MDA Bulletin

Volume 32, Issue 4, Winter 2013
ISSN 070-1717

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DR. AMARJIT RIHAL
PRESIDENT, MDA

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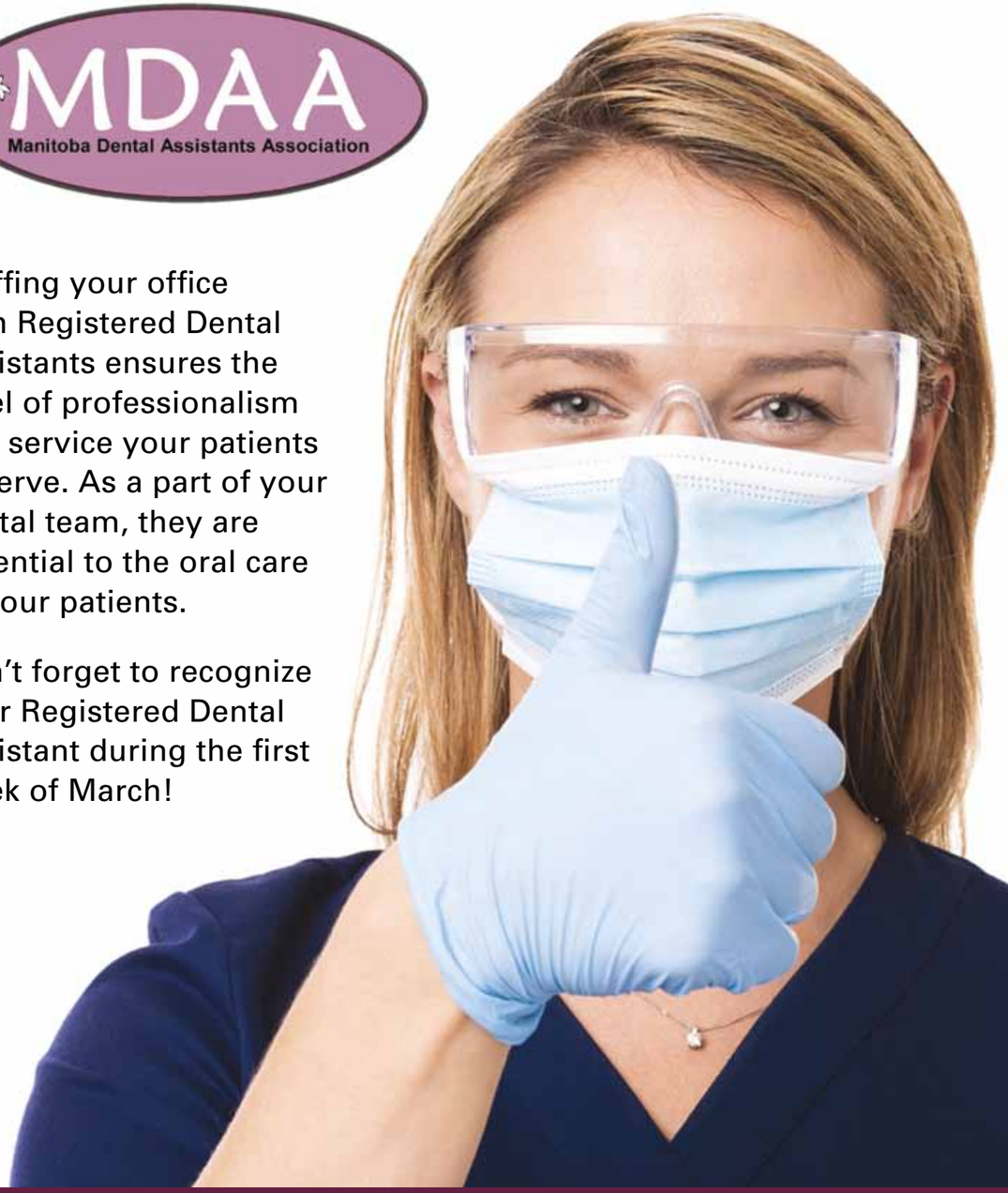
Dental Assistants Week
March 2nd - 8th, 2014

MDAA
Manitoba Dental Assistants Association

Staffing your office with Registered Dental Assistants ensures the level of professionalism and service your patients deserve. As a part of your dental team, they are essential to the oral care of your patients.

Don't forget to recognize your Registered Dental Assistant during the first week of March!



Celebrating The *Essential* Assistant

President's Message

DR. AMARJIT RIHAL
PRESIDENT, MDA

"The Road to Wellness "

My topic for my last bulletin article as President has to do with wellness. I had the pleasure of attending the CDA/CDRAF Wellness conference in Toronto last year and I was amazed at the scope of addictive problems and how they affect all practitioners and health care providers. Studies suggest 15% of our colleagues have an identifiable addiction. Addiction can be defined as:

> "a disease process characterized by the continued use of a specific psychoactive substance despite physical, psychological or social harm"

There is a belief that we are immune to the harms of substance use. Social stigma seems to outweigh the need to access appropriate means to recognize and help practitioners that have substance problems. Dentistry as a whole seems to attract people with a compulsive nature; have high expectations; have high standards, and require social approval/status. In the same context dentists have a high prevalence of musculosketal disorders with lower back pain being the most common at an alarming 87%. These factors - combined with our knowledge and access to pharmacological agents - make us vulnerable to addictive characteristics, problems or coping mechanisms.

