaves your office. As a result, knowing the collagen will stay in place overnight, you can dismiss the patient fully confident that you have eliminated one serious potential complication of a graft from the palate, namely postoperative bleeding from the donor site. I can frankly say that I have not experienced even one case of palatal bleeding since using this technique.

Post operative instructions for the patient (always given in writing) are:

1. Leave the stent in until the next morning.
2. At that time remove it and resume brushing/flossing your teeth as normal. The collagen might fall out, that is OK.
3. Leave the stent in FULL time for the first week, removing it only for brushing and flossing.
4. After the first week use it for eating and sleeping until you feel comfortable without it. At this point the stent is only for your comfort and will not affect the outcome if you leave it in more or out more.
5. If a second graft is planned, please save the stent!

Using this technique WILL assure more comfort and compliance for you patients. And consider that you might enhance relationships with your periodontist by telling them about this technique tip if they are not already using it! I can assure you from personal experience, periodontists have struggled with this issue also. Once they have tried it they will thank you for suggesting it to them. Enjoy it and let us know your experiences.

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1. Wennstrom J, Mucogingival Therapy. Ann Periodontology 1996; 1 (1) 671-701
2. ibid
3. Hagorsky U, Bissada N. Clinical assessment of free gingiva graft effectiveness on the maintenance of periodontal health. J. Perio 1980; 51 (5):274-278

About the Author

James Kohner, DDS, is a Periodontist from Scottsdale, Arizona. He has over 35 years clinical experience and has been teaching for over 20 years. He does workshops on Crown Lengthening and Soft Tissue Grafting for the Perio Institute, and is a sought after consultant for in-office surgical coaching. He can be reached at James@JamesKohner.com.

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CE Exercise Questions

The NJAGD invites you to test your knowledge of the preceding article, **“Periodontal Technique Tip: Maintaining Palatal Comfort Following a Gingival Graft”** by James Kohner, DDS. Reading the article and successfully answering 7 of the following 10 questions will qualify for 1 CE credit from the NJAGD.



- 1** Which of the following describe common patient perceptions of gingival grafting?
 - a. Approximately 50% of patients know someone who had a painful experience with the procedure
 - b. One-half of patients having the procedure explained, state “that sounds painful”
 - c. Some patients report the procedure was “the worst dental experience of my life”
 - d. All of the above are True and are embarrassing to our profession
- 2** Which of the following is a common issue associated with gingival grafts:
 - a. Patient discomfort at the donor site
 - b. Periodontal dressing that fails to adequately protect the donor site
 - c. Reduced patient acceptance due to anticipated discomfort
 - d. All of the above
- 3** The author states that ADM has gained popularity with some clinicians because it eliminates the need for a palatal donor site. ADM is an abbreviation for:
 - a. Autogenous Dental Material
 - b. Autogenous Dermal Matrix
 - c. Acellular Dermal Matrix
 - d. Acellular Dental Matrix
- 4** Which of the following is NOT a characteristic of ADM?
 - a. It is derived from a human donor
 - b. It retains all cellular activity
 - c. It is very technique sensitive
 - d. It results in a thinner, non-keratinized, graft site
- 5** Which of the following is NOT a stated benefit of autogenous gingival grafts?
 - a. They have been shown to be predictable in stopping recession
 - b. They have been successfully used for over 50 years
 - c. They can improve patients’ plaque removal by reducing discomfort around thin and receding gums.
 - d. Patients are often agreeable to this procedure which has minimal palatal discomfort.
- 6** The author recommends using a stent made of 0.20 clear vacuform material. The stent should be trimmed to extend 2-3 mm onto the tissue on the buccal and just short of the soft palate.
 - a. Both statements are True
 - b. Both statements are False
 - c. The first statement is True, the second statement is False
 - d. The first statement is False, the second statement is True
- 7** The author recommends placing 2 layers of a collagen material over the donor site. The stent should exert firm pressure on the collagen material.
 - a. Both statements are True
 - b. Both statements are False
 - c. The first statement is True, the second statement is False
 - d. The first statement is False, the second statement is True
- 8** A remarkable benefit of using the collagen and stent technique is that it creates almost immediate clotting.
 - a. True
 - b. False
- 9** Post operative instructions given to patients should include all of the following, EXCEPT:
 - a. The collagen material might fall out, but that is normal
 - b. Wear the stent full time for 1 week, except for brushing and flossing
 - c. After the first week wear only during eating and sleeping as necessary
 - d. If bleeding occurs, wear the stent more, that is normal
- 10** The author described a simple and effective technique that should provide all of the following, EXCEPT:
 - a. Increased patient comfort at the palatal donor site
 - b. Increased success at gingival graft recipient site
 - c. Increased patient acceptance and compliance of gingival grafting procedures
 - d. Decreased bleeding complications at the donor site

Indicate your answer by circling the correct response and then tear-out or photocopy this form and return to:

