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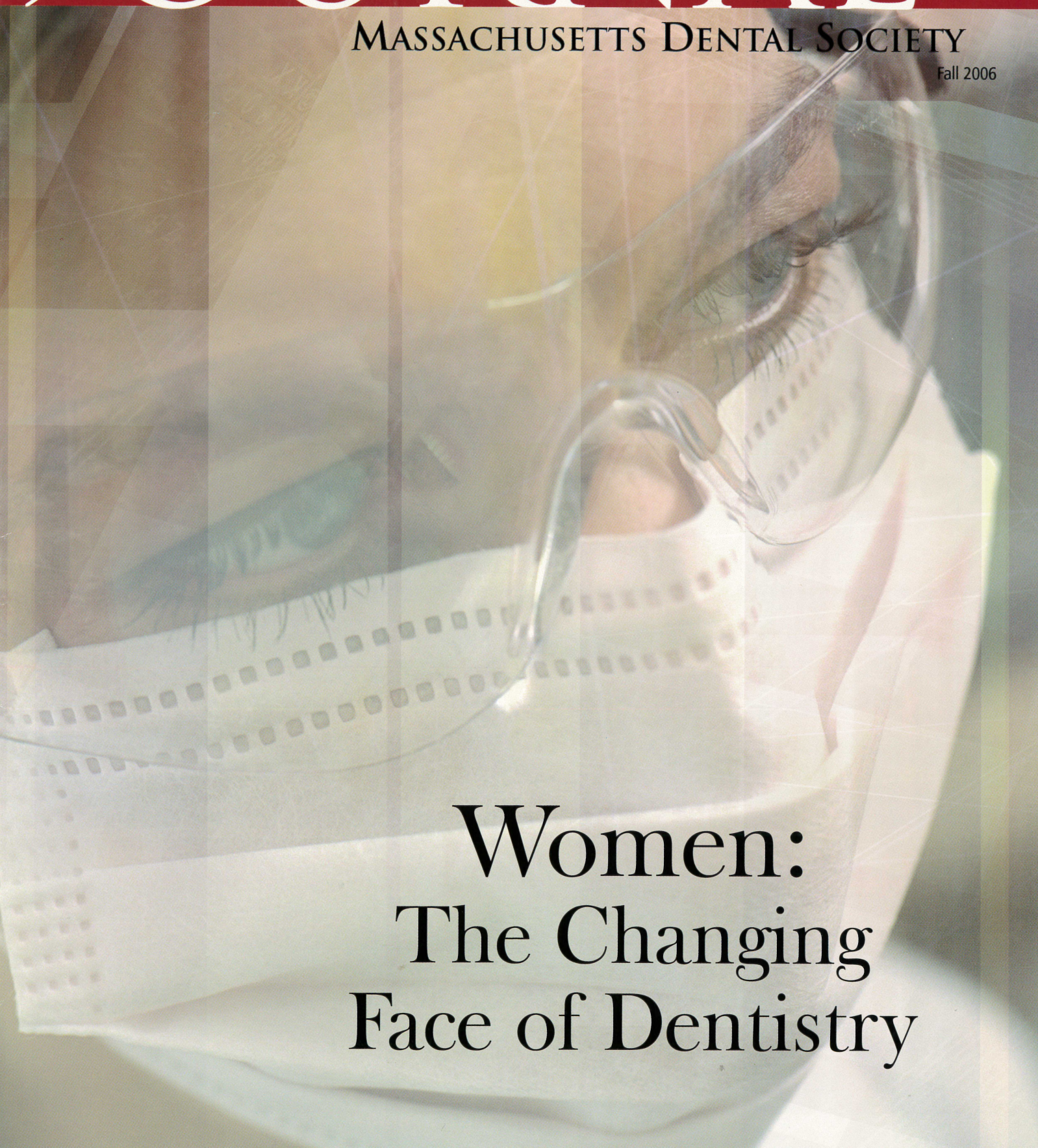

Women: The Changing Face of Dentistry

CELEBRATING THE CHANGING FACE OF DENTISTRY

Our culture is replete with grievous gender inequalities. In the business world, women still earn less than men for identical jobs. Women in our profession should be seen as *dentists*, yet they are still too often labeled as "women dentists." Meanwhile, men in our profession are never described as "men dentists."