Professional training and licensure does not grant us immunity from the realities of our humanity and the potential to experience illness, grief, family problems, stress, trauma or depression.

Among addicted dentists, over 80% prefer drugs over alcohol with the most prevalent abuses being hydrocodone or nitrous oxide (the most difficult to treat). The high stress of our profession, perfectionist expectations and a feeling of invulnerability all fuel these statistics. Stress is defined as:

> "Feelings of low self-esteem, depression, anxiety and hopelessness"

In our practices, the biggest causes of stress are money; lack of control in scheduling and coping with the expectations of staff and patients. In fact, younger dentists are more prone to the effects of stress than older practitioners so addiction knows no age boundary or limitations.

Once an addiction is formed it can never be completely cured but can be effectively managed with treatment and support. On a positive note, studies have shown a better than 85% recovery rate for dental professionals who complete treatment.

Prevention and early recognition should be a main focus of our profession. The social stigma of this problem is the biggest factor that prevents dentists from seeking treatment for their illness. We need to develop systems that recognize the need for help and allow the individual to maintain their professional image and reputation. With time and focus I think we will see these initiatives come to fruition.

As part of this initiative, the MDA is pleased to have Dr. Graeme Cunningham and Dr. Paul Earley as speakers at our annual convention this year. Dr. Cunningham's story is raw and compelling in its acknowledgement of the addiction abyss and how close many professionals are to it.

Dr. Earley will explain the underlying physiology of addiction and the feedback cycles it creates for our brains. I encourage all members to attend these lectures to help raise awareness of this serious and often unspoken problem. The onus is on us to recognize the onset of individual personality changes and seek help or encourage our colleagues to do the same.

My time as president of the Manitoba Dental Association is coming to a close and as I sit and reflect on our accomplishments this year I can say with a great deal of confidence that I have been honored to represent the members of my province.

This year has provided growth for me both personally and professionally and I would like to thank all members for their confidence in my leadership. I would also like to personally thank the MDA Board and my executive Dr. Sullivan, Dr. Cogan, Ms. Berg, Mr. Mohammed and Dr. Van Woensel for all their dedication and hard work.

Last but not least, the MDA staff are the true heroes for they hold us together and work incredibly hard with an amazing amount of professionalism and positivity. Donamae, Diane and April I have enjoyed working with you and look forward to my future MDA involvement with you.

In closing, I hope the holiday season finds your family and loved ones happy and healthy with the new year bringing you joy and prosperity. Happy holidays, I look forward to seeing you all at the annual convention.

If there is anything I can do for you please feel free to contact me.

Best Regards,

Dr. Amarjit Rihal
President, Manitoba Dental Association

Registrar's Message

DR.MARCEL VAN WOENSE
REGISTRAR, MDA

The volunteer efforts of dozens of our members form not only the backbone but the life blood of the MDA as a regulatory body. From the Board of Directors to the behind the scenes efforts at the annual convention, the willingness of our members to give of their time, knowledge and abilities can never be sufficiently acknowledged.

This positive energy motivates my contributions in supporting their activities. In 2013, those activities have been numerous and significant. Introduction of office assessments; re-evaluation of continuing competency; development of inter-provincial and inter-professional relationships; bylaw consolidation and renewal; preparation for The Regulated Health Professions Act; review of registration practices and access to care have all been undertaken this year.

With so much going on - so much that is trying to be achieved - there is a tendency to focus on the process and minutia of the task. You can lose track of the most critical element for success - people.

A couple of Friday's ago, an unexpected issue occurred that required the Board to make multiple decisions in order to give direction. The timeline for the decision was short and internet communication was unsurprisingly challenging. Mid-process, I expressed my concerns to our President, Dr. Rihal in a brief three page email. I concluded by associating the situation with feline ranching.

In a simple eloquent response, he reminded me of the importance of our activities and value of process. His words emphasized that frustration comes from within and the real challenge to success in any endeavour is to recognize and direct that frustration to making positive changes. Moreover, in considering much of the world's population experiences far more serious and fundamental concerns, he reminded me to keep this in perspective and not take everything so seriously.

Every member shall have received the revised and consolidated bylaws. There are a variety of changes but the primary focus of the effort was to improve accessibility by standardizing the format, language and processes contained in the bylaws. The administration of regulatory decision-making is more explicitly defined.

There have been significant efforts by committees and the Board to address issues and achieve a practical balance in the bylaws. The bylaws are interconnected with decisions focused on the totality of the system not necessarily on singular issues.

As you review the bylaws, you will identify aspects where you have a different personal preference or even disagree. Under our current legislation, members have the right to accept or reject a bylaw at a general meeting. As stated in each bylaw, ratification of a bylaw at a general meeting requires the written request of ten members. This is a powerful right few professions still have. With great power comes great responsibility. This right comes with the fiduciary responsibility to act in the interest of the public even if it conflicts with an individual self interest. Members are responsible to carefully review the bylaws and understand the issues. As Dr. Rihal reminded me, keep things in perspective and don't lose sight of the big picture. Board members, committee chairs and I are available to discuss the implications of bylaws.