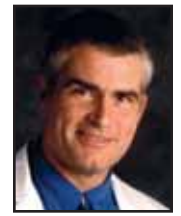
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The *Seven Habits*



Dr. Mark T Murphy
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of Highly Effective Dental Teams

As a resident faculty member at The Pankey Institute in Key Biscayne, Florida and the former Vice President of Operations and Director of Continuing Education for DTI Dental Technologies Inc. (an operator of premium dental labs throughout the United States and Canada), I had the opportunity to be exposed to a great number of different learning mediums, training programs and influential people. Once, a friend of mine, Barry Polansky DMD, interviewed me for his newsletter “Dental Life”. He asked me what were the five most influential books I had ever read. One of the books I had the fortune to read is Steven Covey’s *The Seven Habits of Highly Effective People*. He observed habits that, when embraced, are likely to lead a person towards being more complete, successful and effective.

The seven principles were to *be pro-active* (a principle of personal vision), *begin with the end in mind* (the principle of personal leadership), to *put first things first* (the principle of personal management), to *think win-win* (the principle of interpersonal leadership), to *think first to understand and then to be understood* (the principle of empathic communication), to *synergize* (the principle of creative cooperation), and finally to *sharpen the saw* (the principle of balanced self renewal). Covey’s book and these seven habits have inspired me to use the same format and to find seven habits embraced by highly effective dental teams as they live and practice with peace of mind. This column is aimed to help you develop a “highly effective” philosophy and vision for your practice that you can share with your dental team and work to together to implement.

As I reflected on the habits of highly effective dental teams, I decided they fall into the following top seven.

1 Highly effective teams have highly developed, empathetic communication skills. Recognize that **communication** skills can be pro-actively developed, practiced and utilized effectively with team members, patients, friends, and families. Communication is a learned activity we can work to develop, enhance and support trusting relationships in dental practices..

2 Highly effective dental teams have a **shared philosophy and vision**. It is one they all desire and have collaboratively designed to drive the style of the practice. The style of the practice isn’t by chance.

3 Highly effective teams have discovered that a **comprehensive initial examination** experience is the best way to set the stage for excellence and to truly get to know

your patient and to allow the patient to know you. You should be pro-active about slowing down, talking with your patient and discovering together what is going on in that patient’s mouth, general health, life, etc.

4 Highly effective teams aspire to a higher **understanding of occlusion** and its relative importance to predictability and restorative and periodontal health. This means some pro-active learning and skills attainment for both the dentist and supportive Care Team.

5 Highly effective teams have a well thought out protocol for collaborative interdisciplinary and comprehensive **treating planning**. They adhere to and enhance systems that ensure excellence in comprehensive treatment

6 **Clinical excellence** was the table stakes for entry into this game. Dr. Pankey always said that you had to have it on the shelf. It is true that we need to develop clinical skills that result in excellent patient care and predictability to be effective. The comprehensive care model, personalized for each patient provides an opportunity to do what is appropriate and restorative solutions that last.

7 Highly effective teams realize that the art and science of obtaining mastery in dentistry is the result of continuous and **never-ending improvement** and a quest to be you’re very best. The pro-active “journey” becomes an objective rather than a destination.

Discuss these “highly effective” habits (or traits) of successful dental teams in greater detail. Start by asking yourself, “What is the style of my practice? Did it happen by design or by chance?” What is it that we hope to accomplish in this business model (after having fun and making money). What skill sets will help us get there?

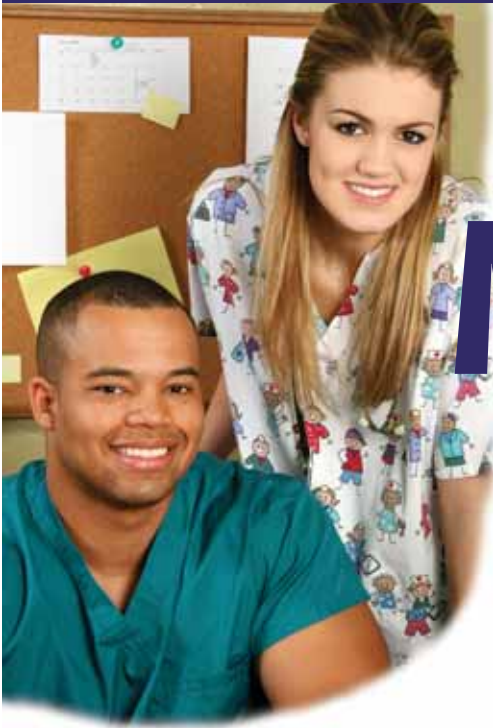
By the way, for those of you who are like me and have been wondering what the other four books were, here they are. *Good to Great* by Jim Collins, *When Generations Collide* by Lynn Lancaster and David Stillman, *The “E” Myth* by Michael Gerber and *The Boy Scout Handbook*.

