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Spring 2014

# LVI Visions

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IACA

# 10 Year Anniversary

Jessica Carter

DENTISTRY BY
Dr. Todd Fincher, Greenwood, MS

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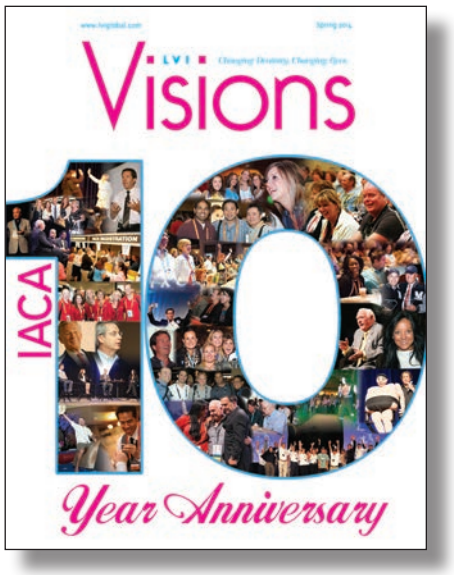
# Contents & Contributors




**This issue is dedicated to the past 10 Years of the IACA.**



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## editor's note

*Dr. Heidi Dickerson is the President of North American/Australian Operations at LVI Global and has been a featured lecturer at every IACA meeting.*

**When you go to the dentist you expect him/her to have up to date skills and the latest in technology. Change in dentistry continues to happen all the time. Continuous education is necessary for every practitioner to stay on top of all the changes and advancements made each year.**

In some fields, continuing education isn't an option. Dentists and many other licensed professionals must complete a certain number of credit hours to maintain their professional licensure. Many Dentist's choose to take 'just enough' credit hours for maintenance. Wouldn't it be great to go to someone who takes well beyond the 'requirement' to be the best that he/she can be?

That's exactly what I love about the IACA! Not only is the education presented there the very best… but so are the docs that attend. They desire to learn above and beyond what the minimal requirements are by their states. They desire to learn the very latest and greatest and to increase their skills by leaps and bounds! That's exactly the kind of practitioner I want taking care of me!!

This issue is dedicated to the past 10 Years of the IACA. Many thanks go to all those who make this organization a premiere choice for dental education. Most of the articles in this issue are written by presidents (past and current) of the IACA. Take the time to read them all… you JUST might learn a thing or two!

Cheers and congratulations to the IACA…

Heidi

H. Dickerson, DDS

**hdickerson@lviglobal.com**

# ADVANCING THE ART OF DENTISTRY

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# Why the IACA?

Dr. Bill Dickerson the founder of the IACA.

The IACA was launched in 2005 because many organizations in dentistry were philosophically exclusive with a closed door policy about progressive, cutting edge information. One in particular that previously had been the cutting edge organization had not only fallen to a level of mediocrity but to a position of protecting the status quo like so many others and was intentionally preventing podium time to any differing philosophy, going to extremes to eliminate any physiologically based science and techniques from being presented at their annual meeting. There needed to be a new organization that would not only pioneer the profession but allow good solid debate of controversial issues, allowing both sides to present their case which would propagate the growth and advancement of the profession.

Because of the demand for an organization like this, with only six months preparation, more than 600 people gathered for the first meeting in San Diego in the summer of 2005. The evolution of the organization progressed through the years and it has become the voice of the physiologically based science of dentistry that has been known as neuromuscular dentistry. Now in its tenth year, it has led the way in fighting the professional ignorance, insurance company backed advocates and special interest groups with vested interests in stifling any growth of this logical and evidenced based field of dentistry. Because of the IACA, thousands of dentists have been able to help tens of thousands of their patients improve their lives. It will celebrate its tenth annual meeting this summer in Atlantis in the Bahamas with over 1,000 attendees expected to gather in paradise for this historic event.

It has also become the most positive, upbeat and inspiring meeting in dentistry. The energy and excitement at these meetings is infectious and carries over to the dentist's practices when they get home. On Monday information is practical and eye opening, giving many the direction and avenues they need to improve their practices and treatment for their patients. Everyone leaves knowing that doing the best for your patients is not only the right thing to do; it's the only thing to do. Because of all this, while other organizations are losing members and attendance at their annual meetings during these economic times, the IACA continues to grow.

***Because of the IACA, thousands of dentists have been able to help tens of thousands of their patients improve their lives.***

This positive attitude is carried through on the IACA forum where valuable information is shared on a daily if not hourly basis, since there are members from all over the world. The support for each other is palpable, unlike most animus and hostile dental forums that litter the internet. Many will ask questions while a patient is in a chair and will receive a response within minutes. Along with the addition of the IACA buying club, free subscription to Vision's magazine, reduced rate for the annual meeting, free IACA educational webinars, reduction in educational courses at LVI, industry discounts and the quarterly newsletter, members are placed on the website for patients looking for IACA dentists and allowed to use the IACA logo for promotional purposes.

But for the freedom for ANYONE to practice dentistry that THEY feel is best for their patients, the IACA has become THE voice for that freedom. There is a concerted effort by various interest groups to dictate how we as dentists

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must practice so we do what they think is best or by abiding by the dictates of insurance procedures for example. The IACA strongly believes in the fact that you are educated doctors, who can review the available information out there and make your own decisions as what is the best treatment for your patients. Just look at some of the things the IACA does to protect your right to decide how YOU practice:

**1. IACA fights against the threat and assault on progressive dentistry by creating a strong and powerful voice that only a large membership can do.**

**2. IACA sends representatives to critical meetings to protect your rights representing a large membership.**

**3. IACA sends letters to government bodies, dental organizations and industry leaders supporting your rights representing a large membership.**

**4. IACA supports those that need help with technical advice and direction in legal or board related matters.**

**5. IACA initiates TMD Alliance responses to help protect your rights.**

**6. IACA initiates letter writing campaigns to support your rights.**

**7. IACA facilitates articles that support NM dentistry representing a large organization that improves the chance of publication.**

**8. IACA has a team of employees behind all this that work incredibly hard to organize these efforts. None of this could be done without these employees efforts.**

**9. IACA has the network to monitor and report on practice restrictive movements happening in various board and ruling dental associations.**

**10. IACA is available for advice on local issues of concern.**

**11. IACA is able to provide world-wide information on movements among restrictive groups that could affect you later.**

**12. IACA promotes NMD research to be published.**

**13. IACA places on the Internet through their website, letters to editors that a publication might refuse to print making it show up higher on searches with the SEO of the IACA.**

**14. IACA meeting makes possible an interactive discussion on physiologic base dentistry which provides a better chance for ideas than a newsletter or email.**

**15. IACA meeting provides up to date information on developments which lessens your chance of coming under attack by uninformed people that are in authority positions.**

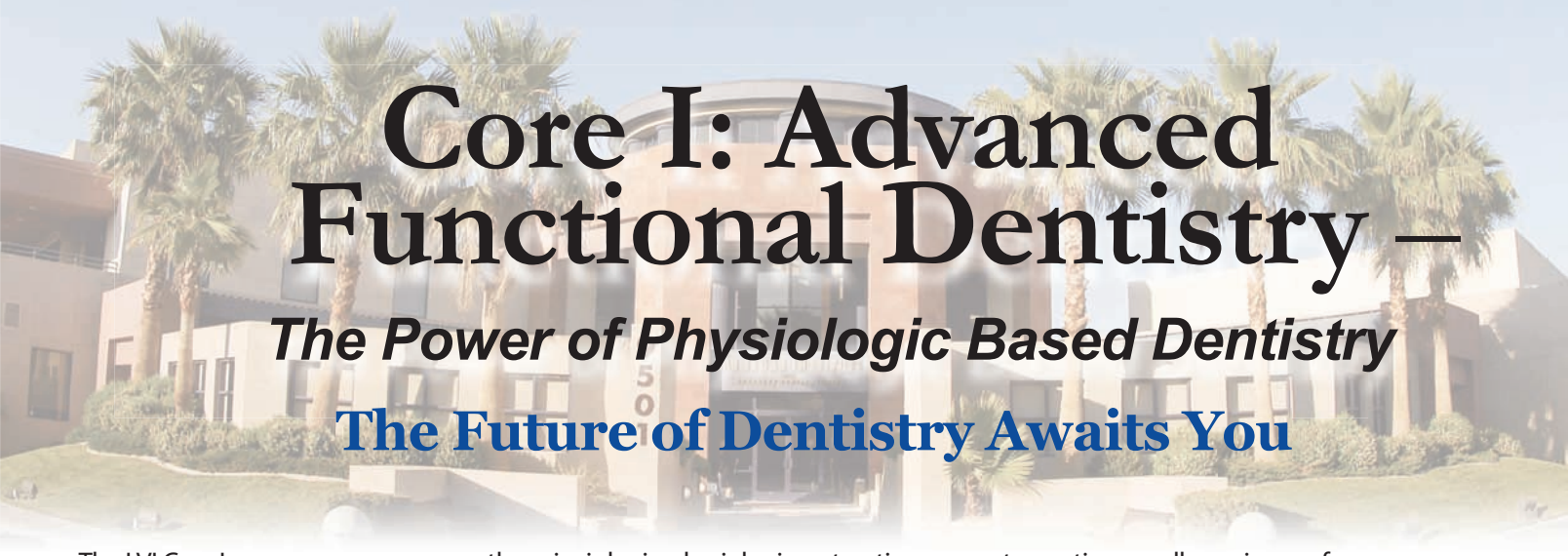
**16. IACA is like an Army and with a larger trained and active force opposing forces will be hesitant to attack versus if it is only YOU!**

**17. IACA meeting provides enough yearly CE hours in one meeting that qualifies for re-licensure for most licensing bodies.**

**18. And most importantly… it gives you a sense that you are involved and participating in the efforts to save dentistry from those that would like to take our individual practice freedoms away and supporting the growth of the organization that is the voice of physiologically based dentistry.**

## *Can you imagine what would happen if there was no IACA?*

So here is to the ten year annual meeting anniversary of the IACA and all I can say is…. Thank you to all of those that have supported this amazing and essential organization. Here is to ten more years of growth, making the voice of reason even more powerful.



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The LVI Core I program encompasses the principles in physiologic restorative concepts creating excellence in care for your patients and prosperity for you. This program will start you on a path to greater understanding and enjoyment of our profession while creating loyal, enthusiastic and grateful patients!

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In essence, become a mouth doctor with ability to do things you never were taught in dental school. You have patients in your practice RIGHT NOW that can benefit from these concepts and you have the opportunity to change their lives starting the day you return to your office.

Dr. Bill Dickerson, Dr. Heidi Dickerson and Dr. Mark Duncan will present this information in a practical, easy to understand manner where you will feel comfortable presenting these exciting and practice building new options to your patients on Monday. Don't miss this golden opportunity to find out about this incredible world of dentistry that awaits you!

## Core I guarantee: We are so sure you will be satisfied with this course that we offer a money back guarantee!

**"LVI has given me a new driving force in my career. It has recharged my enthusiasm for dentistry and made me realize that my career choice was not a mistake."**

—Dr. Charles Shin, Stouffville, ON

**"I wish I would have attended LVI earlier in my career. I still have time to make a difference but this info is too valuable to not be used throughout an entire dental career."**

—Dr. Tim Stirneman Algonquin, IL

**"Not only did I learn what I didn't know about dentistry, I learned how to help my own long history of pain in the head and neck. Thanks for the missing link."**

— Dr. Paul Bell, Denver, CO

### Upcoming 2014 DATES

**March 27-29 -** Toronto
**June 18-20 -** LVI (Las Vegas)
**October 1-3 -** LVI (Las Vegas)
**December 10-12-** LVI (Las Vegas)

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*Dr. Joseph Barton was the IACA President during the 2005 meeting in San Diego, CA and the 2006 IACA meeting in Montreal, QC.*

# HISTORY of the IACA

As founding president of the IACA I wanted to share a little history about how and why the IACA started and how it has evolved today.

*"There comes a time when the status quo isn't good enough. When professionally you feel the need to be challenged and learn new concepts."*

Prior to the inception of the IACA, there were a limited number of organizations that dentists, committed to furthering their education and advancing the profession, could affiliate. A small, dedicated group of dentists (the founding members of the IACA) identified the importance and value in keeping abreast of the latest advances in oral health care and providing the very best care for their patients.