I mentioned earlier the efforts of the volunteers who participated in the bylaw review process can never be fully acknowledged. As both Registrar and a member, I do wish to express my gratitude for their thoughtfulness, thoroughness and patience in the process.

I would also like to thank the Board, its executive - Dr. Rihal, Dr. Sullivan, Ms. Berg and Mr. Mohammed - and the MDA staff (Donamae, Diane and April) for the opportunity to be involved, their support and tolerance.

To all our members, I wish you the best of the holiday season.

Happy holidays,

Marcel Van Woensel
Registrar, Manitoba Dental Association

SUMMARY OF MDA INQUIRY PANEL DECISION

Pursuant to The Dental Association Act, the following publication is a summary of a recent decision of an Inquiry Panel of the Manitoba Dental Association Peer Review Committee.

Dr. John David Chimilar practicing dentistry at 306-400 St. Mary Avenue in the city of Winnipeg, Manitoba was charged with:

1. Professional misconduct related to failing to provide a dental report on a timely basis.

The Inquiry Panel of the Peer Review Committee made the following findings:

1. The member pleaded guilty and was found guilty of professional misconduct of the above charge.

Upon the joint recommendation of Dr. Chimilar and the Association, the Inquiry Panel of the Peer Review Committee made the following order:

1. Dr. Chimilar receive a reprimand for the professional misconduct;
2. Payment by Dr. Chimilar of $15000.00 as part of the costs to the Association for the investigation and hearing;
3. Publication.

Canadian Dental Association's Message

DR. A. MUTCHMOR, DMD
CDA BOARD REPRESENTATIVE

This August, the FDI World Dental Federation held its 2013 World Congress and Parliamentary meetings in Istanbul, Turkey. I thought I would take the opportunity in this Bulletin, to mention this conference and the significant role the CDA plays at this international stage.

FDI – the World Dental Federation is composed of 130 national dental associations representing more than one million dentists. As the global voice of dentistry, the FDI focuses its efforts on:
1) advocacy on international issues;
2) the formulation of position statements based on member consensus;
3) serving as an international forum for discussion of common issues and exchange of information; and
4) providing services to member countries with an emphasis on developing countries.
FDI works at the international and national levels through its own activities and those of its members. FDI is in official relations with the World Health Organization (WHO) and a member of the World Health Professionals Alliance (WHPA).

This year, the FDI Congress Scientific Program drew more than 8,300 registered delegates, and more than 80 countries and 150 voting representatives attended the parallel parliamentary meetings. With it's limited resources, FDI has been doing solid work on the management of global dental issues and has been a leader in representing the interest of the dental profession on issues such as dental amalgam, drug shortages, disease prevention, etc. The FDI parliamentary meetings continue to draw representatives from all regions of the world and provide a unique opportunity for full discussions on key oral health matters.

Again this year, the CDA and Canada had a significant impact on the discussions during the FDI parliamentary meetings. The CDA had consulted all of its Corporate and Constituent Members on the proposed FDI position statements for 2013 in advance of the Istanbul meetings and provided comments to FDI on each of the position statements being discussed. Canada's contribution to the discussions was publically recognized by FDI and special thanks were expressed for the significant amendments CDA proposed on the Bisphenol-A position statement. CDA has also been playing a leading role on the issue of drug shortages and was the driver of a motion for continuing monitoring of the issue at the international level by the FDI.

I previously mentioned its limited resources. In the past, FDI has faced budgetary challenges that were due mostly to the financial deficit of past congresses. In another Canadian connection, The FDI expressed its thanks to Dr. Ron Smith, a Past CDA President, for his work on the FDI Congress Task Team, which proposed a new model for holding congresses. This new model takes the financial risk away from FDI and places it with the host country, resulting in a much-improved financial standing of FDI.

I also told you, in a previous Bulletin, that as part of its collaboration with the Dental Corps of the Canadian Army, CDA is supporting the establishment of a national dental association in Afghanistan and that the Canadian support would include sponsoring the Afghanistan Dentists Association (ADA) into membership in the FDI. The two Afghan dentists attending FDI meetings in Istanbul were its current President, a woman, Dr. Farzana Nawabi, and its Vice-President, Dr. Hasamuddin Alamyar. They attended all key FDI events with CDA and had many opportunities to network and build relationships with colleagues in other countries. This initiative was a tremendous success and the CDA support was applauded both publicly by FDI and privately by several associations, including the American Dental Association, which will be carrying a story on this in their magazine. The Americans also expressed an interest in working with Canada in similar initiatives in the future.

In closing, I come back home to Manitoba. Just as the CDA made a big impression on the international stage, this year, the MDA will make a big splash on the national stage. In January, our MDA Annual Convention will be co-branded with the CDA. This means that, in addition to our usual tremendous local support, we will be joined by our colleagues from across the country. Soon, the whole country will be talking about the MDA and what a great event they put on. I encourage you all to come out and enjoy both the educational and social aspects of this fabulous event.