About the Author

Mark Murphy is a featured presenter for the National Dental Network and the National Lab Network. And lectures internationally on a variety of dental clinical and behavioral subjects. He practices part time in Rochester Hills Michigan and teaches at The Pankey Institute in Key Biscayne where he served full time as the Director of Professional Relations during 2005 and 2006.



Michael Massotto



Making Staff Number 1

The purpose of this article is to outline several of the most vital practice management tools, which when implemented, will instantly transform your office culture and open the way for unprecedented business expansion and growth. Yes, dental practice is a business as many of you may or may not have discovered the hard way. However, the most fundamental and critically important element of a successful practice is often the least understood and most neglected — your people. As practice management consultants and coaches who work exclusively on-site or in small, intimate groups on an intense week-to-week basis, we devote 50% of our time to the personal development, understanding, and handling of staff. Since they drive the practice and make or break whether or not your office systems, procedures, and policies get and stay effortlessly and flawlessly implemented in the service of you and your patients, it is vital that you truly understand and use the following distinctions and tools in the ongoing development of your practice.

1 Get a true and complete understanding of the currently existing state of your practice and its culture

The derivation of the word culture comes from the French *colere* meaning to tend to or to cultivate. Cultivate in this case means to cause to grow by special attention or by studying, advancing, and developing to refinement. Thus, your practice culture is determined by how much attention you put on your people in their training, integration, development, and advancement as individuals in support of your purposes and goals. How effectively you understand, know and can inspire your staff will ultimately determine the level of practice growth you can achieve.

You therefore need to start by simply surveying (and afterwards interviewing) people with a direct, straight to the point

questionnaire to get a clear and accurate assessment from their perspective of how they view themselves, their teammates, and you and your associates in relation to the practice. Some sample questions should be: What is your position or what post do you hold in the office? What do you do and what are you responsible for? Does your work interest you? Do the duties you perform align with your position in the office? How do your responsibilities contribute to the practice? What barriers do you run into while doing your job? What works about your job and what needs improvement? What works about the practice as a whole and what needs improvement? Where do you feel you need improvement? What works about the doctor(s) and what needs improvement? What could be changed to make your job easier and help you get your job done more effectively? All are powerful questions, which will assist you in gathering common themes and in the identification of potentially detrimental personal and practice blind spots, which often go undetected. Conversely, this discovery process will also allow you to recognize what is right and working about you and your practice which is just as important so as not to change or deviate from your successful actions as a leader and entrepreneur.

During the survey and interview process you must be sure to create a safe space for your people to be completely honest without fear of repercussion or resentment. The truth may hurt, but without it you cannot make changes. Resisting, justifying, defending, and rejecting your staff's reality, whether you can readily understand where they are coming from or not, will invalidate them and create upsets and resentment. Sometimes it is just best to shut up and listen — it can be very therapeutic and beneficial in the end.

However, you will never get total candor without acknowledging how you have been in the past, cleaning it up, and giving permission in the present to allow full, uncensored expression from your people. You could position these surveys and interviews as follows: "In the past I may not have been as open as I am now to hearing the truth and to be willing to make changes. I have realized

that there may in fact be things about me and the practice that need attention and improvement, and I need your help in handling these areas. So I want you to know you have my full permission to share with me, without fear of repercussion or resentment, what you see needs handling. I want you to know that I value your opinion and I am ready and willing to hear whatever contribution you have to me and the practice.”

Of course, how you deliver this message and whether or not it truly comes from the heart will determine your success. People can tell when you are genuine and sincere, and will make the decision to trust you or not based upon this and your agreement and compliance to confidentiality, if so desired.

Once you get agreement from your team to participate wholeheartedly in this discovery process, set aside a full day to conduct private one-on-one meetings with each individual staff member, including part-timers, when they can openly discuss and elaborate on their survey answers and offer solutions and suggestions. Be attentive and interested, listen, ask for specifics or clarification when needed, and take good notes. Remind them it's all confidential and okay to share whatever they want if they feel it's important to the improvement of themselves, the practice, and you. Do not have a stopwatch on them, and acknowledge and thank them for their time and contribution in assisting you in transforming the practice.

After completing this first step toward getting the existing reality of your practice and its culture, you now have the momentum generated to move on to the next steps in creating and maintaining the ideal office culture.

2 Separate fact from opinion

A fact is the truth and can be proven as such. An opinion may have some fact in it but is not always entirely the truth. After conducting your interviews, gathering data, and recognizing common themes, you must decide on what is factual information to act upon and what is not. Through simple observation and further investigation, it should become apparent where you need to focus your attention and efforts toward improvement. Usually if more than one person is giving you the same specific data, it's probably true. When in doubt, look at where the information is coming from. Is the person cynical, negative, or generally unhappy in life who seeks to criticize rather than contribute? If so, you may need to decide if their viewpoint is accurate and can be trusted.