The IACA was established to provide a vehicle for health care professionals to learn and experience advanced oral health and practice management education. One of the IACA's priorities is also to create an enjoyable environment in which doctors, family and their team members could interact.

Here is the time line and highlights of the past meetings. As you can see we have been to some amazing locations and have had quite a good time both learning and renewing friendships.

## 2005 Inaugural IACA Meeting; San Diego, California:

The 2005 inaugural IACA meeting attracted more than 400 professionals to the Paradise Point Resort and Spa in San Diego, CA. The opening session set the stage for the caliber of this meeting with a Panel Discussion on Dentistry's Future featuring Dr. Omer Reed, Dr. Bill Dorfman and Dr. Bill Dickerson. The overwhelming response to this meeting resulted in rooms overflowing out into the hallways to hear primetime speakers like Dr. Matt Bynum and Dr. Heidi Dickerson. The unprecedented exchange of information, knowledge and experience set the standard for future IACA meetings and brought our profession to a level that only a highly enthused collaboration can foster.

## 2006 Montreal, Quebec:

Over 600 aesthetic professionals from Canada, Australia, United States, and Russia were in attendance in the convention hall at the Fairmont Queen Elizabeth. The IACA was proud to offer a broad range of highly motivating presentations in Montreal that provided our members with the most cutting edge advances in aesthetic dentistry and practice management. To accommodate our French-speaking dentists an entire day of translated lectures coincided with the IACA general session.

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## 2007 Chicago, Illinois:

A great city and a great event, in the words of many: The best conference anywhere ever! Sitting in lectures beside the giants of dentistry, listening to the most state-of-the-art concepts and techniques, enjoying camaraderie all but lost at many CE Events. This year's event featured two outstanding panels one focused on "Practice Management: Getting Your Practice to the Next Level" and the other "Incorporating Occlusion in Your Practice." A great opportunity to learn, grow and become encouraged to be the best that we can be.

## 2008 Orlando, Florida:

The IACA met in Orlando for what was considered the young organizations best meeting yet. The IACA assembled an international group of attendees and speakers who enjoyed four days of incredible presentations and camaraderie. The highlight of the meeting was a very inspirational and motivating lecture by Dr. Bill Dickerson "The Road to Success: Talent is Never Enough", and a talk moderated by Dr. Bill Dickerson with the Legends of Aesthetic Dentistry: Dr. Ron Jackson, Dr. Larry Rosenthal and Dr. Ross Nash. This meeting was so excellent it set the bar for the rest!

## 2009 San Francisco, California:

Nearly 1,000 dental professionals got together under one roof at the historic Westin St Francis hotel in San Francisco. The cozy atmosphere coupled with the typical San Francisco chill made it a perfect setting for camaraderie, learning, fun and new friendships. Neil Jeffrey, former San Diego Chargers quarterback, began our opening session with an entertaining and inspiring talk challenging everyone to: "Dream big, believe with your heart, show up and make a play." The IACA has always been committed to the entire office and the Team Panel featuring Sherry Blair, Ginny Hegarty, Sally McKenzie and Judy Mausolf reinforced this commitment.

## 2010 Boston, Massachusetts:

What an outstanding meeting this was! The lectures offered such variety and depth of knowledge that every session ended up causing everyone some serious thought as to which one they would attend.

IACA is a family and the camaraderie and spirit is palpable. It is the buzz in the hallways and the friendships being made and renewed within an atmosphere of joy in our profession that is unrivalled in the continuing education world. The comment from the executive staff of the Westin Boston Waterfront that this was the best conference ever held in the hotel because of the delegates, their attitude, participation is a true testament of what the IACA has become.

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## (in under 4 minutes)

# You Don't Want to Miss an Episode!


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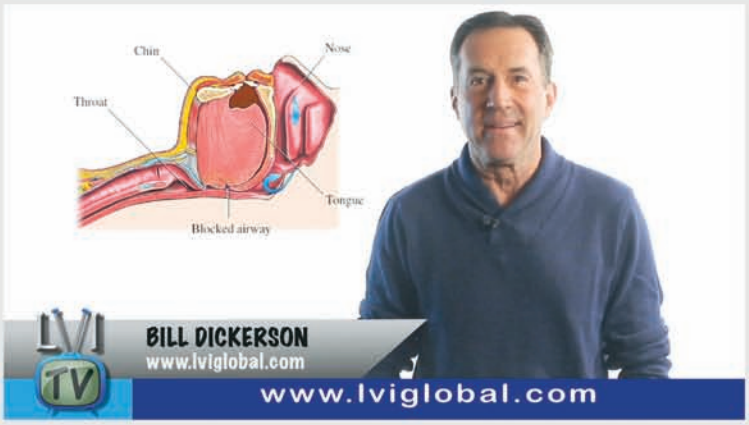


Episode 7: What you are not learning in dental school


Episode 8: Heart Health

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## 2011 San Diego, California:

As we went back to our flagship city in San Diego, like the inaugural conference in 2005 San Diego again surpassed the expectations of everyone who attended the conference. A vital part of our success is our laboratory technicians and this was reinforced by LVI Master Technician, Mike Milne's presentation: "Developing Porcelain Masterpieces." Several mentioned that it was the perfect balance of lectures and activities in a meeting that they have ever attended, as well as the most amazing closing ceremony ever aboard the USS Midway!

The IACA is truly the one meeting where colleagues new and old can learn the most up to date information and techniques in Neuromuscular Dentistry as well get together with friends and family.

## 2012 Hollywood, Florida:

In 2012 we headed back to the East coast and enjoyed some beach time in Hollywood, FL. Like the previous conferences, Hollywood continued on the tradition on being one of the best meetings to attend in Dentistry today! The Total Health Concept in the dental practice was introduced with a panel moderated by Dr. Heidi Dickerson including discussions on nutrition, gut health, and the oral health systemic connection featuring Dr. Keith Holden, Jill Taylor, nutritionist Paula Mendelsohn and Dr. Joseph Barton. The annual international Tug of War took to the beach for again one of the highlights of the meeting. The IACA continues to strive for perfection at each meeting and 2012 was no different.

## 2013 Calgary, Alberta:

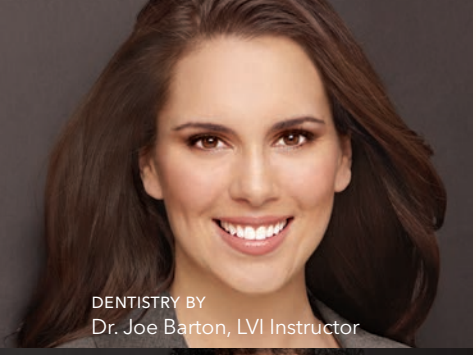
Once again the IACA returned to Canada to a very warm welcome. The main focus of this year's theme was protecting our right to practice dentistry within the scope of our training. Specifically targeting the threat Neuromuscular Dentistry is facing in Canada and other countries. With an opening session panel featuring Dr. Bill Dickerson, Dr. Sahag Mahseredjian, Dr. David Miller and Dr. Prabu Raman the IACA has become The Voice of Neuromuscular Dentistry and is committed to working toward protecting our freedom to practice. With topics ranging from total health and nutrition to advanced techniques in Neuromuscular Dentistry and Sleep Medicine, the IACA continues to set the bar for education.

## IACA Has become The Voice of NM Dentistry - What We Have Done For You?

The members of the IACA continue to be a united voice on behalf of those who practice Neuromuscular Dentistry. This voice is important to protect our freedom to practice within the scope of our training. We need your support as a member of the IACA to show our strength in numbers and to continue to be a powerful voice.

## 2014 Atlantis, Bahamas:

Join us at Atlantis in the Bahamas for the ten year anniversary of the IACA to not only show your support for Neuromuscular Dentistry but also to participate in an amazing learning experience unlike any other in Dentistry.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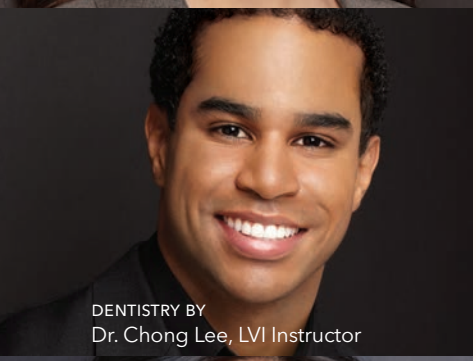
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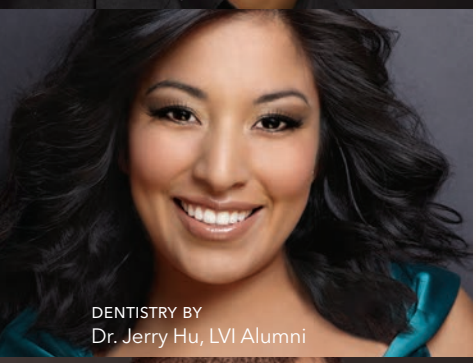
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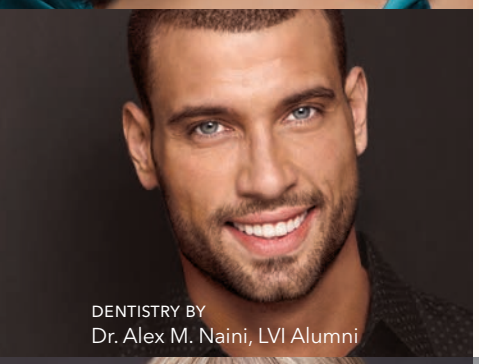
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Columbus, OH 5/30–5/31 · Sacramento, CA 6/6–6/7 · Vancouver, BC - Canada 6/20–6/21

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This activity is supported by funding from MicroDental Laboratories. LVI Global has a number of corporate partners who contribute products and services that enhance the educational experience of those attending LVI Global courses and events, which are disclosed to participants at the activities.

MICRODENTAL LABORATORIES

*Dr. James Harding was the IACA's President at the 2008 IACA in Orlando, FL.*

# Having One Team Member NOT ON BOARD Can Sink the Entire Ship…

## *Or at the Very Least, Steer it in the Wrong Direction!*

Let's face it doctors, when it comes to building those great dental teams we all hear and dream so much about, we are "not too good" at this part of our job. Most of us poorly recruit, interview, hire, train and build the employees who are vitally important in making our practices successful. Not to mention having the right team in place makes for a much more enjoyable place to spend 40 hours a week! What perhaps is most alarming is how we continue to make the same mistakes with these team issues hoping for a better outcome. I know we have all heard the definition of insanity so no reason to rehash that here!

While there are many reasons why a high percentage of dentists fail miserably in this critical part of our professional lives, a strong case could be made that we simply were never given the proper tools in dental school to succeed. Additionally, the day to day hustle and bustle of running a busy dental practice is usually not conducive to training employees and team building. I think most dentists would be shocked if they realized how much more time, energy, and resources are spent in the corporate world on employee development. Systems and policies on how to run every facet of a company are the norm in the business universe while they seem to continue to be the exception in dental practices.

One very interesting example of this cooperate dedication to employee development is Verizon which has been regularly recognized by Training Magazine as the top company in the area of employee development and training. Verizon invests $300 million in development, education and training of its employees and another $100 million in tuition assistance each year. This equates to almost $13,000 per employee every year for training. That type of commitment clearly demonstrates why they are considered one of the best companies to work for with high employee and customer satisfaction when compared with their competitors.

*We dentists should look at these types of programs more closely when we are trying to build our teams.*

A few years ago I purchased a small rural dental practice from a retiring dentist. Along with the purchase I inherited a group of employees who had been working together for several years. Unfortunately, the extent of the team training primarily consisted of going to a yearly OSHA update seminar.

While important this did not exactly constitute high-level systems and policy training and team building. Recognizing that this would never work I immediately set down a path of

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Rx Only

transforming this group of employees into a "team." Looking back on this process of righting the ship it is interesting how I did several things very well and others, well...not so much!