It seems incredible that in these modern times we are still dealing with issues of gender inequality, especially in dentistry, where women are quickly becoming half of all dentists and often comprise greater than one half of some dental school classes.

So why, then, are we devoting this edition of the *Journal* to women dentists and the unique problems they face as practitioners?

Once we reach the point where our profession and our patients routinely look upon male and female dentists as equally qualified and engaged in our professional and personal lives, "special editions" such as this will become superfluous and irrelevant. At this point, however, we feel it is reasonable to present topics specific to the myriad challenges women dentists routinely face in daily practice.

The Massachusetts Dental Society (MDS) is making a concerted effort to get more of its member dentists involved in volunteer and leadership roles. As an adjunct to this effort, the Society is also endeavoring to attract more women members to become involved in MDS activities, at the state, district, and community levels.

The Women's Leadership Task Force has been established to assist the Society in identifying issues specifically pertaining to women dentists and implementing programs that will facilitate positive changes. For example, the Task Force suggested that the Board of Trustees invite Guest Board Members to serve on the Board in a nonvoting capacity. This has proven to be an excellent adjunct to the long-established district representative model. The Board now has women, minorities, new professionals, and academics witnessing the benefits of leadership involvement in moving their specific agendas. As an extra bonus, the new perspectives these participants bring have given the Board additional resources to help in the decision-making process.

The American Dental Association predicts that within 15 years, 30 percent of this country's practitioners will be women. The dental student population in Boston is already composed of nearly 50 percent women, and the rest of the country is quickly catching up. Yet it is interesting to note that in the United States, the number of women dentists and dental students still lags behind the female participation in other professions, such as law, medicine, and veterinary medicine. In some European and South American countries, more than 75 percent of practicing dentists and 65 percent of dental students are women.

There is still work to be done to make our profession equally attractive to qualified women and men. We hope this edition of the *Journal* helps to hasten the process. ■

David B. Becker

Arthur I. Schwartz

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The 5th Annual MDS Foundation Golf Tournament & Dinner Fundraiser

It was a hot day for the golfers at Walpole Country Club, the setting for the 5th Annual MDS Foundation Golf Tournament and Dinner Fundraiser, which was held on June 19. But as the temperature rose, so did the charitable donations: This event is the Foundation's most successful outing yet, raising nearly $48,000—almost 40 percent more than the previous four tournaments. All proceeds benefit the MDS Foundation—the charitable arm of the Massachusetts Dental Society—which is dedicated to improving access to quality dental care for underprivileged children and adults in Massachusetts and enhancing educational opportunities for those who wish to pursue a career as a dental hygienist, assistant, or lab technician.

As part of the Society's initiative to get more women dentists involved in organized dentistry, the Women's Leadership Task Force was instrumental in recruiting 10 women dentists to play in the tournament. In addition, the MDS Foundation hosted its first Golf Clinic to entice non-golfers to join in the fun. A group of nine women joined MDS President Alan Gold, DDS, for a group lesson, which was sponsored by the Middlesex District Dental Society.

Golfers had several opportunities to win prizes during the Closest-to-the-Pin and Longest Drive contests. James Hanratty, DMD, of the North Shore District, sunk a 20-foot putt to win the Putting Challenge sponsored by Delta Dental of Massachusetts. Bob Alconada, MDS director of governmental affairs and grassroots advocacy, was just a little over 9 feet away from winning a brand-new Lexus RX350 in the Hole-in-One contest sponsored by Lexus of Norwood. After the tournament, both a live and a silent auction, which began online a month before the event, were led by Dr. Gold and Golf Committee Chair Michael Seidman, DDS. Attendees were able to bid on Red Sox tickets, rounds of golf at exclusive clubs, a hot air balloon ride, and much more. The Cape Cod and South Shore Districts' Golf Tournament generously donated several raffle items, such as Ping, Calloway, and Taylor Made clubs, to spice up the raffle this year.