3 Get to the real “whys”

After compiling the facts, you need to devise a strategy and plan to handle the root causes of cultural and practice deficiency by identifying the “whys.” You should be able to trace all the numerous problems you are having with your people and your business back to several underlying main causes, which will handle all the symptoms when addressed. In other words, stop putting out fires and take away the matches. You can then have a permanent handling of persistent problems and upset. Our favorite analogy to further understand this point is the problem the maintenance crew had with the Lincoln Memorial Monument in Washington, DC.

There was an ongoing problem with bird droppings collecting on the walls of the monument. After months of power washing,

engineers decided to further investigate the source of the problem. They brought in a bird expert and found out that there were many insects residing in and around the monument, which were attracting the birds. So an insect expert was brought in and it was discovered that what was attracting the insects was moisture collecting on the roof. Once the drainage problem was handled, away went the insects, the birds, and the droppings. Isolate sources, and recurring practice problems can be resolved once and for all.

4 Roll out to your team for agreement to change

Once you have a strategy and plan devised from the identification of the real why's as generated from your discovery process, you need to roll out to the team what you have learned and realized about yourself and the practice for agreement going forward around your plan to improve and change. This will open up the lines of communication like never before in your practice and lay the groundwork for an ongoing open forum to discuss and co-create your future and fulfill on the needs of your team.

During a roll out meeting with the entire team you need to get total agreement and alignment to your plan by handling any distractions, disagreements, and opposition amongst your people. Ask a question such as “can you tell me how this is not going to work?” If you handle these fears, uncertainties, and any resistance by demonstrating and ensuring how it can and will work, you will get enthusiastic compliance and cooperation as long as you are committed to walking your talk.

5 From now on, make staff #1 and patients #2

Although it defies conventional business logic, the only way your patients will ever be taken care of with the highest level of quality, professional service and care will be when you make your people number one. When your primary focus becomes taking care of your internal customer by ensuring they are happy and fulfilled, acknowledged and appreciated regularly for their service, and given security and constancy by providing them sufficient salary and an incentive or bonus plan in a sane and peaceful working environment, your patients will automatically be made number one.

We believe quality control is an oxymoron. Great quality and impeccable service should not have to be enforced. It should be an automatic byproduct of empowered, happy people working as a team to push forward a common purpose in the care of others. The needs and wants of your team should always be considered first in your executive decision-making. Twelve-hour days may be great for you and convenient for your patients, but overwhelming and exhausting to your people.

6 Put in structures for on-going communication with your team

Communication lines are the power of your practice. Keep the lines of communication open and flowing on a consistent basis, and you will keep morale up and productivity happening. Have a daily morning and afternoon huddle with a structured agenda. Focus on the game for the day and not just on a review of the day's schedule.

Look for opportunities to fill holes in production and recommending needed treatment. Role-play patient scenarios and brainstorm handlings to be proactively prepared for each patient prior to their arrival. Hear your team's concerns; make sure they are all ready and fired-up for the day, and always inspire and motivate while making it fun.

Additionally, be sure to hold entire team staff meetings no less than twice monthly. Be prepared with an agenda, which should include time for an open forum of issues. Have people come to the table with solutions to problems to keep it from becoming a gripe session. Review policies both new and old, and ensure they are being enforced. Managing by policy and statistics and not emotion will keep staff and patient relations clean and positive. Always end the meeting on a win and with training on some aspect of practice procedure that you feel needs attention and improvement. How you can ensure that new patient intake, financial presentations, hygiene re-care, etc. are going to your satisfaction is to drill and role-play them until they are mastered.

Finally, implement departmental meetings on a regular basis as well. Designate a hygiene, assistant, and administrative team leader to hold short meetings structured around their areas of specialty. These agendas should include not only discussions on technical issues but on team interaction and relationships as well.

These six points if implemented properly will dramatically improve staff relations and patient service. It is important to understand that there is no such thing as business and personal. It is all personal when dealing with human relations. There is no "shutting off" certain aspects of your life and who you are as a

person when you come to work. The sooner you realize this and learn how to effectively communicate, interact with, develop, and understand your people and have them recognize the value of doing so with each other, the sooner you will be on your way to profound practice cultural and business development.

About the Author

Michael Massotto is the founder and CEO of Staff Driven Practices. After 10 years of business consulting success, Mr. Massotto used his extensive expertise in business and personal development to master their application in the dental field. ABC, FOX, CNN News, and Dentistry Today have nationally recognized him. Since 1997 his unique approach to dental practice development has helped create effortless and fulfilling lives for dentists and their teams.