*It is my strong opinion that the first thing most dentists need is to enlist the services of someone to help create a high functioning dental team and the necessary systems to run a high functioning dental office.*

In my case, I have procured the services of Sherry Blair at The Las Vegas Institute for many years and for numerous different issues. Sherry has not only completed in-office training multiple times for my teams, she has taught them at LVI during Core courses and perhaps just as importantly, always been there to answer my calls and emails of desperation and panic! This type of training has proven to be vital in all areas of business management that I'm willing to admit is not my strength.

For most of us highly driven dental types who tend to be more involved and concerned with the bond strength of our latest resin, we require someone to help "steer" the office in the right direction and prevent the inevitable "sinking" of our practices when the whole team is not on board. This office I purchased was very eager to learn a whole new way of doing dentistry so that proved to be a very valuable starting point. Unfortunately, there was one very important piece of this puzzle known as a dental team who did not fully buy into the "new" way of doing things. I was, as often is the case, the last person to realize how this one team member had become a cancer and threatened the success of this adventure!

Just before mutiny broke out on my ship I finally listened to the rather obvious hints and suggestions of the rest of the crew and removed the employee. I think the rest of the team would have rather she walked the plank than spend another day bringing down our ship! What was even more interesting was that the pieces of a great puzzle were right there already on payroll just waiting to be given the opportunity to succeed! All that was required was some minor additional training from our trusted consultant, Sherry Blair and the team was off and running. The systems can be there but if they are not being utilized by everyone it will remain difficult if not impossible to reach your full potential.

In a matter of two months after this "Super Crew" took control of our ship the office was regularly doubling the production of the prior six months and the accounts receivable went from a figure that caused me to have heart palpations to being in a "negative" range I never imagined was possible. Our case acceptance went through the roof and people were paying in advance for all of their dental procedures. Additionally, with everyone so much happier at work the atmosphere became amazing. Not a single day would go by without this being recognized by our clients which was validation of how much better the environment had become.

Now that the ship has been righted and we no longer need to be constantly bailing water we have moved on to bigger and higher level Team Development. This conglomeration of employees has become a TEAM and now craves new learning and growth. All I can do is try to hold on and gently steer them in a direction where this dental office remains a place where people enjoy coming to work each and every day. If I don't keep up they might throw me overboard!

Does your team have a piece that does not fit and is holding you back or worse yet, sinking your ship? Don't repeat the mistakes I made and be the last one to know. Take a close look at your employees and office systems to make sure you are ready to set sail. Most importantly, seek the services of someone you can trust to help build the practice of your dreams. Become the captain of your office!

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*HAPPY PATIENT CAPTURING THE CHANGE ON HER iPHONE!*
*Dr. Fred Calavassy was a speaker at the 2009 IACA in San Francisco, CA.*

# DIRECT BONDED COMPOSITE RESIN "VENEERS" AS A CONSERVATIVE OPTION FOR AESTHETIC TREATMENT

The power of conservative adhesive aesthetic dentistry is very relevant in the dental arena and can be well exhibited in the treatment case below.

Despite many material choices available to us today, conservative cosmetic adhesive dentistry can achieve exceptional, long term success and also provides a means to prevent tooth loss in the future. This case demonstrates that conservative adhesive dentistry, used in the correct way, can provide excellent results and durable long term restorations. The difficulty with this treatment lies in the "creation" of such beauty, though with adequate understanding of color, shape and contour, magnificent aesthetic results can be achieved directly. It should also be noted that clinical excellence with direct bonded composite resin (whichever brand!) can be achieved in a day to day clinical setting not simply in a teaching environment with time to spare.

## H I S T O R Y

The patient is a 37 year old female in good physical health. Her remaining dentition is in good health. I first met Mrs. P. C. at a function as she is in the dental industry. Despite her attractive appearance, her smile was hindered by the extent of erosion to the incisal edges due to a history of bulimia in the past.

The teeth were periodontally sound and there were no neuromuscular symptoms though some signs of occlusal disharmony. The anterior open bite was definitively conducive to an "additive" conservative aesthetic approach to care. The pre-treatment appearance of the smile and teeth are shown in this article.

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## TREATMENT

The treatment involved direct bonding of the 13-23 with the desired effects being as follows:

- Replace eroded enamel with direct bonded composite resin
- Evening of the smile line
- Brightening of value
- Re-creation of natural tooth contour to emulate nature.

*Clinical treatment involved the following steps:*

Pro-operative impressions to manufacture a wax-up of the ideal contours of the teeth. A putty stent was manufactured to recreate the wax up and to be used as a template for the direct bonded composite resin.

Clinically:

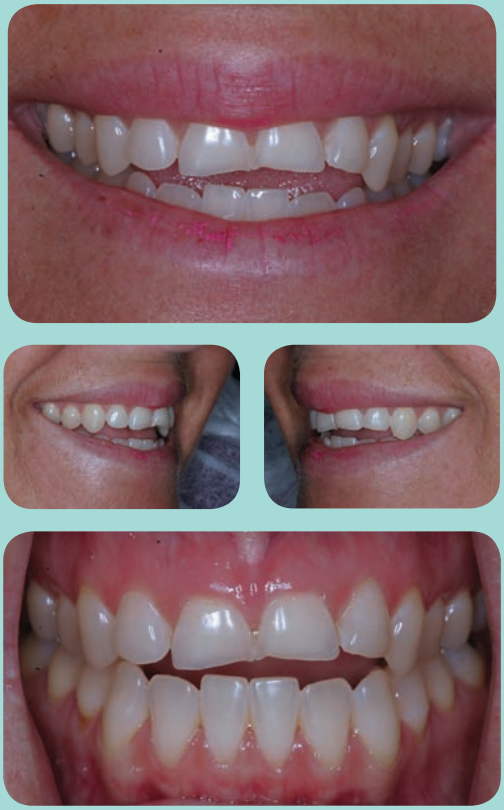
1. Occlusion was checked and noted. This was to allow a mental image of the finish lines of composite resin on the lingual inclines.

2. Local anaesthetic was used as the extent of enamel loss on the palatal aspect in particular has led to severe sensitivity.

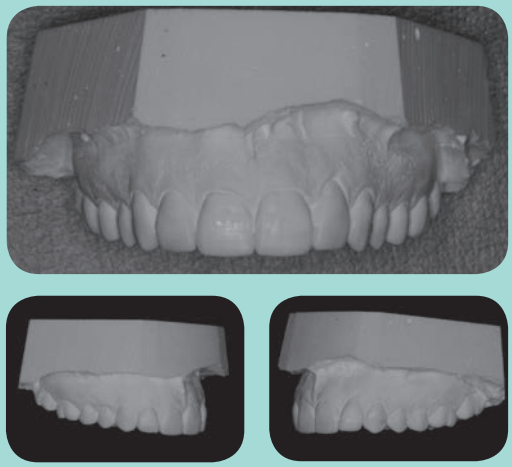
3. Shade selection was performed prior to placement of rubber dam and tooth dehydration. In this case a 3M Espe product was used ("Filtek Supreme XTE") due to its ease of placement and non-slumping characteristics as well as it's superb polishability and excellent durability. The shades chosen were WE and B1B.

4. As the patient was happy with the shape and length of the wax up done prior to treatment, a direct putty stent was made to facilitate replication of the existing shape and length of the ideal wax up.

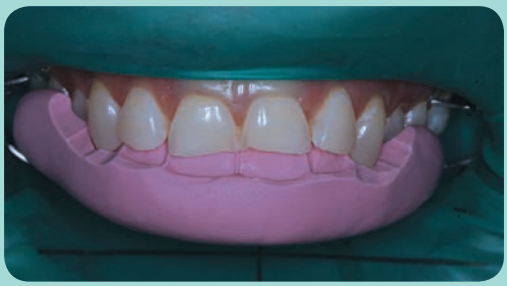
5. The anterior segment was isolated with rubber dam to facilitate a dry operative field. It is worth noting the importance of placement of rubber dam even whilst working in the anterior segment due to high relative humidity which may affect bonding through contamination. During palatal sealing of the rubber dam with fast setting bite registration material, the putty stent was seated to allow the ability for the stent to be seated while the rubber dam is in situ and sealed.



PRE-OPERATIVE IMAGES



PRE-OPERATIVE IMAGES



RUBBER DAM ISOLATION AND PUTTY STENT TRY-IN

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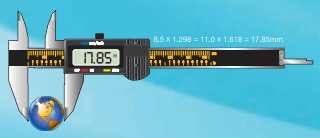

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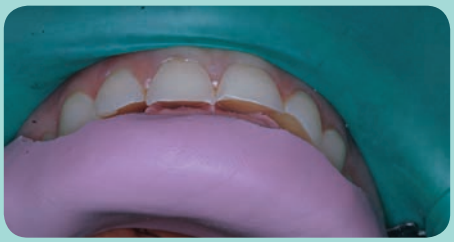
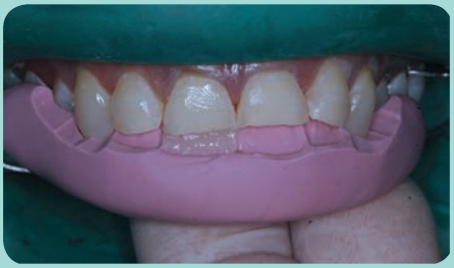
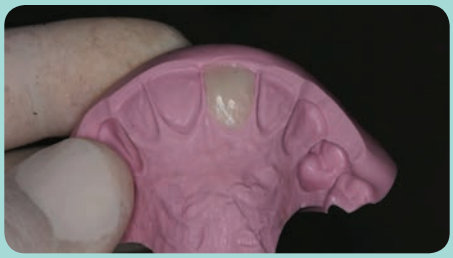


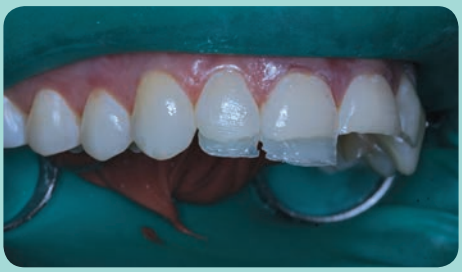
PUTTY STENT SHOWING EXTENT OF PALATAL EROSION



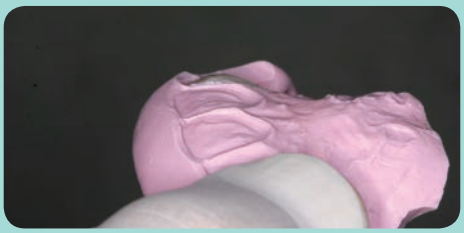
INITIAL TRANSLUCENT SHADE BUILDING UP PALATAL WALL OF TOOTH SHADE – WE



INITIAL COMPOSITE RESIN INCREMENT PLACED ON THE PUTTY STENT APPROXIMATING THE THICKNESS OF THE DEFICIT TO MINIMIZE EXCESS



CONTINUATION OF PALATAL WALL PLACEMENT FOR EACH TOOTH SHADE – WE



NOTE THE OVER-CONTOURED RESIN TO ENABLE EXCELLENT ADAPTATION TO THE PALATAL WALL SHADE – WE

6 The existing teeth were "roughened" using a high speed handpiece and the teeth prepared for delivery of the new definitive restorations.

7 The teeth were etched with 37% phosphoric acid and washed as per recommendations.

8 Scotchbond Universal was used as the adhesive utilizing a wet bonding technique following total etching of the preparations.

9 Incremental build up of direct bonded composite resin was placed utilizing the stent for guidance of length and lingual wall position. An initial layer of shade WE was used followed by a second layer of B1B followed by a third layer of WE. The additions were "framed" using more opacious body shades to simulate an incisal "halo". The teeth were separated after each palatal increment using an interproximal saw with care to not create gingival irritation or bleeding. "Filtek Supreme XTE" is exceptional at color blend and matches natural tooth translucency/opacity extremely well. The author prefers to slightly over-contour the final layer to shape through "cut back". Some clinicians prefer "building up" sculpture rather than "cutting back".

10 Following composite placement, the resin was grossly contoured then the rubber dam was removed.

11 Prior to final finishing, occlusion was checked for interferences and canine protected lateral excursions. Chew cycle interferences were also removed.

12 Composite resin was finished with interproximal finishing strips, "Soflex Discs" (3M), and finally with "Pogo" rubber impregnated polishing wheels (Dentsply) to create a high surface lustre.