I'll see you there!

Dr. A. Mutchmor, DMD
CDA Board Representative

TRAILBLAZER DEFENDER REBEL VISIONARY INNOVATOR EXPLORER TRAILBLAZER DEFENDER REBEL VISIONARY INNOVATOR EXPLORER

Hiring Strategies

BY LISA PHILP RDH, CMC
PRESIDENT, TRANSITIONS GROUP

You have carefully considered your need for an additional team member and have determined that you do need to hire an employee. This decision is typically made for one of two reasons:

A) Your ability to increase production, provide better service for patients or to support the current providers in the practice is being hindered because you do not have adequate team members to cover

B) You have a need for a specific skill that is not present in your existing team i.e.: PDA, Treatment Coordinator etc.

When you hire, you need to do it right which means doing it in the most cost effective and time efficient manner possible. Hiring a new employee may seem like a fairly straightforward endeavor upon first examination, but don't act before carefully preparing.

While there are never any guarantees that the person you hire will work out, there are some steps you can take to attract the best candidates and precautions you can take to improve your chances of making an informed decision.

A) Determining What You Need

Before you start the process of hiring somebody for a new position, you have to know what you are looking for. The more completely you understand the position for which you will be interviewing, the better you will be able to evaluate applicants and choose the best ones for consideration.

Job descriptions and specifications are two tools that will greatly help you evaluate potential candidates.

A job description is a written record of the responsibilities of a particular job. It indicates the qualifications required for the position and outlines how the job relates to others in the practice. In a clear, concise manner, the job description should indicate:

- Position title
- Salary or compensation method
- Area that they will work in
- To whom they are accountable
- Work schedule
- A summary of the job
- Major responsibilities
- Qualifications needed

The job description should be organized in such a way that it indicates not only the responsibilities involved, but also the relative importance of these responsibilities. Within the broad categories mentioned above, you will want to include such information as the following examples:

- Computer experience required
- Working conditions
- Terms of employment

If the position is new, the job description will help you clarify what the position entails and its necessary qualifications. If you are filling a position that has been vacated, and if it is possible to do so, ask the departing employee to update the job description. It is possible for a job description to become quickly outdated. A departing employee may also help you review the job description to determine if activities being performed are still critical to the functioning of your practice and still add value.

- What is the purpose of the job?
- What day-to-day duties are performed?
- What other duties are performed?
- How is the position supervised?
- How much or how little control is exercised over this position?
- What instruments, computer or equipment must be used?
- What external or internal contacts are required?
- What verbal, numerical or computer skill is necessary for the position?

1.Determining the Requirements of the Position

When you are determining the hiring criteria, you will need to examine experience, education, intelligence and personality requirements. By establishing these requirements objectively through the use of the job analysis, job descriptions and job specifications, you will eliminate bias that might be caused by poor values and will be able to look objectively at traits tied directly to performance of the job.

As you define selection criteria, you will need to look at the recent job performance of the former employee and isolate two or three characteristics that have had the most impact of his or her successful job performance. Before you begin your search for qualified applicants, consider the following:

- Education, experience, physical requirements and personality requirements

Be careful that each requirement that you identify is specifically job related. This can help you avoid potential problems later. Don't make these job determinations in a vacuum. Ask the other team members for their perspective.

Lisa Philp is the President of Transitions Group North America, a full service coaching company for dentistry. She graduated from East Tennessee State University as a Registered Dental Hygienist in 1987. Her career began with clinical hygiene in United States and Canada to the creation of a periodontal disease management program in which she coached thousands of dental professionals. She is currently a leader, author, and coach and highly sought after North American speaker.

Lisa is committed to being an eternal student in the areas of personal growth, leadership, change management, human capital potential, adult learning, advanced training techniques and communication skills. Her mission is to make dentistry simple and fun allowing dental professionals to achieve personal and professional fulfillment in the workplace.

Faculty Corner

DR. ANTHONY IACOPINO
DEAN OF DENTISTRY
UNIVERSITY OF MANITOBA

Evolving, Adapting, Improving

Faculty of Health Sciences the next phase in the restructuring of healthcare in Canada

By now, it shouldn't really come as any great surprise to anyone that the time has come for a major realignment in the design and delivery of healthcare in Canada.

Certainly from a patient perspective, the signs are all there and have been apparent for some time: extended waiting times and lists throughout care centres wherever they may be; patients presenting with increasingly complicated and multifaceted conditions; complex-care facilities forced to treat chronic illnesses while struggling to be efficient and cost-effective.

These types of public-facing issues are well known and continue to apply significant pressure to the governing bodies of these facilities as they struggle to meet the increased demand spurred by an aging, diverse and often under-served population. Unbeknownst to most however is that in recent years significant pressures have also been brought to bear upon post-secondary institutions all across the land that are now facing a new reality spurred largely by this changing public dynamic and increasing economic pressures from all sides.

It is a plain and stark reality that health professions education is becoming an increasingly costly enterprise for universities, especially as government funding decreases and community expectations escalate with growing rapidity. The costs associated with complex teaching technologies, such as sophisticated simulation laboratories, medical devices and equipment, and community service continue to rise. Dental education, for example, is now the most costly university program on a per student basis due to the need to provide patient care/teaching clinics on site.