Mr. Massotto is the author of the book: *The 25 Surefire Ways to Destroy Your Dental Practice*. In 2004, he wrote, produced, and directed a movie based on the book which has received rave audience reviews. He has been a guest speaker at New York University School of Dentistry, Columbia School of Dentistry, and The University of Medicine and Dentistry of New Jersey (UMDNJ), where he offered practice management advice and guidance to dental students. In addition to his regular contribution of articles in *Dentistry Today*, he is also featured in the *Journal of the New Jersey Dental Association* as well as the *Doctor of Dentistry Magazine*. Mr. Massotto created the *Dental Office Managers Association (DOMA)*. DOMA is a professional association created exclusively for office managers. It provides an empowering, informative, and fun forum for the leaders of dental offices to learn practice and people management skills, as well as to enhance their personal and professional lives. He is happily married and the father of two children. He is a high-energy, dynamic, and motivational speaker and coach with a true passion for helping dentists and their teams win the game of dentistry!

Mike can be reached by contacting his NJ office at 973-812-2188 or on the web at www.staffdriven.com.



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Nathan G.
Browning

The Value of Planning as Retirement Approaches

Not long ago, “retirement” for many people meant living on a combination of Social Security and a fixed pension. Today, retired people are living longer and better, and they also are making more personal choices. Most retired people want to “live it up” in their golden years, not watch life pass them by. That puts even more of a burden on the pre-retirement planning process.

Retirement Is Not Predictable

In today’s world, many people slip into retirement gradually in a transition period that occurs over months or years. In some cases, this period begins at an unexpected time, such as when an employer announces layoffs. Few people can predict with certainty which day will be their last on the job, while many people want to keep working (at least part-time) well into the retirement transition.

In the absence of predictable retirement dates, many people put off the serious planning that should take place before retirement. Instead of anticipating changes in their lifestyles or financial circumstances, they wait until too late and then react. This can lead to poor decisions made under pressure, and an unproductive start to their golden years. As a rule of thumb, it’s a good idea to start serious retirement planning at least one year before the transition period begins. This allows adequate time to obtain professional help, understand the many choices available, and make important decisions.

Key Issues and Decisions

What issues and decisions should you evaluate in this pre-retirement planning process? The following are often important:

- **Investment asset allocation** — Retirement is a good time to assess how much risk you want to take with your investments. Once you stop working full-time, it may be harder to replace assets lost if markets turn down. Also, you may have less time available to recover from a loss. An asset allocation process guided by a qualified financial professional can help to develop an overall investment framework that aims at a specific level of risk, with adequate diversification among asset classes.
- **Income from investments** — Many retiring people expect that investment income will replace part of their paychecks. Since few stocks pay dividends above about 3-4%, that can mean repositioning assets from the stock market into bonds or cash. Fixed annuities provide guaranteed monthly income payments that can help to fill budget gaps when paychecks stop. In some cases, retired people find that income can be obtained for special needs by borrowing against the accumulated cash values of their life insurance policies. A pre-retirement review can identify the level of income needed and the best sources of investment income.
- **Social Security benefits** — The decision of when to begin Social Security retirement benefits is important, and usually can’t be changed once made. Whether you apply for benefits as a worker or spouse, you currently can begin receiving benefits as early as age 62. However, permanent benefit reductions are imposed for each month that benefits are received prior to your Normal

Retirement Age. As retirement nears, it’s a good idea to check the free Social Security Statement, which contains your earnings history and an estimate of benefits.

- **Health benefits** — This can be a major issue for people who retire prior to age 65, when Medicare and Medigap coverage may begin. Many employers do not offer to extend group health coverage beyond the period required by law. Even then many retiring workers must dig into their pockets to pay premiums. At age 65, coverage under Medicare Part A (hospital) is automatic for most people, and most retired people also elect to pay the modest premium required for Medicare Part B, which covers doctor bills and miscellaneous medical charges. It’s also important to evaluate private Medigap policies, which cover Medicare co-payments and deductibles.
- **Retirement distributions** — When workers retire, they can be offered the full balance of “vested” money in their company retirement plans. But before you accept a check for so much money, it is wise to have a clear idea of tax implications and investment choices available. One choice is to receive this money and roll it over to an IRA within 60 days. But even if you meet the rollover deadline, 20% of plan money goes to the federal government in withholding taxes. In many cases, it is better to have the plan directly transfer money into an IRA. Since you don’t handle the transfer, there is no federal tax withholding and 100% of your nest egg can grow tax-deferred.
- **Estate planning** — **It’s best to start planning for your estate as early as possible.** In recent years, there have been many changes (and proposed changes) in estate tax laws. That makes this a good time to review any existing estate plans, and also to take care of details such as writing a will or creating trusts. Park Avenue Securities (PAS) and The Guardian Life Insurance Company and the representative do not provide legal or tax advice or services. If you reach a point at which you feel pressured to make major decisions without adequate planning, you’ve waited too long. So, obtain the information and guidance you need to calmly consider all your choices. Competent financial professionals will offer illustrations that can help you chart a course through retirement, while projecting the levels of income and assets you need to maintain your lifestyle. In pre-retirement planning, you will make some of the most important financial decisions of your lifetime. Don’t make them in haste or alone.