As can be seen, conservative direct bonded composite resin can achieve excellent results and maintain the integrity of the existing tooth structure if tooth position, shape and contour would like to be maintained. This result has allowed the patient to forget the problems which the past history created and, once again, I encourage all to explore the artist within and attempt the use of direct bonded composite resin anterior restorations, as materials have come a long way since their inception.

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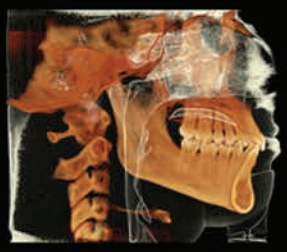

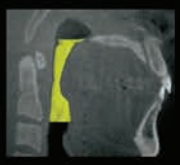

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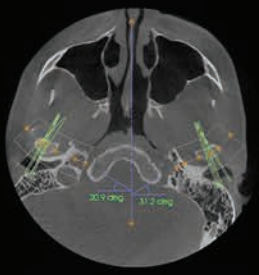
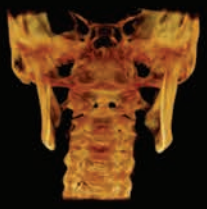


Paranasal Sinuses
TMJ's



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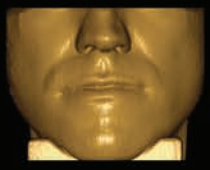
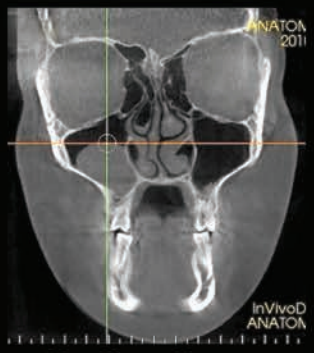
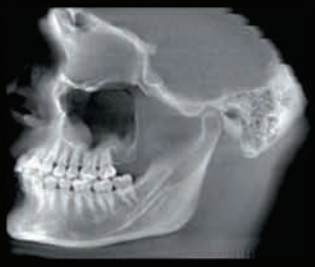


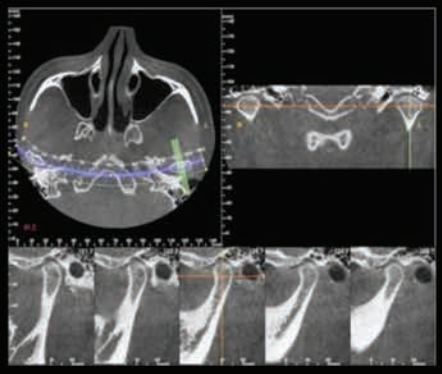
Soft Tissue Filters



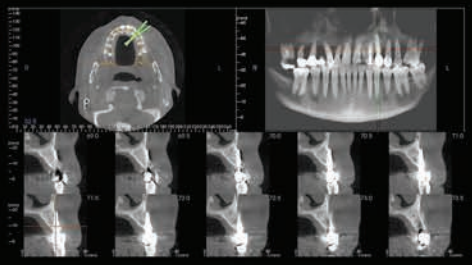

Maxillary Sinuses

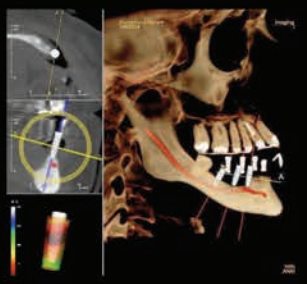


TMJ's, Maxillary Sinus Pseudocysts



TMJ's, Deviated Septums





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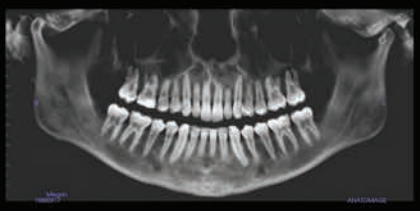

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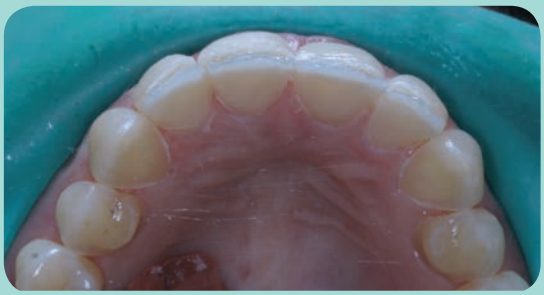
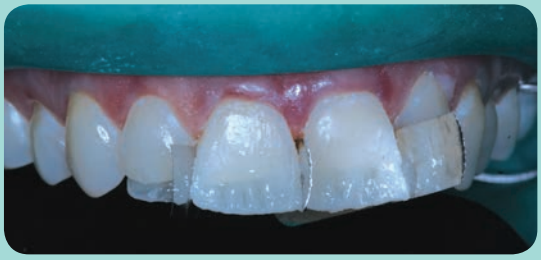
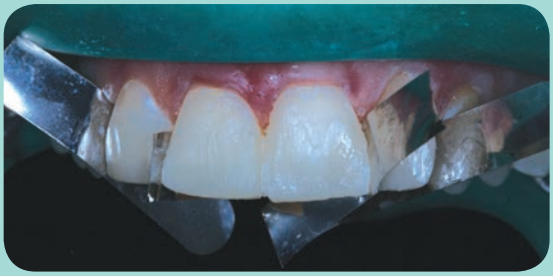
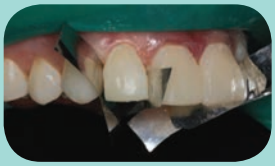


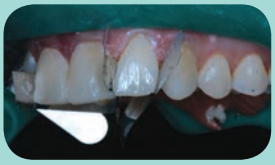
PALATAL IMAGE SHOWING FORMATION OF THE PALATAL ASPECTS OF THE 12-22 TEETH



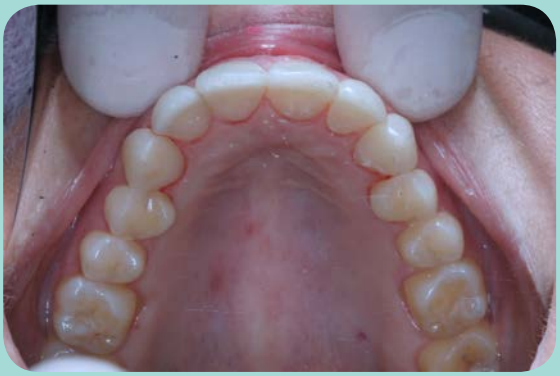
"FRAMING" OF THE ADDITION WITH MORE OPACIOUS SHADE – B1B



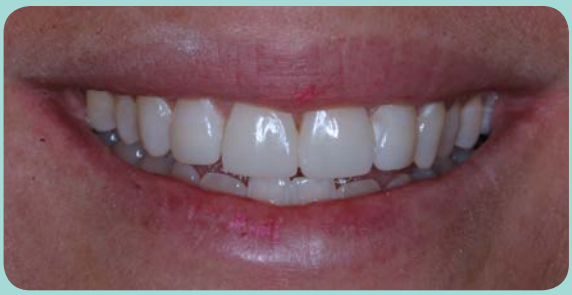


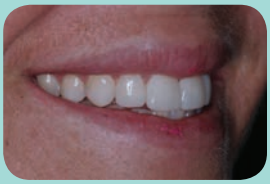


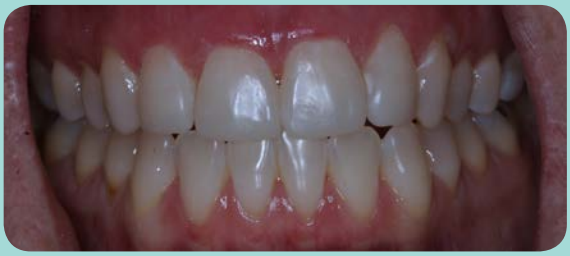
FINAL LAYERS OF ENAMEL SHADE – WE

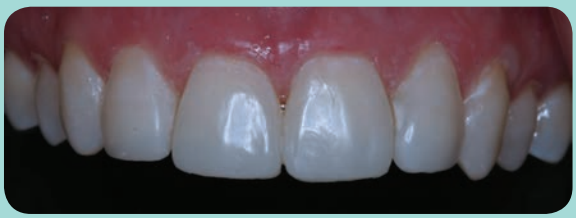


PALATAL CONTOUR SHOWING 13-23 COMPLETED









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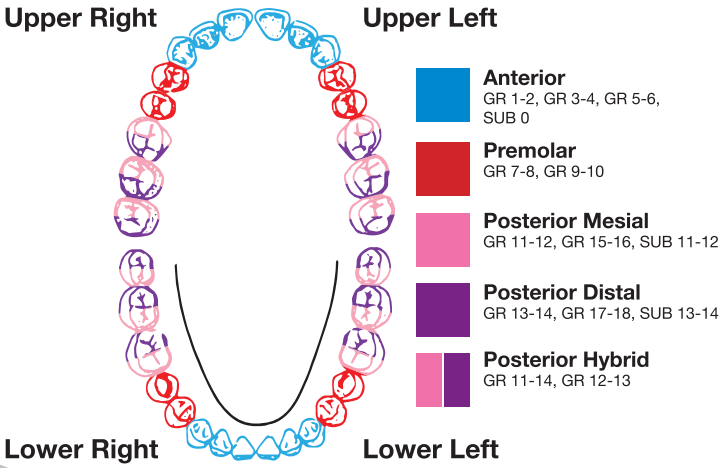


**Anterior**
GR 1-2, GR 3-4, GR 5-6, SUB 0

**Premolar**
GR 7-8, GR 9-10

**Posterior Mesial**
GR 11-12, GR 15-16, SUB 11-12

**Posterior Distal**
GR 13-14, GR 17-18, SUB 13-14

**Posterior Hybrid**
GR 11-14, GR 12-13

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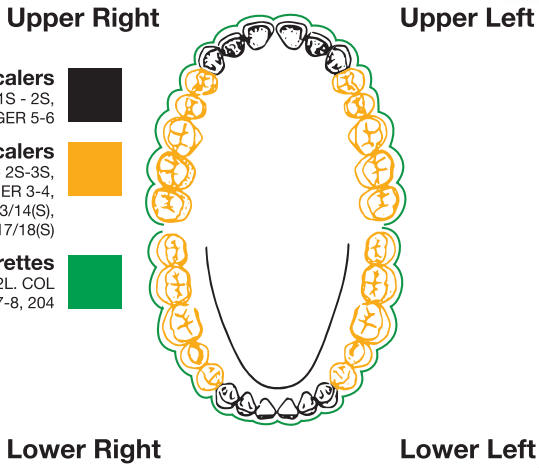


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*Dr. Anne-Maree Cole was the IACA's President at the 2010 IACA in Boston, MA.*

# Embracing Your Destiny

There is this adventure called life and we only get to experience it once. We develop hobbies, passions and pursuits that suit who we are and enhance the tapestry of life we are creating. Woven into that tapestry is a great chunk of our allotted time, our time dedicated to where we go to earn a living. So much time is spent there, this place called work, that if we don't create a hobby, passion and pursuit within this allocated time we risk developing resentment, a void. Time stolen. Such a waste...

But it need not be that way. To paraphrase Viktor Frankl author of Man's Search For Meaning, "Until the day we die we get to choose the attitude we bring to any situation. We can create meaning and meaningfulness that empowers us and changes the course of our destiny."

For me the daily grind can get in the way. Every so often I find myself being ordinary, getting in the way of my own dreams and success. Sometimes it is by what I am doing but more often in what I am failing to do. Failing to read the books I know will inspire me. Failing to step in and say: "I'm sorry, but that action is unacceptable to me". Failing to return to my oasis of learning where I know it will challenge and motivate me. Failing to understand that each decision I make or do not make, each step I take or do not take, each moment, I am creating the life that lies ahead of me.

*The more I learn the more I realize how little I know.*

But far from being daunted by that; it excites me. The challenge of being the best I can be for my patients and for those who have sought me out to learn from, fuels my desire to continue to learn and fills me with humility. These wonderful people deserve that from me. Deserve me to be my best and my best, to be the best, must keep changing. If Lexus is not apologizing for upgrading their models, neither should we. In fact we should be proud of it.