Several district dental societies generously contributed $1,000 or more toward the tournament: Cape Cod, Merrimack Valley, Middlesex, Southeastern, and South Shore. We would also like to extend a special thank-you to major sponsors of this event: Gentle Dental Associates, MDS Insurance Services, and Astra Tech Dental. The Golf Committee has already begun work on preparations for the 6th Annual MDS Foundation Golf Tournament, which will most likely be held in May or June 2007.

Tournament Winners

Best Ball of Four: 1st Place Gross
Drs. John Caravolas, Donald Burgoyne, Efrain Ruiz, and Mr. Stephen Dellelo of Eastern Dentists Insurance Company

Best Ball of Four: 2nd Place Gross
Drs. Kevin McNeil, Daniel Mahoney, William Dupont, and Gus Levanos

Best Ball of Four: 1st Place Net
Dr. James Thiel, Mr. James Thiel, Mr. Jesse Rodriguez, and Dr. Michael Rubin

Best Ball of Four: 2nd Place Net
Mr. George Gonser of MDS Insurance Services, Mr. Rob Anderson, Mr. Steve Anderson, and Mr. Chris Choate

Best Ball of Four: 3rd Place Net
Drs. Paul Epstein, David Schmid, Richard Bush, and Mr. William Curtin

Scramble: 1st Place
Mr. Mike Coletti, Mr. Jeff Blair, Mr. Chip Buckley, and Ms. Chris Gerrard of Sullivan-Schein Dental

Scramble: 2nd Place
Mr. Dean Ribeiro of National Dentex Corp., Mr. Cory Spencer of H&O Dental Laboratory, Dr. Steven St. Germain, and Mr. Scott Negrucci of 3M ESPE

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FINANCIAL SERVICES CORNER

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ESTATE STRATEGIES CAN PRESENT CHALLENGES FOR S CORPORATIONS

With advice from counsel and their CPAs, many small business owners choose Subchapter S as a business entity, primarily due to liability and income tax considerations. However, such election may often result in business continuation challenges in later years, when estate planning becomes a more crucial issue. Thus estate planning for S corporation shareholders is essential because the improper transfer of shares could potentially terminate the corporation's S status. Therefore, a carefully drafted buy-sell agreement is of utmost importance to all shareholders.

Buy-Sell Agreement Considerations

A buy-sell agreement must address several key issues to ensure the proper transfer of shares and to maintain the integrity of the S corporation status. The agreement should detail who can and cannot be the recipient of shares. This may include prohibiting the transfer of shares to partnerships, corporations, nonqualifying trusts, and individuals other than nonresident aliens. A sound agreement should also contain a provision ensuring that the number of shareholders will not increase beyond 75. Otherwise, the S corporation status could be terminated.

Another important issue that resulted in closer scrutiny from the Internal Revenue Service (IRS) was the possibility that a buy-sell agreement could create a second class of stock. However, regulations have been enacted stating that as long as there is a bona fide agreement to redeem or purchase stock upon the occurrence of a specified triggering event (i.e., death, disability, divorce, or separation of service), such redemption or purchase would not constitute the creation of a second class of stock.

Additional planning considerations arise with respect to the valuation of shares. In order for the valuation of shares under a buy-sell agreement to be recognized for estate valuation purposes, the buy-sell agreement must (1) not serve as a mechanism for transferring shares to family members for less than full and adequate consideration; (2) be a bona fide business agreement; and (3) have terms and provisions similar to an "arm's-length transaction." Also, the share price that is set must apply both during life and at death.

Finally, a determination must be made as to the type of buy-sell agreement that will be utilized and how the agreement will be funded. Although various hybrid arrangements exist, there are essentially two types of buy-sell agreements: a cross purchase and an entity purchase. In brief, with a cross purchase, the individual owners buy out the deceased or disabled owner's shares. With an entity purchase, on the other hand, the business entity buys out the deceased or disabled owner's shares.

Both arrangements have various advantages depending on the type of entity and the goals of the shareholders. For instance, under a cross purchase arrangement, a key advantage to the surviving S corporation shareholders is that their basis will increase by the amount of interest each shareholder purchases, respectively. An entity purchase does not afford shareholders this benefit. However, because a cross purchase requires arrangements between shareholders, the demographics of the shareholders (e.g., significant age disparity or disproportionate ownership interests) may be detrimental to the overall success of such a plan. In this respect, an entity purchase may be more appropriate in some situations.