About the Author

Nathan G Browning is a Registered Representative and offers securities products and services offered through Park Avenue Securities LLC (PAS), 7 Hanover Square, New York, NY 10004. PAS is a member NASD, SIPC. Material discussed is meant for general illustration and/or informational purposes only and it is not to be construed as tax, legal or investment advice. Although the information has been gathered from sources believed reliable, please note that individual situations can vary, therefore the information should be relied upon when coordinated with individual professional advisor. For questions on this and other financial planning matters, Nathan G Browning can be contacted at 866-807-8727.



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Images in Clinical Practice

submitted by: Evan Spivack, DDS, FAGD

Case presentation

A 24-year-old Caucasian male presented to University Hospital-UMDNJ for full mouth dental rehabilitation under general anesthesia. The patient's medical history was significant for autism. Review of the full mouth radiographic series led to the treatment planning for extraction of teeth number 18 (carious, nonrestorable) and 19 (impacted, overlying area of tooth number 18).



Surgical elevation of a full thickness mucoperiosteal flap was accomplished to gain access to tooth #18. Both teeth were removed without incident despite the need for removal of a significant quantity

of surrounding buccal bone. On reflection of the flap, the alveolar bone was noted to exhibit a bright yellow coloration. Postoperatively, it was confirmed by the guardian that the patient had a history of long-term tetracycline use several years previously.

Discussion

While it is widely known that tetracycline causes staining to the dentition when used during the period of tooth development, it is less commonly appreciated that pigmentation of other tissue types can also occur. There have been numerous reports in the medical and dental literature of yellow discoloration of alveolar bone following tetracycline use. Similarly, minocycline (a semisynthetic analogue of tetracycline) is often implicated in pigmentation of bone, breast milk and various soft tissues.

Although the exact mechanism is unknown, it is believed that tetracycline is deposited in adult bone in unchanged form, and in developing bone as the oxidized drug bound to calcium. Alveolar bone is remodeled through a complex process of osteoclastic and osteoblastic activity at a rate of approximately ten percent per year; as such, it may take several years for evidence of tetracycline use to diminish.

Acknowledgment:

Surgical procedure performed by Dr. Maano Milles, New Jersey Dental School-UMDNJ, Department of Oral and Maxillofacial Surgery.

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Cockings JM, Savage NW, Minocycline and oral pigmentation, *Aus Dent J*, 43(1):14-16, 1998.

Do you have any cases of clinical interest that you would like to share with your colleagues? If so, please e-mail the editor, including the image and related clinical information, at spivacev@umdnj.edu



Shirley Feuerstein

A Better Retirement Strategy

If you are like most dentists, you have done a relatively poor job, at least up until this point, of accumulating the necessary funds for your retirement. You should not feel embarrassed, only concerned. You are just one of the vast majority. The longer you have until retirement, the easier is to put off the need to make substantial contributions to your retirement savings. The ADA reported in 1994 that less than 4% of dentists would be in a financial position to retire at age 65. The ADA further reported in 1997 that dentists in the 50 to 54 age group only put aside 11.4% of their income towards retirement even though the smallest of retirement plan types allows a contribution of 15%.

Obviously, most 55-year-old dentists are probably quite far behind in funding for their retirement. With only ten years remaining, some critical, life-changing financial decisions will have to be made. One of three things will happen over the next 10 years to these 55 year olds.

- Statistically, a very large number of these dentists will continue to ignore the “ticking clock” and will not do anything (or at least very little). Many will reach age 65 only to discover that their practice is not worth what it was 10 years earlier and many will have to continue to practice because they will simply not be in a financial position to retire comfortably.
- A much smaller group of these 55 year olds will really knuckle down and start pouring as much funding as they possibly can into a pension plan. If they remain healthy and their practice income does not drop off over the next 10 years (as most practices do), many will reach age 65 with adequate retirement dollars. Unfortunately, it will be necessary for most of these dentists to sacrifice many personal financial needs and goals in order to fully satisfy their retirement needs. In addition, maximizing pension contributions for the doctor also means maximizing contributions for the employees. Not that the employees don’t deserve it, but it will represent another significant cash flow drain on the doctor.
- And finally, a very small percentage of these 55 year olds will make the most of their options. This group will not only adequately fund for their retirement, but will do it without suffering any reduced personal income and without sacrificing any personal needs and goals. And it is to those who wish to be included in this lucky group that we devote the remainder of this article.

Dr. Lucky is one of these 55-year-old dentists in our final group. Dr. Lucky sells his practice now for \$500,000 utilizing the Pre-Sale

Program and receives not only favorable tax treatment (we will discuss this more), but also a contractually guaranteed 10% interest rate. The structure of the Pre-Sale Program allows Dr. Lucky to continue to work full-time (less if he desires) for as long as he chooses and be compensated 40% of his personal collected production. In addition, he will be able to pick and choose the procedures he wants to do and the patients he wants to continue to treat.