*In everything, it is important to find the purpose, the lesson, and the impetus.*

There is a reason you are reading this today. Why of all days did this message fall across your path? What do you need to envelop, to master? Where are you heading - towards your dreams, or towards mediocrity? That computer sitting on our shoulders holds the answers when we ask it the right questions, when we feed it empowering thoughts.

*Please don't abandon your dreams. Drop the negative self talk instead.*

Embrace, live and explore. Challenge yourself with new adventures. Learn a new skill. Each of us is 100% responsible for the outcomes we create, good or bad or worse, indifferent. Why is indifferent worse? It stimulates no action. It provides no emotional response and without the polarizing responses at either end of the bell curve, towards exhilaration or despair, we are not motivated to change. And without change we sink deeper into mediocrity. And how sad is that - to live a life less than it could be?

*I cannot control all circumstances I encounter in my life yet I can control many more than I do.* However I definitely can control how I respond, what I believe, what my attitude is and what I do about it. Knowing all this does not make it easy but it does make it doable, and challenging and exciting. It puts me at the correct end of the bell curve. It makes me emotional and with emotion, I switch my mindset and take action to do what I need to do to turn things around. Because I can! We all can!

*Dr. Prabu Raman was the IACA President at the 2011 IACA in San Diego, CA.*

# THE EVOLUTION OF Physiologic Neuromuscular DENTISTRY

The concept of Neuromuscular Dentistry (NMD) is often misunderstood and mischaracterized, even though Dr. Bernard Jankelson discovered it 60 years ago. There are many reasons for it. Much of it is based on an ignorance of the concept, the treatment protocols and its solid foundation on sound scientific principles that won Nobel prizes for their discoverers – Sherrington, Hill, Myerhof, Piper, Krebs, Huxley, Hodgkins et al. Some of the mischaracterizations are driven by a few that cling to their authoritative positions based on defending anachronistic and mechanical concepts of masticatory functions.

As any ground breaking new paradigm, Neuromuscular Dentistry was borne from looking at the problems of occlusion from an 'outsider's perspective'. It was the collaboration of an otolaryngologist and a dentist that was trying to improve his techniques to provide a better fitting and better functioning set of dentures. Dr. Jankelson utilized the fortuitous location of trigeminal nerve and facial nerve relatively close to the surface and accessible for electrical stimulation through the mandibular notch. By stimulating those nerves[1] with Ultra Low Frequency - Transcutaneous Electric Neural Stimulation (ULF-TENS) pulses, slow enough to allow plenty of time for nerves to repolarize, he effectively contracted and then let the muscles relax inducing restoration of circulation. Through this, he achieved an unstrained status of all the muscles innervated by those two nerves.

By recording the trajectory of the mandible moving through space when all of these muscles were involuntarily contracting from Physiologic rest, Dr. Jankelson diagnosed the starting point of occlusal rehabilitation – i.e. complete dentures. He also used the involuntary pulses to border mould the denture bases for superior stability and retention. As related by Dr. Bob Jankelson, patient zero was the wife of the governor of an island near the arctic circle visiting Seattle on a short trip. She had several failed and painful attempts at dentures to fit her resorbed ridges. Upon receiving her dentures, she went out to have lunch and returned to question, in very colorful language, why none of the other dentists were ever able to make her such well fitting and well functioning dentures. She refused to let Dr. Bernard Jankelson even touch 'her dentures' lest he might compromise the perfection that she had in her new 'Neuromuscular dentures'. NMD was borne that day since it was not just another theory but a new paradigm of correcting mandibular misalignment by treating the physiology of the muscles of mastication that effectively treated challenging cases. The new technology consisted of a box – "Myomonitor" – that delivered a mild bilateral simultaneous 0.5 second electrical pulse once every 1.5 seconds to the mandibular notches.

This 'classic' NMD was attacked almost immediately by the establishment that clung to their positions of authority in dental schools and teaching institutions, which rested on mechanical concepts of hinge axis and centric relation of the condyles while ignoring the physiology of the muscles that actually move the mandible during function.

This classic NMD was augmented by jaw tracking in sagittal plane, visualized by oscilloscopes and later using Apple and PC computers. Introduction of the ability to measure the electrical activity of the muscles – Electromyography (EMG) led Lynn, Gerber, with their Functional Orthodontics background, and Mazzacco to devise bite techniques to go beyond trajectory, guided by EMG's.

## Adoption of NMD by LVI in 1999 led to many innovations:

Dickerson devised a method of diagnosing the optimal mandibular bite position from the EMG's when bringing the mandible into first contact (CO Rest). It has proven to be a very critical scan in diagnosis of NM disharmony. He also started diagnosing the trajectory on the frontal plane in addition to the classical sagittal trajectory.

Through a double blind clinical study (Dickerson/Milne) and clinical observations with an 'n' of several hundred, the concept of mounting the maxillary cast to Hamular Notches and Incisal Papilla (HIP plane) was proven to be a highly reliable means for consistency and accuracy in mounting the maxillary models. Other studies with CT scans showed its correlation with the level of Atlanto-axial (C1-C2) joint (Thomas) which is the center of rotation for mandibular movements according to Guzay.[2]

Dickerson developed the quick technique for a fixed LVI orthotic, achieving aesthetics, compliance and patient comfort, achieving faster joint stability.

Normal value of 'Shimbashi' measurement of Neuromuscular anterior vertical relation is 19 mm +/- 2 mm. With a range of 17 mm to 21 mm, it was too large for use in clinical restorative dentistry. Dickerson used the centuries old concept of Golden Proportions, and a more useful aesthetic anterior vertical norm was established based on the width of Maxillary Central Incisor width – i.e. LVI Golden Vertical.

Measuring posterior verticals added new dimensions to tracking the changes made and maintaining the desirable treatment positions throughout the various treatment steps. The decompression achieved at the TM joints and condylar position changes which affect the pitch, roll and yaw changes of the mandible were better tracked by this addition.

Dickerson then created the EMG GPS Bite Technique using the Anterior Temporalis as the "reins" of the mandible allowing fine tuning of the bite for optimal positioning and adjustment.

Innovations continued with the added technique of ULF-TENS treatment of Spinal Accessory nerve in 2006 (Raman/Cole) to affect cervical muscles that are innervated by CN XI.[3]

An understanding of Sleep Breathing Disorders including Obstructive Sleep Apnea led to combining treatment of TMD and OSA with Neuromuscular sleep appliances. A large double blind clinical study showed the efficacy of a LVI NM sleep appliance (Dickerson) over the conventional Oral Appliance therapy.

Dickerson's addition of Golden Trajectory Optimized (GTO) bite technique allowed a starting point with optimally decompressed TM Joints.

An increased understanding of the role of posture and in particular, the effect of cervical restrictions on mandibular posture led to adding Cranio Cervical Physical Therapy techniques to the ULF-TENS treatment of Cranial nerves V,VII and XI (Raman). This facilitated the determination of mandibular posture after optimizing not only muscles of mastication, but also those of cervical and thoracic musculature. When the cervical spine is better aligned the pharyngeal airway that is partly anchored to the upper cervical vertebrae is unstrained as well to result in an improved airway akin to an untwisted hose (Thomas). Optimized upper cervical alignment also improves vertebral blood flow to the brain.

These evolutions have made such exponential improvements upon the classic NMD foundation laid by Dr. Bernard Jankelson 60 years ago that it is more apt to be called Physiologic Neuromuscular Dentistry (PNMD). PNMD allows a well trained NM dentist to start with an optimal jaw, neck & spine position with an LVI Fixed NM orthotic to efficiently resolve a myriad of TMD / Cranio Cervical Mandibular Dysfunction (CCMD) symptoms that were given incurable medical diagnoses with lifelong pain management as the only choice.

The IACA played an important role in this evolution since its inception 10 years ago. With its vision of open-minded inclusion of various philosophies and techniques that impact aesthetics, we invited speakers from disparate perspectives: experts on airway, surgery, orthodontics, chiropractic, physical therapy, oral myology, pharmacology etc. Those views had a positive impact on this evolution. I invite every dentist to explore PNMD through serious study with an open mind.

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[1] Fujii, H., Mitani, H. Reflex Responses of the Masseter and Temporal Muscles in Man, J Dent Res September-October 1973 Vol. 52 No. 52 Thomas, N.R., The Relationship Between the Upper Cervical Complex and the Temporomandibular Joint in TMD and Its Treatment Correction. LVI Visions 2009 Jan-Apr Pp. 60--683 Raman, P. Neurally mediated ULF-TENS to relax cervical and upper thoracic musculature as an aid to obtaining improved cervical posture and Mandibular posture. The Application of the Principles of Neuromuscular Dentistry to Clinical Practice. Anthology Vol IX, ICCMO pp. 77-85

[2] Thomas, N.R., The Relationship Between the Upper Cervical Complex and the Temporomandibular Joint in TMD and Its Treatment Correction. LVI Visions 2009 Jan-Apr Pp. 60--68

[3] Raman, P. Neurally mediated ULF-TENS to relax cervical and upper thoracic musculature as an aid to obtaining improved cervical posture and Mandibular posture. The Application of the Principles of Neuromuscular Dentistry to Clinical Practice. Anthology Vol IX, ICCMO pp. 77-85

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*Dr. Randy Jones was the IACA President at the 2012 IACA in Hollywood, FL.*

# WHY CONTINUING EDUCATION?

Like some of you, I went from working 5 days a week, to 4 days, to 3 1/2 days down to 3. I now average 13 days of work per month and have been doing so for the last 10 years. If you educate not only yourself, but your team, properly, you will be able to do in three days what you used to accomplish in four, leaving you with more time to spend at home with your family, or however you want to. Your techniques will improve, and you will be much more prepared and equipped to treat people the best you can. You will put systems into place. Your confidence will grow. You WILL have a more financially profitable practice, but more importantly, it will be a practice you enjoy. Ask others who have done numerous post grad education courses how they used to run from room to room and not have enough time to return a phone call much less treat patients correctly. At the end of the day, all the stress and chaos does not reflect in the amount of money the office has collected.

Do not stress yourself at work all day long and go home worn out and in a bad mood. This is not fair to yourself or your family. There is absolutely no reason to have a dental situation come into your office that you feel you cannot handle properly due to a lack of knowledge. A great continuing education program can teach you to do it faster, more efficiently, more productively, and more confidently. What an advantage to being educated!

Believe it or not, being better educated will make you a better parent and a better spouse. But how can you afford time away to get a better dental education? How can you inconvenience your patients, let alone your family, by being gone out of the office and away from home for a week trying to learn? Your patients have been scheduled for six months in advance and expect to see you at their hygiene visit. Who will take the kids to soccer or help with homework while you are gone? Time away would not be fair! What will your spouse think - left there all alone to hold down the fort while you are away supposedly studying? No, you cannot do that to your patients and your family. Or can you? The answer really is when you care enough about your patients to give them the very best you have to offer, this will carry over to your family, and to your life. Your family should be the biggest reason you go to work. Do not become better educated just for yourself, do it for your family.

As far as your patients are considered, a wise man once told me, "If you treat people truthfully, with respect, and do treatment on them that you would do on yourself or your family, you will NEVER, EVER have to worry about buying groceries." I think that says it all about money.

As far as continuing education goes here are some interesting facts:

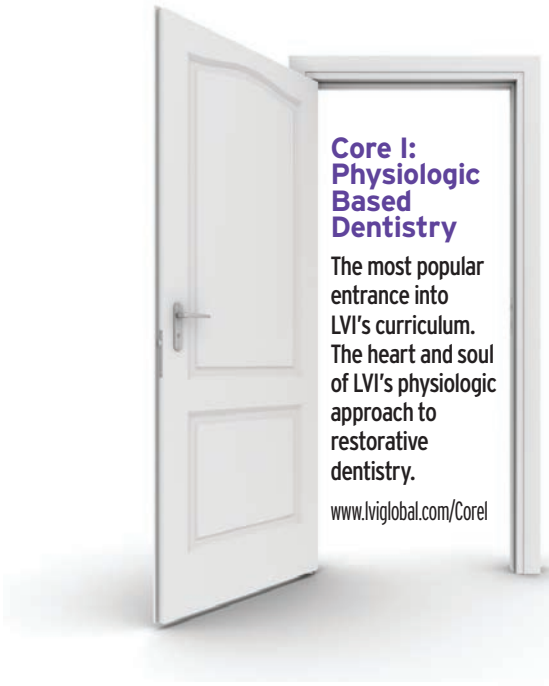
IACA

- The IACA is such a progressive meeting in topics/subject/research.
- The IACA has the best value in terms of CE hours for the dollar (18 CE credits for $995).
- The IACA has the most social fun allowed of a PACE sanctioned event.
- The IACA has a Fellowship status opportunity - FIACA
- The IACA offers scholarships for those dentists "in need" to attend the meeting complimentary of the organization.
- The IACA has the most progressive internet forum.