In order to respond to a rapidly changing health care and research environment, improve patient care and public health outcomes and address rising costs in an era of constrained resources, academic health professions in other jurisdictions are increasingly coming together around a unified mission, supported by a common governance and administrative structure. We believe the time is right for this type of alliance to be pursued at the University of Manitoba.

At the University of Manitoba, we have come to realize that the solution lies in the concept of inter-professional health education and practice. It's a relatively new idea that carries with it a bold proposition: a complete redesign of educational paradigms, facilities, and organizational structures as well as the manner in which educational programming interfaces with the practicing community and healthcare systems. Although it seems ambitious, this new structure offers the promise of major advances for all stakeholders in general and our oral health community in particular.

It begins with a near-total restructuring of our academic framework here at the institution specifically by incorporating the Faculties of Dentistry, Medicine, Nursing and Pharmacy, and the Schools of Dental Hygiene and Medical Rehabilitation into a new Faculty of Health Sciences containing professional colleges of Dentistry, Medicine, Nursing, and Rehabilitation Sciences.

In a nutshell, our new Faculty will combine and streamline like never before, creating myriad benefits and opportunities for all involved as a result. It's a collaborative approach that will see each of the disciplines contribute to the development and deployment of inter-professional curriculums that will reduce duplication and maximize each unit's area of strength for the benefit of the common good.

We will lead the accelerated development of enhanced collaboration on all fronts including teaching, research and public service. We will actively pursue a more holistic approach to research planning and development so as to enhance our presence in an increasingly crowded and competitive field. We will identify and reduce duplication in infrastructure and support services in all areas related to biomedical sciences teaching and research, clinical training, community outreach activities, student services, accreditation, faculty development, external relations and general administration.

Inter-professional education and the pooling of resources are the lynchpins of this new framework. And there seems to be little doubt that major gains can and will be realized through pursuit of this cooperative and collegial model.

First and foremost, we can increase team and inter-professional approaches and participate in multi-site and multi-professional frameworks that will lead to greater opportunities for innovation in academic programme development and community outreach.

This, in turn will allow us to better sustain a more pronounced research presence – a critical element in high quality programming in both clinical and basic science, particularly at the graduate level.

This approach will also be applied to our day-to-day operations. More strategic use of our material and human resources will only enhance the learning and work environment for students, faculty and staff; Further, as duplication is addressed over time, it will all ow resources to be re-directed to the Faculty's academic activities.

Nothing spurs opportunity better than change, and the creation of our new working reality could well be one of the most significant opportunities in recent history.

Although we are only still in the preliminary stages of this new design, we are currently actively engaged in exploring some marvelous new opportunities here on our Bannatyne Campus that may stem from this initiative. Chief among these is the development of an all-new, state-of-the-art healthcare centre that will be unlike anything that exists within the province today.

Inter-professional in its design and focus, we envision a full service, public-facing Faculty practice facility that will feature new dental clinics and oral health practitioners front and centre, working in concert with our healthcare colleagues from all other disciplines in what might best be described as "the clinic of the future".

This is only the start of what could well be the beginning of a complete transformation of the Bannatyne Campus. We are only now scratching the surface of our potential. And this, like most all of our other undertakings, requires your assistance, guidance and input. Our future is found in our friends. It is you who have made it possible for us to reach the point we are at today. With your continued involvement, we can control and shape our world and position the University of Manitoba as an international leader in health professions education, research and practice. As always, I look forward to hearing from you.

Grazie.

Current Diagnostic and Treatment Technology

BY DR. TIM DUNMORE
DMD, BSc, MSc, FRCD (C), DIPLOMATE ABO

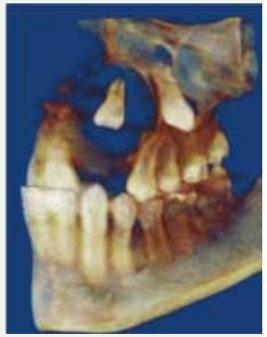
To look back at Orthodontics a hundred years ago, one would find a time when diagnostic information was typically derived from a clinical exam and plaster models, as cephalometrics did not arrive in a significant sense for some time, and photography did not easily lend itself to clinical practice. Treatment with fixed appliances was in its infancy, and the reality was that orthodontic care was reserved for a select few. Of course, at that time, the automobile had yet to be invented, indoor plumbing was a luxury enjoyed by a minority, and the Toronto Maple Leafs would not win their first Stanley Cup for another year (though I should add, Winnipeg had six wins at that point). With that in mind, let us consider how technology is changing the state of the art for orthodontic diagnosis and treatment. We will begin with diagnostic technology, then discuss the latest in treatment, and consider the convergence of the two.

CURRENT DIAGNOSTIC TECHNOLOGY

1. Digital Photography. When I began my residency in 1995, clinical orthodontic photography involved slide film, though digital photography was available in the 1980's (Reference 1). In 1999, I purchased my first digital camera, the Olympus D620L, which boasted 1.4MP. Today, cameras can boast resolutions over 20MP, though such high resolution is not typically necessary in dental photography.