But there is more to Dr. Lucky’s story... the majority of the practice sales proceeds (at least 75%) are taxed at very favorable capital gains rates instead of top bracket ordinary income tax rates (his accountant absolutely loves this). Under current law this represents a potential annual tax savings of approximately 30% of the income received! This obviously creates an enormous financial advantage. If Dr. Lucky uses his “tax favored” practice sale proceeds to support his family’s annual living needs, he can then use his provider compensation (the 40% independent contractor seller commission) to maximize his annual contributions into a pension plan. In fact, under current tax law, he may be able to utilize a defined benefit plan to shelter virtually all of his commission income thus having very little income that is taxed at ordinary income tax rates! And another major advantage is that Dr. Lucky will have no employees of his own after he sells his practice thus he will not be obligated to make pension contributions for anyone other than himself.

What does all this mean? Freedom and Dignity! Dr. Lucky will easily fund a handsome retirement nest-egg by age 65 (or probably even sooner); he will pay far less in income taxes each year; he will enjoy substantially more after-tax income (unless he decides to offset the higher income with less clinical time); he can enjoy more frequent and longer vacations; his family will be fully protected in the event of disability or death; he will not have any more practice overhead; and he will not have any more practice administrative responsibilities.

The time to begin planning your retirement and your freedom is long before you actually retire. You can plan your final practice years to be much more enjoyable and considerably more profitable.

About the author

Shirley Feuerstein, a transition consultant for PARAGON, INC., has vast experience with practice sales, mergers, presales, progressive ownership programs, partnerships and practice valuations. Ms. Feuerstein has over 30 years experience in the dental profession and understands the goals of dentists and can provide information about the transition process. She can be reached at her office (908) 222-0199 or cell (908) 868-9330 or email shirley@paragon.us.com.

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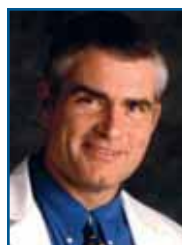
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Presentation by
Dr. Mark T. Murphy,
DDS, FAGD

Date: Friday, January 25, 2008

Location: Mount Laurel Marriott

7 CE credit hours

Co-sponsored by NJAGD, Southern Dental
Society, Vident, Sterngold &
Colonial Dental Lab

For information or to register,
visit the website at www.NJAGD.org

| October | November | December | January | February | March |
|--|--|--|--|--|---|
| <p>11 Thursday NJAGD AIM Mastership Program Presentations</p> | <p>2 Participation Co-Sponsored by NJAGD and the Perio Institute Speaker: Dr. Jim Kohner "Connective Tissue Grafting 'hands-on' Workshop"</p> | <p>3 Wisdom Deadline for Winter 2008 Issue</p> | <p>7 NJAGD Membership and Board Meeting</p> | <p>2 Wisdom Deadline for Spring 2008 Issue</p> | <p>7-8 Participation Co-Sponsored by NJAGD and the Perio Institute Speaker: Dr. Steven Cooper "Perio Surgery Hands On Workshop"</p> |
| <p>12-14 Thurs.-Sun. NJAGD AIM Mastership Program Speaker: Dr. Ira Schecter "Implant Placement"</p> | <p>9 Friday NJAGD 2010 Special Membership and Board Meeting</p> | | <p>25 Dr. Donald DeFonce Memorial Lecture Speaker: Dr. Mark Murphy "Seven Habits of Highly Effective Dental Teams"</p> | | <p>12 Lecture & Participation Speaker: Dr. John Burgess "Restorative Dentistry Update 2008: Improving Your Impression-Making & Provisional Skills"</p> |
| <p>24 Wednesday Lecture Speaker: Dr. Edward Swift "Clinical Dental Materials: A Practical Review"</p> | | | | | |

NJAGD highlights

NJAGD Annual Meeting Atlantic City, NJ June 6, 2007



AGD Annual Meeting

San Diego, CA

June 27-

July 1, 2007



Bermuda Continuing Education Cruise

August 12-17, 2007



The New Jersey Academy of General Dentistry would like to congratulate the following doctors on their achievements

2007 Fellows

Todd T. Garland, DDS
James C. Burden, DMD
Michelle Sabater Weddle, DDS
Nathan A. Dinsbach, DDS
Douglas M. Masi, DMD
Michael J. Bixby, DMD
Stephen J. Malki, DMD
Anthony S. Corello, DMD

2007 Masters

Laurence C. Breiterman, DMD, FAGD
Peter E. Ciampi, DDS, FAGD
Omar F. Suarez, DMD, FAGD
Frank T. Sagen, DDS, FAGD
Mark A. Vitale, DMD, FAGD
Paul M. Tedeschi, DMD, FAGD
Jerry M. Strauss, DMD, FAGD
Andrew P. Galante, DMD, FAGD