As a past president of the IACA, I want you to know there are countless hours and major efforts that go on behind the scenes to make this all available to you in order to better you in your profession. So many people take this all for granted. We want to better your education! Education is a key to success in your professional and personal life!

# What Entrance Is Best For You?

*At LVI there are many options available to become part of the enthusiastic alumni!*



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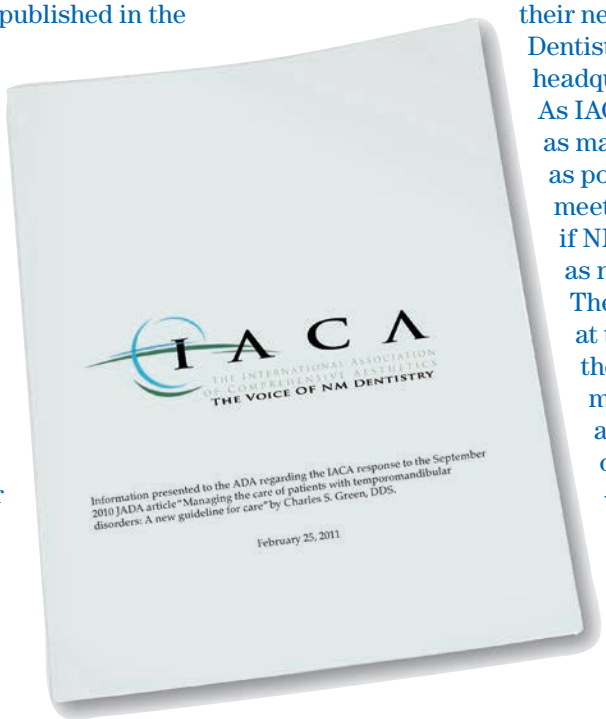
*Dr. Dan Jenkins was President at the 2013 IACA in Calgary, AB.*

# IACA

## *Defense of Freedom to Practice*

February 25, 2011. I couldn't believe I was in the conference room on the 22rd floor of the American Dental Association Headquarters building meeting with four ADA leaders for a scheduled one hour meeting. After the obligatory handshakes, self-introductions and group pictures taken by Jennifer, an ADA News staffer, I found myself seated at the end of the table. Directly across from me looking right into my eyes was Dr. Ray Gist, President of the ADA. Dr. Gist is a kind, humble man and while I could see that in his eyes, I could also see that he was nervous in addressing yet another potential firestorm meeting with "some rebel dental group." Seated on Dr. Gist's right on the side of the table was Dr. Daniel Meyers, Senior Vice-President, Science/Professional Affairs for the ADA. Next to Dr. Meyers right, and on my left, was Dr. William Calnon, then ADA President-elect. To my right on the other side of the table was Dr. James Willey, ADA Director, Council on Dental Practice. Seated between Dr. Willey and President Gist was then current president of the IACA, Dr. Prabu Raman. (Dr. O'Laughlin and Mr. Springer did not attend.)

There was tension in the air as this meeting had come about from an article published in the Journal of the American Dental Association promoting Dr. C.S. Greene's Bio-Psycho-Social TMD-CMD philosophy in the name of the American Association of Dental Research. In response to that article IACA members had responded to a call for letters to the JADA Editor. The response was historic in that over 200 letters were sent for that one article. (JADA normally receives about 100 letters in one year for all of their articles combined!)




However, our purpose of that meeting was to only make the IACA known to the ADA leaders and voice our concern for the way the article was headlined and written as it made it seem like Dr. Greene's philosophy had become the "standard" for the ADA. In fact, in my initial request to meet with either Dr. Gist or Dr. Calnon I only requested ten minutes as I knew they were busy at this time during the Chicago Mid-Winter Meeting. As the meeting began I thought back on the events leading up to this.

As the editor of the IACA I have always written in support of the freedom of all dentists to practice in a manner they felt was best for their patients. My involvement in an open defense of neuromuscular dentistry began in June, 2006 when Drs. G. Klasser and J. Okeson had an anti-SEMG article published in JADA. While most told me they doubted JADA would publish my letter I knew from my involvement in the American Association of Dental Editors that JADA did not receive a large amount of letters. My letter to the editor was published in October. Another development was the ADA's invitation to attend their new Evidenced Based Dentistry conference at their headquarters in May of 2008. As IACA Editor I called for as many IACA members as possible to attend this meeting. My concern was if NMD might be classified as non-Evidenced Based. There were 150 attendees at that meeting. Of the 150 attendees the majority were from academia. There were only 55 private dentists –half of those were IACA dentists!

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**Drs. Jenkins, Willey, Meyer, Calnon, Gist and Raman pose prior to the IACA-ADA meeting at ADA Headquarters on 02-25-2011.**

When JADA published Dr. C.S. Greene's article I called for all NM dentists to write responses to JADA. The number of letters got the attention not only of JADA Editor Dr. Michael Glick, but also the publisher of JADA as he had just taken over that position. When I called Dr. Glick to discuss possibly publishing an article on the neuromuscular philosophy he at first thought I was calling to see why my own letter was not published. I told him I understood why he could not publish all of the letters and that was not what I was calling about. He agreed to receive the paper but would have it reviewed by his reviewers as he himself did not consider himself qualified to review TMD material. We did discuss other "editor" things but ended the conversation in a cordial manner.

At the Dental Editors' conference in the Fall of 2010 I discussed the "Greene" article with then ADA President, Dr. Ron Tankersley and gave him an IACA flash drive card with over 100 letters to the editor. He said he felt it was good for members to speak up on an issue that is important to them.

The NM philosophy article was denied publication and Dr. Prabu Raman and I were trying to come up with a way to get the message out. As we were both long-time involved ADA members I suggested we ask for a meeting – it wouldn't hurt to ask! With the support of the IACA board and Dr. Bill Dickerson, I made a call and talked to ADA Coordinator of officer services, Sandy, at the ADA headquarters asking if I could have 10 minutes with either the President or the Vice-President during the Mid-Winter meeting. The email I received back blew me away:

Hi Dr. Jenkins,

Dr. Gist and Dr. Calnon are happy to meet with you during the Midwinter meeting. A meeting has been scheduled for Friday, February 25 at 2:30-3:30pm to be held on the 22nd floor of the ADA Headquarters Building, 211 E. Chicago Avenue, Chicago, IL 60611. In addition to Dr. Gist and Dr. Calnon the following staff will be present. Please confirm that you are available.

Dr. Raymond, Gist, President, Dr. William Calnon, President-Elect, Dr. Kathleen O'Loughlin, Executive Director, Dr. Daniel Meyer, Senior Vice-President, Science/Professional Affairs, Mr. Michael D. Springer, Managing Vice-President Publishing, Dr. James L. Willey, Director, Council on Dental Practice.

Upon finding how big this meeting was going to be – I called for help and asked Prabu if he could join me. The weeks prior to this meeting involved many calls and literally hundreds of emails between me, Prabu, Bill Dickerson, and others to provide information and advice. At this point I had only met Dr. Meyer once briefly at the EBD conference in 2008. While Prabu worked on the IACA position statement, I put together a 72 page booklet which included the IACA position and had it bound. To keep costs down only 13 were made and one was provided to each attendee at this IACA-ADA conference.

The night before the ADA meeting I was invited to dinner with some other non-IACA NMD dentists but could not disclose to them what was going to happen the next day or risk hurting their feelings.

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**Since getting involved with the IACA I have been able to meet and interact with people I never would have been privileged to.**

The next day during the TMD Alliance meeting there was talk of what to do about this issue but the various groups would not authorize a letter from the Alliance as they needed to get permission from their organization. No letters to the editor were ever sent from the Alliance in response to the Greene article.

Now, to start this IACA-ADA meeting, I passed out to the leaders their copy of the booklet with the IACA response, the IACA position with 168 references that Prabu had written, and a history of Dr. Greene's anti-NMD activities. I then read to them the IACA response in asking for freedom to practice. Prabu presented a video of actual NMD cases. When Dr. Meyer brought up EBD we were able to point out that over half of the private dentists attending his EBD conference were our members…he was impressed. In fact, it was at that point that he looked at me and asked if the IACA would be interested in participating in a scientific "discussion" over NMD at the ADA meeting that Fall. Prabu and I both responded immediately with a "Yes!" The one hour meeting ended up lasting one and a half hours together and then longer with host Dr. Willey.

From that meeting the IACA has been able to defend NMD at the ADA scientific session, from proposed changes in peer review in California to adopt BPS in Quebec, CA, adoption of BPS by CADTH in Canada, and more attacks by Danielle Manfredi in both JADA and OOOE.

My association with the IACA since its first meeting has been a real adventure for me. Since getting involved with the IACA I have been able to meet and interact with people I never would have been privileged to. Most of all, it has been a privilege to represent the many fine fellow professionals I have met within our organization. I encourage all to also participate as much as possible in the IACA. You will also find the satisfaction I have found. Whether you practice NMD or not, please help the IACA defend your right to practice how you see fit.

*Dr. Mark Duncan is an IACA board member.*

# THE IACA Revolution

## A baker's dozen reasons why the IACA is changing the face and future of dentistry.

### 1 The IACA's open format philosophy

The fundamental reason behind the IACA is to create an organization that stood together to protect the doctor's right to determine which philosophy is most appropriate and useful for them – not to have that dictated by restrictive philosophical motivations of the president and organizers.

### IACA stands strong against the Goliath 2

The power of scientific evaluation has led to amazing insight into the importance of proper physiology in our patients. Antiquated concepts published as dogma about how things like migraine pain is self-limiting and shouldn't be treated in the JADA and dresses it up as the JADA's position. It was the IACA that led the charge in the letter campaign and created a fair and open debate on occlusion at the JADA meeting.

### TEAM IACA! 3

Core to the mission of the IACA is empowering success in the doctor member's office and the key to that is motivated and trained TEAM. Without their support the success of the practice will always be less than its potential and often **significantly** less! The IACA provides leadership workshops and motivational presentations through webinars, lectures, and workshops.

# 4 IACA 24/7

Well, 24/3 unless the meeting is four days long… overcome by excitement and camaraderie, the IACA generally kicks off prior to the meeting with receptions, dinners and good times in general – and continues throughout each evening flowing from the lectures to the cocktail receptions to the dinners to long hours of laughter and sharing.

# 5

## Legendary IACA

Like every year, the speaker lineup is powerful and full of dentists sharing what creates success in their office as well as names everyone knows. This year is a special legendary sandwich with Dr. Bill Dickerson kicking off the IACA and Dr. Ron Jackson sharing the culmination of his life's work and philosophy in the close!

# 6

## IACA AFTER DARK

For years the evenings have been a blend of exploring the local haunts and meeting for the IACA After Dark. Costume parties, karaoke, bull riding with plenty of dancing have filled the ticket before – this year is a Pirate's party, so don't forget your parrot! Arrggg Matey!

# 7

## Total Body Health

Some of the IACA programs focus on the bigger picture to round out your care and help you live a longer, healthier and happier life! Topics like functional health are common at these meetings as are motivational presentations to help heal your inner self!

# 8 International Competitions

With representation from the US, Canada, Russia, Australia and the Republic of Texas, it has become a common event to have a Tug-of-war to see which country can pull the hardest – so go ahead and supersize that meal and we'll see you on the beach!

## 9 Honors & Awards

Every year there are awards given for various things such as the IACA Aesthetic Eye. LVI honors their alumni each year with the LVI Alumnus of the Year and awards the LVIM with a presentation of their cases and last year was no exception to the chance to see dentistry done on a level that most of the profession doesn't even know is possible!