For orthodontists, digital photography offers ease of storage, manipulation of images, input into correspondence, digital transfer, patient education, and many other benefits. Today, it is rare to find an orthodontist who has not embraced digital photography.

2. Radiography. The standard exposures for orthodontic diagnosis include cephalometric and panoramic radiographs. Introduced in the 1930's by Broadbent and Hofrath , cephalometrics has evolved into and remains a cornerstone of diagnosis, though some question the emphasis on static measurements of the skull in this manner. When I purchased my Planmeca digital ceph / pan machine in 2000, it was one of the first in the country. Today, most orthodontists appreciate digital radiography for the ease of tracing and superimpositions that it offers, and similar to digital photography, simplicity of storage and transfer.

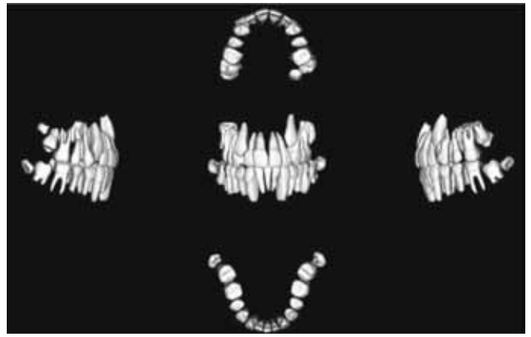


3. CBCT. One of the most significant changes in orthodontics has been the evolution of 3D radiography, in the form of Cone Beam Commuted Tomography. CBCT has been a controversial topic, with concerns that the exposure to radiation may not justify the significantly increased diagnostic value (Reference 3). However, as technology has improved, exposure levels have continued to decrease and it is likely that we will see CBCT become the standard of care in the future. In my practice, a majority of patients still receive a standard ceph/pan series, but CBCT is used to aid in isolating impactions, or to assess mid-treatment root positions, avoiding the limitations of panoramic radiography. The ability to see crown/root positions three dimensionally helps ensure optimal alignment including root position within the alveolus, and ultimately, improved patient care.

4. Digital study models. The typical orthodontic practice features vast amounts of storage for plaster study model. When I renovated my practice 3 years ago, we made practically no allowance for model storage. The difference? The iTero intraoral scanner we purchased over three years ago means that digitally captured study models can be stored on a server. There are currently a number of intraoral scanners available for orthodontic purposes, and the technology is rapidly evolving. New scanners coming to market will offer faster scans at a significantly decreased cost. Of course, digital models can also be acquired through via traditional alginate or PVS impressions. Numerous labs will accept your impressions to produce virtual casts, or affordable desktop scanners can be used to scan impressions or plaster casts in your office.

Regardless of how you acquire your digital models, the benefits that they offer are truly exceptional. Digital models allow you to treatment plan outside of the office without having to lug plaster around! Convenient and accurate measurement tools simplify assessment of the dentition and easy sharing facilitates interdisciplinary treatment. Personally, it took me a few weeks before I felt comfortable using digital study models, but at this point, I can't imagine going back to plaster.

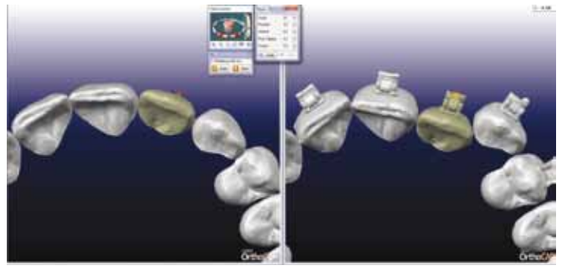
An interesting offshoot of digital study models comes from casts derived from CBCT data. Services such as Anatomodel from Anatomage, will produce virtual study models that include root data, allowing the orthodontist to truly treatment plan in three dimension. For some practices, diagnostic records consist of photos and a CBCT scan, from which digital study models are produced. From a patient's perspective, the records appointment is now just a few minutes. Three dimensional assessment of root position within the alveolar bone now becomes a more real aspect of your diagnosis.



CURRENT TREATMENT TECHNOLOGY

The shift to digital technology is also affecting how we treat our orthodontic patients. The information gleaned for diagnosis can then be used to facilitate treatment. Treatment simulation on the computer allows the user to better visualize the result of a prospective treatment plan. The simulated movements can then be used to effect actual tooth movement in a number of ways.

1. Virtual bracket placement. Most readers will be familiar with Indirect Bonding (IDB), whereby orthodontic brackets are placed on a cast of the teeth, then trays fabricated that allow the brackets to be transferred to the dentition. In the virtual world, computer algorithms allow the user to see where a tooth will move given a particular bracket position, so that an optimal setup can be produced. Once bracket positions have been confirmed by the doctor, the setup is sent to the IDB service for fabrication of trays.



Cadent offered their OrthoCAD iQ service for many years, but the company was purchased by Align Technology for the iTero scanning technology, and the iQ service was discontinued in April 2013. However, the number of intra-oral scanners in orthodontic practices is on the rise, and numerous labs are rushing to fill the void left by OrthoCAD.