2007 Life-long Service Award Recipients

Mark Messer, DDS, MAGD
Brad Strober DMD, MAGD
Bruce Small, DMD, MAGD



REGISTRATION FORM



ONE FORM PER PERSON
PLEASE DO NOT ALTER FORM

PLEASE DUPLICATE IF NECESSARY

Please check one: DDS DMD RDA RDH Office Staff

Name (please print): _____

Primary Address: _____ City/State/Zip: _____

AGD#: _____ Phone #: _____ Fax #: _____

Payment Information (A form of payment must accompany the pre-registration form in order to be processed)

Check (payable to NJAGD) MasterCard Visa AMEX TOTAL AMOUNT: \$ _____

Credit Card No.: _____ Exp. Date: _____ Billing Zip Code: _____

Print Name: _____ Signature: _____

Course Fees

Please check box

- Day/Date: Wednesday, September 19, 2007 / Lecture A
Fee: **Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00**
Speaker: Dr. Marvin Simring
Course Title: "Occlusal Management"
- Day/Date: Thursday, October 11, 2007 / AIM #9
Fee: **Fee already paid in April 2007**
Speaker: Dr. Douglas Damm
Course Title: AIM Mastership Program (Critique from April 2007)
- Day/Date: Friday—Sunday, October 12—14, 2007 / AIM #10
Fee: **Mbr. \$1,250.00 (2 ½ days) Non-Mbr. \$1,600.00 Light \$850.00**
Speaker: Dr. Ira Schechter
Course Title: AIM Mastership Program "Basic Implant Surgery Workshop"
- Day/Date: Wednesday, October 24, 2007 / Lecture B
Fee: **Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00**
Speaker: Dr. Edward Swift
Course Title: "Untangling the Confusion of Today's Restorative Materials"
- Day/Date: Friday, November 2, 2007 / Lecture C
Fee: **Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00**
Speaker: Dr. Jim Kohner
Course Title: "Connective Tissue Grafting Hands On Workshop"
- Day/Date: Friday, January 25, 2008 / Lecture D
Fee: **Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00**
Speaker: Dr. Mark Murphy (DeFonce Lecture)
Course Title: "Seven Habits of Highly Effective Dental Teams"
- Day/Date: Friday—Saturday / March 7—8, 2008 / Lecture E
Fee: **Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00**
Speaker: Dr. Steven Cooper
Course Title: "Perio Surgery Hands On Workshop"

Please check box

- Day/Date: Wednesday, March 12, 2008 / Lecture F
Fee: **PARTICIPATION & LECTURE Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00
LECTURE ONLY Mbr. \$110.00 Non-Mbr. \$125.00 Guest \$99.00**
Speaker: Dr. John Burgess
Course Title: "Restorative Dentistry Update 2008:
Improving Your Impression-Making Skills & Provisionals"
- Day/Date: Thursday, May 15, 2008 / AIM #10
Fee: **Fee already paid in October 2007**
Speaker: Dr. John DiPonziano
Course Title: AIM Mastership Program
- Day/Date: Friday—Sunday, May 16—18, 2008 / AIM #11
Fee: **Mbr. \$1,050.00 (2 ½ days) Non-Mbr. \$1,400.00 Light \$475.00**
Speaker: Dr. John DiPonziano
Course Title: AIM Mastership Program "Implant Prosthetics & Restoration"
- Day/Date: Wednesday, May 21, 2008 / Lecture G
Fee: **PARTICIPATION & LECTURE Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00
LECTURE ONLY Mbr. \$110.00 Non-Mbr. \$125.00 Guest \$99.00**
Speaker: Dr. Dennis Brave
Course Title: "Real World Endo"
- Day/Date: Friday, September 19, 2008 / Lecture A
Fee: **Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00**
Speaker: Dr. Dennis Thompson
Course Title: "Bone Grafting & GTR Hands On Workshop"
- Day/Date: Wednesday, October 15, 2008 / Lecture B
Fee: **Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00**
Speaker: Dr. Joseph Massad
Course Title: "Advances in Complete Removable Prosthodontics
Including Enhancements in Implant Dentistry"
- Day/Date: Friday, January 16, 2009 / Lecture D
Fee: **Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00**
Speaker: Dr. Robert Fazio (DeFonce Lecture)
Course Title: "Pharmacology"

Please mail or fax to:

NJAGD
One Dental Plaza, PO Box 6020, North Brunswick, New Jersey 08902-6020
Fax: (732) 821-1082

INCOMPLETE REGISTRATION FORMS WILL NOT BE PROCESSED
CONFIRMATIONS WILL BE MAILED PRIOR TO THE LECTURE

Cancellation Policy: All requests for refunds must be in writing. Requests post-marked or faxed after 30 days prior to the course date will not be honored. Please allow up to six (6) weeks after the conclusion of the course for refund processing.



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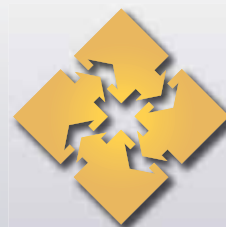
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