## 10 IACA & Success

Common themes at dental meetings are boredom and catching up with friends so you can promise to call to get together before next year. At the IACA there is an energy of open sharing of strategies and techniques to create success and you find that everyone there is dedicated to improving their lives and practices and are happy to share what they found useful. It was perfectly encapsulated in the presentation by Dr. Bill Dickerson several years ago that still lingers in the hearts and minds today where you will find IACA docs sign emails with "Love & Gratitude" because they feel that in their hearts!

## 11 The IACA Family

In amazing locations and venues, the IACA has set the stage for a family friendly fun way to learn.

## The Cutting Edge 12

When gathering the most advanced physiologic and Neuromuscular dentists in the world, it is pretty hard to imagine there won't be powerful new information shared – but it's actually the charge given to the speakers. In order to present at the IACA, you have to present material that you haven't delivered before!

## 13 FUN

Friendly, open and sharing people who are excited to be there and driven by passion and success always adds up to a great time! The IACA always contains those ingredients – so make sure you get a taste!

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# IMPLANTS Made Easy

**In the last few years, a "Perfect Storm" of technology and clinical processes have made dental implants as easy as possible.**

Over the years I have trained thousands of dentists and lectured around the world on implants. I have also attended international implant trainings and symposiums with some of the greatest known subject matter experts in the field. I have noticed a common denominator when it comes to implants and the integration of implants for the general dentist... apprehension. And I understand why. Let's face it, many of the "experts" like to "show off" and perhaps show extreme cases and some of these can be intimidating to say the least. But I also understand that implants can be hard to do, they can fail, they can cause potential collateral damage if placed incorrectly and in dental school we were taught to refer implants out. Not to mention it can be expensive to get set up to do implants, then the actual restorative cost can be unknown until you get a lab bill. These are some major hurdles to overcome. No wonder there is so much apprehension to get started placing implants! Most dentists feel it is best not to deal with the "problems" of implants and let their specialist continue to do the implants.

However, in the last few years, a "Perfect Storm" of technology and clinical processes has made dental implants as easy as possible. The first step of making implants easy for the general dentist is case selection. I am sure many of you have heard of the 80-20 rule. The same principals can apply here. 20% of the cases cause 80% of the problems. When starting implants it is important to know what these cases are and outsource them! Focus on the other 80% of cases, and even better, select half the cases that are most predictable and your implant confidence will really take off!

Over the years implant processes have changed as well. The most brilliant minds and educators are amazing at breaking down a problem into its simplest and most basic form and create a process to solve the problem. Today there are so many great, simple and proven implant processes that are so "easy" when combined with today's technology. And it continues to evolve. Consider the implant surgical guide as an example. A new technology that took the uncertainty out of implants, or what I like to call "pucker factor!" What a breakthrough! However, there were still many steps: learning new complicated software, manual measurements with the guide, and honestly a few areas where a clinician could inadvertently fail due to all the steps. However new in 2014, this has been boiled down to 2 easy steps:

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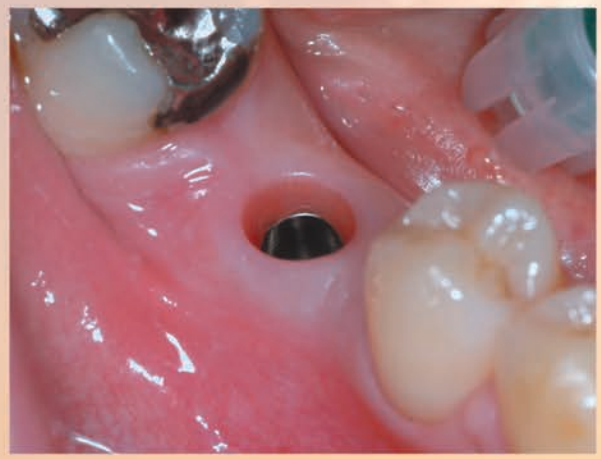
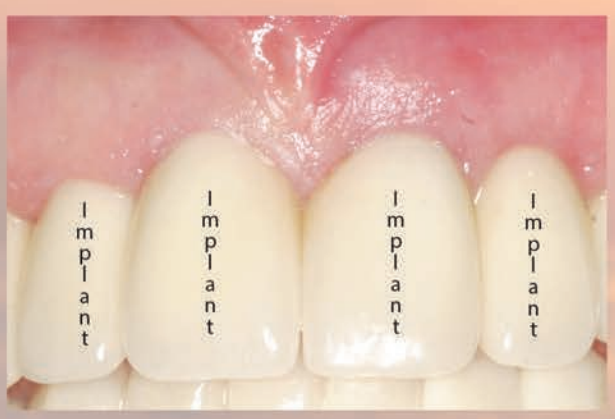


Tissue is not "photoshopped"
It is the new norm!
*Photo Courtesy of Dr. Leonardo Taragetti




No more "black triangles"!
*Photo Courtesy of Dr. Leo Malin

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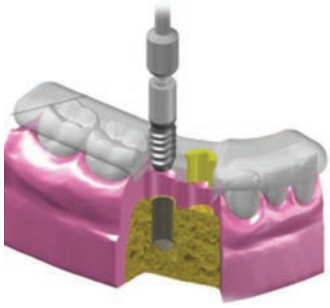
## STEP 1

A custom fit guide has exact orientation and thickness for the desired implant exactly matched to the patient's anatomy for a perfect fit.

Place surgical guide in mouth, insert tissue punch and remove tissue.

A new "insertable" drill is placed in a reducer that fits in the guide with remanufactured stops based on the 3D image and plan.

Press the foot pedal and drill until the drill stop hits the guide, and proper drill depth is achieved. (Yes that is correct, a simple 1 to 2 drill sequence!)



## STEP 2

Remove the guide, drill and reducer.

Place the implant driver into the hand piece and attach implant to the driver.

Insert the implant guide back into the mouth and drive in implant through surgical guide and insert the implant until the stop hits the guide.

The stop disengages the driver, remove the guide, place your healing cap and you are done!

## Now that is not the typical "Surgery!"

- No large flap and bloody mess
- No depth measurement required at time of surgery
- Implant placed through surgical guide for proper placement orientation and depth
- Minimal Manufacturer Tools required for placement
- Simple – Fast – Accurate
- Ability to create custom abutments to be placed at time of surgery

**This is just one of the technology process breakthroughs in the "perfect storm."**

This process has matured and is truly now ready for mass integration to make implants easy. You may be thinking you still need a $150-200,000 3D imaging machine to make this happen and a CAD/CAM computer software to make this guide. Though that is an option, all this can be outsourced for a very reasonable fee. Many imaging centers and practices with 3D technology offer patient scans for $200-$300. Additionally you do not even need software. Third parties can now take that scan, you tell them what implant you prefer to use, how you would like it placed and they can do a real-time screen share with you as you watch them move and position the implant precisely the way you want it orientated. No learning software! Just tell them how you want it positioned and sign off. All that for approximately $25 per implant site. From this information you can now get a custom made guide for $150-$400 to utilize the process above.

Again, this is just one of the technology process breakthroughs in the "perfect storm." Technology has also dramatically reduced the presence of two MAJOR nemesis in implant dentistry: BACTERIA & PRESSURE. I understand you cannot eliminate these factors, but what you can do is eliminate the processes and products that harbor them. When you take bacteria and pressure out of the implant dentistry equation and use the proper processes and products, case select the simpler implant cases and utilize technology to guide you and avoid perforations and invading vital structures, you just made implants easy!

Again, there are MANY more components of the "perfect storm" that make implants easy. Recent innovations make extractions and grafting easy as well. I could go on, but the point is what a perfect time to update your implant training and get going. Today's technology has made implants easy, the costs are down and the baby boomers are ready for a long term solution. BTW, did I mention it is VERY profitable as well!

### Upcoming Implant Course Dates

Surgery 1-Implant Foundation • April 9-11 • September 17-19
Surgery 2-Implant Integration • October 6-8
Surgery 3-Live Patient & Case Planning • May 7-9 • October 9-11
Comprehensive Implant Restorative • June 2-4
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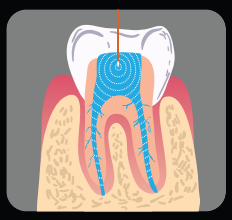

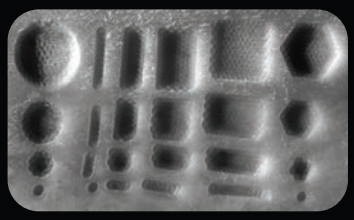

## Superior Predictable Consistent

"First week using my new Lightwalker ATS laser. This is the 4th hard tissue laser in my practice over the last 12 years that included 2 Waterlase systems and also using the Lightwalker DT since July 2011. The new ATS is by far superior! The QSP pulse mode allows me to ablate enamel on par with my highspeed handpiece (1st time ever!!) and I have yet to use any anesthetic this week on any laser patient. Class 1, 2, 3, 4, and 5's!! In addition, the new green aiming beams lights up the target creating a great contrast to the colors of natural tissue. I foresee a paradigm shift in my laser practice!!"

-Rick Cardoza, DDS, El Cajon, CA

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*Dr. Chong Lee is the current President for the 2014 IACA in the Bahamas.*

# FROM MEDIOCRE TO *Magnificent* One Step at a Time!

## An Effective Cosmetic **Consultation**

Just as no two mouths are the same and deserve to be treated individually based on their specific needs and risk factors, no two patients and their capacity for processing information are the same, they are unique unto themselves. With this article, we will share new ideas through the use of technology and research that will enable you to more effectively communicate with your patients and achieve a better case acceptance rate with your TMJ, sleep apnea and full mouth reconstruction case consultations and presentations as well as any consultations and presentations you may encounter in your practice of dentistry.

## **DISC** Assessment

First, let's discuss how to "connect" with your patient and establish an element of trust. Historically, a patient that trusts you is more likely to agree with the treatment you are recommending. Consider the DISC assessment/profile as a tool to help you establish that trust.

The DISC assessment is a behavior analysis tool based on the DISC theory of psychologist, William Marston. Marston's theory centers on four different personality traits: Dominance (Drive), Inducement (Influence), Submission (Steadiness) and Compliance (Cautiousness). Marston's theory was then developed into a personality assessment tool or "personality profile test," by industrial psychologist Walter Vernon Clarke. These behavioral types came from people's sense of self and their interaction with the environment. Finally, Clark published the Activity Vector Analysis, a checklist of adjectives through which he asked people to indicate descriptions that were accurate about themselves. Finally, John Greier contributed to the assessment tool by producing the DISC personality profile. He conducted hundreds of clinical interviews which assisted him in further developing the fifteen patterns which Clarke had exposed. In conclusion, the development and utilization of the DISC profile is used in a wide variety of settings including business, education, sales, coaching and counseling.

It doesn't take much imagination to recognize how the DISC profile could benefit a cosmetic dental practice with every aspect of a case consultation and presentation from the doctor's perspective, to the patient's perspective, to the team's perspective and finally to potential problem solving during the follow-up and maintenance phase.

In becoming familiar with your patient it is imperative in the first few minutes to assess their personality type, and adapt and apply it to your presentation as soon as possible after the consultation begins. A patient who is a "D" is a patient who is a visionary, they want results and they want only the facts that are pertinent to get the job done. A patient who is an "I" is a patient who likes to be complimented and wants to build relationships. A patient who is an "S" is a patient who tries to keep everyone happy, they seek approval and find it difficult to make decisions. And, a patient who is a "C" is detail oriented. They do not like change and they want to know all of the research behind the treatment you are proposing.

With a "D" patient, give them a short, precise description of your findings and your proposed treatment, no long explanations are necessary for them to make the decision. In contrast to the "C" patient who needs a lot of proof and evidence of your findings and allow for the possibility that they want to go home and do their own research on the internet. An "I" patient wants to hear about themselves and needs to have their ego stroked. And, finally, an "S" patient just wants everyone to be satisfied.