2. Robotic Wire Bending. The Orametrix produce Suresmile, allows the user to produce an ideal setup of the dentition, including root alignment if CBCT root data is available. From the setup of the proposed final position of the dentition, the algorithms are able to direct a robot to produce precise bends in the wires, to achieve the desired result. Studies show that this technology can produce objectively better results with significantly decreased treatment time. While the service is not inexpensive, it does offer some practice efficiencies, and for many patients and practitioners, the cost is justifiable. (Reference 4)

Ormco offers a somewhat similar service, Insignia, that includes precision IDB jigs, patient specific brackets, and custom wires, and Unitek's Incognito services uses the concept to make lingual orthodontics a much more practical concept for the orthodontist.

With traditional orthodontics, brackets will only ever get teeth so close to ideal, and wire bending is required to produce excellent results. With computer driven robotic wire bending, we are able to achieve that which the human hand and eye cannot easily achieve.

3. Sequential Plastic Aligners. If you have been living in a cave in the Peruvian mountains for the last decade or so, it is possible that you have not heard of Invisalign. The first cases were started in 1999, and since then, our appreciation for the strengths and weaknesses of the system has grown to the point where a significant proportion of malocclusions can be successfully treated with the system. That in itself is not big news.
The really exciting technology in world of 'aligners' is software that allows the user to create setups in-house, providing much greater control over the process and a significant reduction in cost. Tooth movements are determined and effected by the doctor on screen and this data is used to produce thermoformed aligners. By eliminating an intermediary, the process of producing aligners can be significantly sped up.

4. 3D printing. Much of the previous discussion includes an implicit recognition of the need for 3D printing. Orthodontists first became aware of 3D printing when Invisalign came on the scene, with their use of stereo-lithography to produce resin casts. Today, 3D printing has evolved to the point where printers resemble the inkjet printer that sits on your desk. How is this affecting orthodontic practice?

Imagine a practice with an intra-oral scanner. A patient is scanned and their virtual dentition is now residing in a database. From this data, it is possible to align the teeth in a series of steps, and print sequential casts, to be used to make thermoformed aligners. You might also create IDB setups, and print casts that include bracket placement guides to allow for precise replication of the virtual bracket position on the printed cast; from this, IDB trays can be made. Not far in the horizon, you will be able to create an ideal setup, then print customized brackets, and customized IDB trays. We will also be able to print appliances directly from software, without the need to produce an intermediary cast!

For much of the history of orthodontic treatment, we have seen a picture of photos, plaster and film based radiographs, along with standard brackets and wires as the means to achieve our treatment goals. However, orthodontics is in the midst of a period of rapid change. The biology of orthodontics will always remain the same, but how we diagnose that biological reality and produce changes to it will be much different in the coming years. In fact, our ability to change the biology of tooth movement is moving closer to reality as well. It is an exciting time for orthodontics indeed!

Citations

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BY EVAN PARUBETS
CFP, CIM, FMA, FCSI, CSWP™

The Right Advice Can Help You Achieve Peace of Mind

In a recent survey[1], most Canadian dentists (60%) identified saving for retirement as their top financial goal. The reality is that many dentists face competing demands for their financial resources so, while saving for retirement may be at the top of their list, they may also have to contend with dental practice overhead expenses, supporting children and, possibly, aging parents and paying down debts. However, with careful planning and good advice, it is possible to achieve the goals that are important to you.

How can dentists put a comfortable retirement within reach? The first step is to create a financial plan. A financial plan will help you identify all your financial goals — short-, medium- and long-term — and prioritize them. The plan will have details about your current financial situation and your tolerance for risk, and offer investment strategies and other recommendations for accomplishing your financial goals. This will include information about how much money you will need at the start of retirement to sustain a desirable standard of living during your retirement years, and the steps you should take to get there successfully.

A financial advisor can prepare a plan for you, but who is the right advisor for you? You can protect yourself by dealing only with accredited professionals. The Certified Financial Planner (CFP) designation is recognized internationally as the industry gold standard. As well, consider whether the advisor is truly attuned to your needs and goals or focusing only on investment products and the commissions generated from them.
Once you have a plan in place, your advisor should provide regular progress reports showing whether you are on track to meet goals, such as your retirement objectives. For instance, the retirement income projection may illustrate how much annual income you can expect in retirement, based on your current rate of savings. If you are not on track, your advisor should offer solutions to help get you closer to your desired goal.
As a Canadian dentist, you have access to the financial planning advisors at CDSPI Advisory Services Inc. who have specialized knowledge about financial strategies for dental professionals and their families. This specialization means that you can be confident your advisor truly understands the issues that you may encounter throughout your career. You can also work closely with a dedicated advisor who is familiar with your specific situation and can give you appropriate advice for your needs. Your concerns may vary depending on your life stage and other factors, including, for example, the following:

- If you operate your dental practice through a professional corporation, you may be eager to learn how the corporation can set up a corporate investment account to fund your retirement and whether this arrangement provides any tax and income splitting advantages.
- As a practice owner, you may also be interested in strategies for minimizing the tax liabilities from a dental practice sale at retirement and how to invest the proceeds tax efficiently to fund your retirement.
- For a dentist in the early years of practice, paying down education debt and maximizing registered retirement savings plan (RRSP) contributions to reduce your taxable income may be among your immediate priorities.
- If you are a female dentist, you may be focused on strategies to ensure you will have enough retirement income for your typically longer years in retirement and shorter career span compared to those of a male dentist. Therefore, you may consider starting your investment plan earlier to provide extra time for your registered investments to compound tax free. (Research indicates that women dentists work fewer hours than male dentists during their child-rearing years, and the average career length of female dentists is about 20 years, compared to 35 years for men.[2])

For personalized assistance with your retirement savings and other investment goals, please call me at 1-877-293-9455, ext. 6852 or send an e-mail to eparubets@cdspiadvice.com. (Restrictions may apply to advisory services in certain jurisdictions.)