## Use of **Technology**

Our first recommendation to enhancing your presentation involved building a relationship between you, your team and your prospective patient by adapting your personality to their personality using the DISC profile and assessment theory. Next, we will discuss how to create a more appealing presentation utilizing technology. Patients are visual and as such, tend to be captivated and moved forward in their decision by technology applications to your case presentation, including the iPad, intraoral photography and videotaping to name three of the more prominent means of technology utilization.

The iPad is commonly used during the initial consultation phase. The iPad is used to show short educational videos about different restorative techniques including implant dentistry, crowns and veneers and how they are accomplished. It is important to remember that our mission is "building relationships" with our prospective patient so do not leave the consultation room and expect the video to do your work. Patients do not build relationships with technology; they build relationships with people, unless of course your name is Theodore Twombly (played by Joaquin Phoenix) and your iPad's name is Samantha (played by Scarlet Johansson) from the movie Her!

Intraoral photography is gathered from both a digital camera utilizing mouth mirrors, retractors and an intraoral camera to show defective margins, decay, cracked teeth and broken teeth. In addition, multiple parafunctional habit anomolies can also be photographed including abfractions, cracks and wear facets. All of these photos are used to create validity and believability to your presentation.

The patient can also be videotaped during their "report of initial concern." It is important that if you plan to use the video of your patient for other consultations, publications or lectures that you receive consent from your patient. The videotape is then shared with your master lab technician to demonstrate personality of your patient, facial expression as well as providing a visual of your patient's current status and the potential of what the two of you will create for your patient. Once your case is completed, the patient is again recorded with respect to their initial response to their finished product and this video can be played to market your practice, with the written consent of your patient.

There are numerous other technologies that have potential to enhance your presentation, but we focused on three of the technological advances that have proved most successful during our consultations. Finally, we offer several guidelines to help you improve your case acceptance. These suggestions include:

- **Videos, webinars, smart phone apps, etc. cannot match the power of a person** who is skilled at building relationships and getting case acceptance.
- **People need relationships to build rapport,** and that's tough to do electronically.
- **Some clinicians and team members grasp how to use technology intuitively.** Most of us need some training. Train your team how to use technological tools most effectively to get the job done.
- **With technology, you instantly position** your practice as innovative and forward-thinking.
- **Utilize high quality images** of your own patients and cases. Real people get a lot more attention while stock photographs rarely get the attention you are looking for.
- **Use technology to enhance your efforts,** attempt not to flip the process upside down and build your process around the technology you want to use.

Your patient should feel like they are ultimately making the decision about their mouths and their treatment. You may use "leading" questions and "pace" the conversation to accomplish your goals, however, the opportunity to be able to choose your path when making such a big decision about your dental treatment is very important! Remember that you are the consultant, and the patient is coming to you because of your expertise. That being said, another important point is to ask permission of your patient to share the information you have gathered and present the treatment solutions to them.

**People hardly agree to invest in anything without seeing it.** Usually they want to touch it, hold it and take it for a spin. That's where professionally fabricated, lab created temporaries help you sell your expertise. Your patient gets to see what the final product will look like while the final product is created at the lab.

In conclusion, keep in mind that you are the subject matter expert! And, your team, including your master lab technician and his team, support you and your mission. Building relationships and utilization of imagery through the use of cutting edge technology during your presentations will substantiate your clinical findings and confirm the need for treatment which will ultimately improve your case acceptance.

# Difficult Employee?

Michelle Allen and Tim Twigg

# NO Problem!

As an employer it is safe to say that at one time or another (if not already) you will have to deal with a difficult employee. If you are one of the fortunate few who have not experienced this, then you probably have lent your ear to many a colleague, friend or family member, who has.

Some maybe you inherited when you bought or took over a practice, maybe you missed some signs of their true character when you interviewed them and/or you didn't do an adequate reference check to learn difficulties or problems experienced by previous employers. Now, here you are, feeling stuck.

Once you find yourself in one of these situations there are steps you can take to either correct the behavior or, if necessary, end the employee's employment on more positive terms. This means learning some basic management skills and gaining the confidence to proactively address the problems.

## Negative Neal

Neal constantly complains about policies and procedures and when you make adjustments to your policies and/or procedures he complains about that too. He will openly let you know that your long-term employees don't do their jobs right and that the new employee you just hired doesn't have a clue. Overall his negative attitude is poisoning your practice.

## Bullying Barbara

This employee asserts her will on everyone, even you. She manipulates every situation for her benefit by using condescending language and tone to make people uncomfortable and less likely to express their views, ideas or opinions. She may even carry herself physically in a way that seems threatening.

Over time you find this employee is controlling you and your practice, and your employees are scared to have an opposing opinion. Everyone is avoiding confrontation at all costs. A number of fantastic employees have resigned from your practice as a result and you realize your practice really is run by Bulling Barbara.

## Know it All Al

This employee knows everything, at least he thinks he does, and he does not hesitate to tell you, his co-workers and your patients. He questions your decisions at every turn and does not have a problem publicly stating you are wrong in front of other employees and/or patients causing awkward and uncomfortable moments.

## Better Late Than Never Lisa

This employee is late more often than she is on time. She always has a major emergency that just happens to come up right before she is due into work. Sometimes she will call in to announce that she is running late, and other times no one knows what has happened to her and she is surprised that you and your staff are upset that she is an hour late and did not even bother to call. You have talked with her on numerous occasions resulting in an immediate change that falls back to old habits within weeks.

## I Will Come to Work When I Feel Like it Felix

This employee comes to work when it fits into his schedule and makes it clear that his personal life takes priority. He may or may not call in his absence and will work time off for doctor and personal appointments to maximize his time away from your office.

Initially his requests for time off and excuses for his absences seem legitimate, so you worked with him. Now that some time has passed you realize your staff completely resents him and wonders why you keep this guy around. His absences are causing patient care to go below your standards and you realize a change needs to be made immediately.

**What is the best course of action when dealing with these types of difficult employees?**

As you can see all of these personalities bring great challenges to any practice no matter how big or small--don't think these challenges will magically go away, they rarely do. The longer you wait to address these issues the more problematic each of these difficult employees becomes, at times creating mass destruction in their wake.

First, make sure "your house is in order." Namely, making sure your policy manual is current and up-to-date; having signed acknowledgements and employment agreements with each employee, and having comprehensive, up-to-date job descriptions for each employee and position, including essential duties and core attitudinal and performance competencies.

Your policies, coupled with the essential duties, core attitudinal and performance competencies on the job description, form the foundation, basis, reasoning and/or justification for counseling an employee regarding their job performance or poor behavior. These also support consistent, effective and fair staff management that is objective rather than subjective.

Second, ensure that you have appropriately and objectively documented the past poor job performance issues. Focus on performance-related issues, not the emotions that surround them. This may include supervisory notes describing your verbal remedial intervention and the employee's response or a formal performance evaluation.

Third, have a private meeting with the difficult employee and discuss how his/her attitude, behavior and/or comments are affecting your patients and the overall operation of your practice. Clearly explain your expectations, referencing your policies and the employee's job description as needed.

If appropriate, solicit solutions from the employee. Some employees may be more open to assisting with the solution than others. When employees are part of creating a solution to the area(s) of concern they tend to take more ownership of the situation which increases the chances for a change in their behavior.

Employees who are negative, confrontational or who like to bully do not always see themselves in this negative light. They may be resistant to what you have to say. This is not the time to back down, but rather the time to insist on change and, if applicable, giving them the course of action they should take to make that change.

What happens if the difficulties still persist? Then you meet again with your difficult employee taking a more formal approach through a written employee counseling memo. During the meeting, note that there has not been the necessary improvement needed to meet your expectations regarding attitudes, behaviors and/or comments. Once again use specific examples on the counseling memo and relate those examples to how their negative attitudes, behaviors, and/or comments are affecting your practice. This is also the time that you let your difficult employee know that if they choose not to make the necessary changes further disciplinary action, up to and including termination will follow.

By following the steps mentioned you not only give your difficult employee the opportunity to change, you also are documenting the legitimate, nondiscriminatory reasons for termination if your difficult employee does not heed your counseling and make the necessary changes to be a productive member of your team. Since difficult employees may be in a protected class (such as age, disability, religion, national origin or ethnicity), your documentation is key to supporting your decision for termination and keeping discrimination and/or wrongful termination claims at bay.

**Do not be held captive by your difficult employee, take action and create a better working environment for yourself and your employees. No employee is indispensable especially one that is adversely affecting your practice. There are good employees out there waiting to be discovered.**

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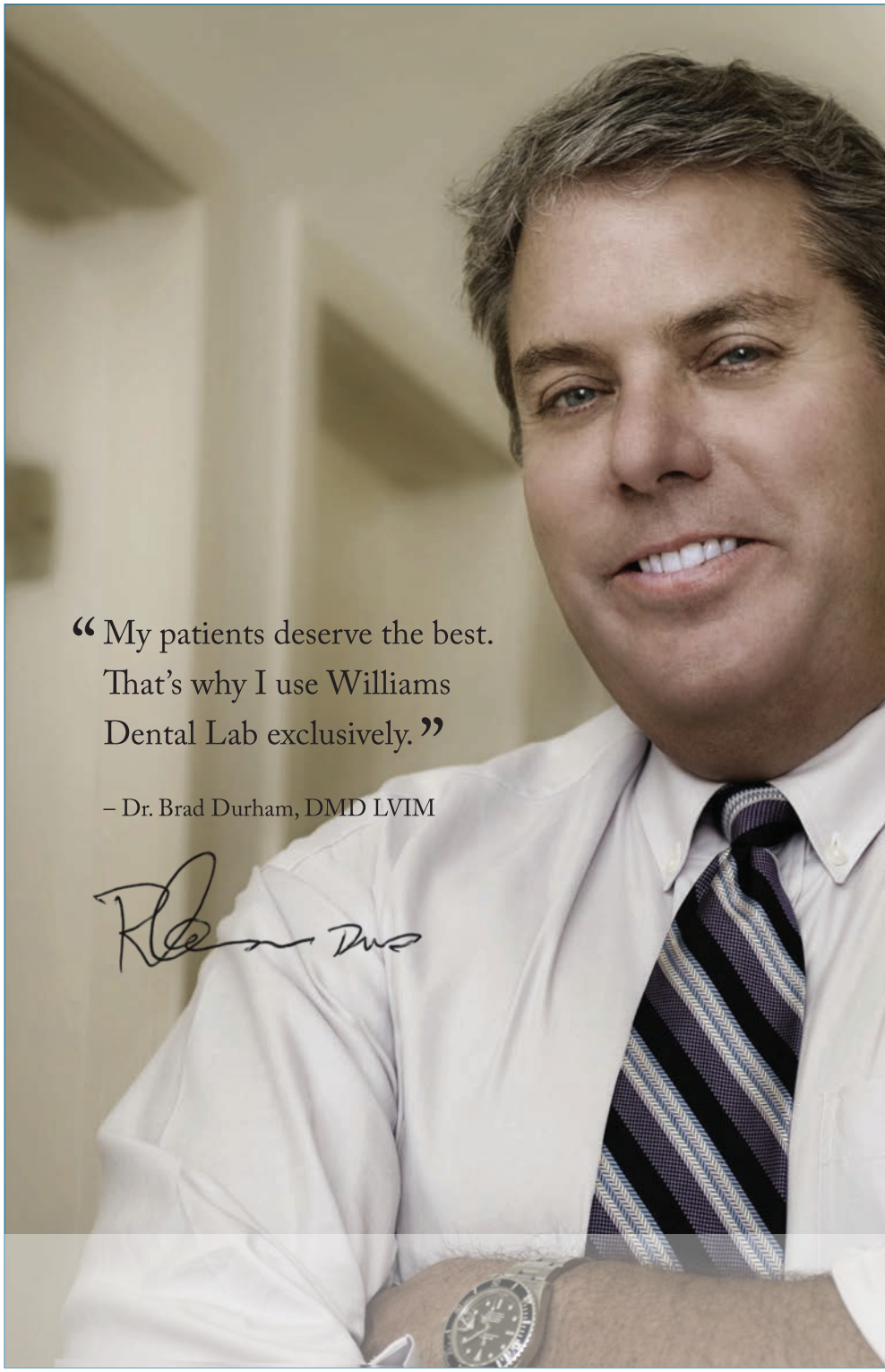


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