Evan Parubets is an investment planning advisor at CDSPI Advisory Services Inc.

[1]Source: 2012 CDSPI Survey conducted by a third party; data collected between July 18 and August 10, 2012.

[2]The Feminization of Dentistry: Implications for the Profession. J Can Dent Assoc 2012; 78:c1.

BY DALE WILLERSTON and JEFF GRANSFIELD
THE LEASE COACH

Selecting the Best Site for Your Dental Practice

When The Lease Coach does site selection for a dentist, we are not looking for the cheapest location we can find, but instead the location that will enable the dentist to maximize his or her patient volume. Paying too much rent for a mediocre location is one thing; however, choosing a poor or weak site will negatively impact the future potential of the practice (and your resale value).

If your office lease is coming up for renewal and your practice is underperforming perhaps you need to consider relocating (yes, we know it's expensive). If a practice is doing $550,000 in annual revenues, but could be doing $750,000 or more in a better location the problem is not going to correct itself. If other dental offices are beginning to move in around you as competition, and leasing newer developments or better locations nearby it will, in turn, make your location that much less attractive to future patients. A poor location will hold back the growth of your practice, reduce the resale value of the practice and make it more difficult to take home a good salary. You can't invest too much time searching for the right location for your practice. Consider neighbourhood, traffic flow, demographics and parking. It is better to have negotiated a poor lease agreement on the right location than a good deal on the wrong location. Dentists about to open their first location typically do not allow enough time. If you are opening a new office or moving, begin your site selection process at least one year before you plan to open. If you are already a tenant, initiate your lease renewal negotiations 12 months before the lease expires. After all, if you can't get a decent renewal, you will want time to negotiate a new lease and relocate without the pressures that every tenant feels at that time.

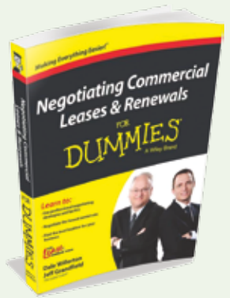
In viewing properties, avoid assuming that all the current tenants will remain – specifically, the anchors (or major stores). Tenants in a strip mall near one of our homes were caught off guard when a major grocery store moved out of the property. None of the business owners who had recently renewed their lease thought to ask if the grocery store anchor was staying. While this grocery store continues to pay their rent on the vacant space, the landlord cannot put another grocery store into the 25,000 square foot anchor spot, due to a non-competition clause in the lease agreement. The landlord continues to receive the rent payments, but traffic to the strip mall had dropped by 50 percent and the remaining tenants suffer the consequences. Brokers and in-house leasing representatives are required to know this type of information and to answer your questions - if you ask them.

Another common mistake you can make is letting a single real estate broker or agent assist you with viewing a variety of properties. Let us repeat this statement since so many dental tenants don't understand it … don't let one broker show you space all over town. Yes, talk to the listing agent and ask questions. But do not let one agent introduce you to another building that is not listed by his or her brokerage. In other words, let the agent know you are willing to look at only buildings for which he or she has an active listing to lease. Speak directly to the listing broker for each building in which you are interested – that is, whoever has his/her name on the "For Lease" sign outside of the building. This will result in your obtaining more accurate information quicker and will avoid commission splitting (where two brokers share the commission paid to them by the landlord for work performed), which could result in an inflated rental rate and may reduce your chance of leasing there if the listing agent has his/her own prospects for the space.

In some cases, the broker will present you with an Offer to Lease or Letter of Intent that states the broker is working in a ***dual agency*** capacity. You can cross this point off the offer and make your desires known to the broker. It is absolutely critical for you to realize that conventional commercial agents work for the landlord who is paying their commission (and not for you, the tenant). They are paid by the landlord to get the best deal for the landlord. Even if there are two agents involved, if they are both sharing the same commission, are they really working for you – the dental tenant?

For a copy of our free CD, *Leasing Do's & Don'ts for Dental Tenants*, please e-mail your request to: DaleWillerton@TheLeaseCoach.com.

Dale Willerton and Jeff Grandfield - The Lease Coach are Commercial Lease Consultants who work exclusively for tenants. Dale and Jeff are professional speakers and co-authors of Negotiating Commercial Leases & Renewals For Dummies (Wiley, 2013). Got a leasing question? Need help with your new lease or renewal? Call 1-800-738-9202, e-mail DaleWillerton@TheLeaseCoach.com or visit www.TheLeaseCoach.com.



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