Funding a Buy-Sell Agreement

Generally, one of the best methods for funding a buy-sell agreement is with life insurance. Life insurance offers some distinct advantages: (1) the only costs to the shareholders (or corporation) are for the premium payments, and (2) the policy's death benefit proceeds are usually not income-taxable to S corporation shareholders. With a cross purchase arrangement, the individual owners purchase a policy on each individual. With an entity purchase arrangement, the corporation purchases a life insurance policy on each individual owner.

Parting Thought

Estate and business continuation planning for S corporation shareholders can be exceedingly complex. Often, such planning becomes a delicate balance between meeting the organizational goals of the S corporation and the personal goals of the shareholders. Thus it is essential that all affected parties consult with qualified legal, tax, and insurance professionals. ■

GEORGE GONSER, MBA
Mr. Gonser is the managing director of MDSIS.

IDENTITY THEFT IS A GROWING CONCERN: ARE YOU PROTECTED?

Do you own a credit or debit card? Do you have a checking or banking account? Do you access the Internet? Are you on one of the many lists of personal information leaks reported each month?

If you answered "Yes" to any of the above questions, you are at risk of identity theft.

It's been prevalent in the news these last couple of years, but what exactly is identity theft? Simply put, identity theft is a crime in which someone steals your personal information—name, date of birth, address, social security number—and creates a "new you." The stolen personal information is used to open credit cards (and run up the cards with lavish purchases), apply for loans for cars, houses, etc. Oftentimes, you are not even aware that your identity has been stolen until it's too late and the new "you" has already racked up thousands of dollars' worth of debt—all in your name. As a result, you are victimized financially while piling up hours of time and effort to recover and restore your name and good credit.

Some of the industry statistics regarding identity theft are startling and downright scary:

- Identity theft is the fastest-growing crime in the United States.
- More than 10 million cases of identity theft occurred in the United States in 2005, and that number is skyrocketing.
- The cost of identity theft in the United States is more than $50 billion annually.
- The average case of identity theft costs more than $10,000 in money, goods, and services.
- In 2005, more than 100 incidents of data leaks affected over 50 million individuals.

To address this growing issue, MDS Insurance Services, Inc., is now offering a benefit-rich, aggressively priced insurance product designed for the individual and/or group. The Identity Guardian product is offered two ways:

- Employer-paid group-based product available for a monthly premium of $8.95 per employee and his or her family
- Employee-paid voluntary-based product available for a monthly premium of $4.95 per employee and his or her family

The benefits include the following:

1. Identity theft insurance coverage of $25,000 for lost wages and restoration expenses backed by AIG
2. A personalized theft case worker to facilitate the recovery process in the event of a theft
3. Prevention of unauthorized exposure of your personal information, including personal, public, and financial records
4. Ability to opt out of marketing databases and unsolicited offers
5. Access to all important identity data sources
6. Identity protection console with updates, threat assessments, and identity theft education modules.

Learn more about identity theft at our Web site, ***www.mdsis.org***, or by calling one of our experienced MDSIS agents at **(800) 821-6033**. For a few dollars a month, you could be saving thousands. ■

So, are you protected?

VIEWPOINT

JOHN P. FISHER, DDS
Dr. Fisher is a general dentist based in Salem and an MDS trustee for the North Shore district.

HOW CAN THE DIAGNOSIS BE WRONG IF THE PATIENT'S CHART IS ILLEGIBLE?

I WAS RECENTLY PRIVILEGED TO PARTICIPATE IN A MEETING WITH two members of the Board of Registration in Dentistry (BORID), Dr. Robert DeFrancesco and Dr. Lawrence DiBona. I say "privileged" because meeting with them gave me many fresh insights and changed some of the perspectives I had held prior to this meeting. These were not necessarily negative perspectives, but I am by nature resistant to governance, mostly because I think of us as professionals and not in need of this oversight. But this meeting gave me new respect for these individuals and all who serve on this Board because it is obviously not easy to be the ones who are charged with policing our profession, particularly since they are our peers. On the other hand, it gives me great solace to know there are those who are willing to serve this role so that we have some dentists, hopefully with knowledge of how difficult our tasks can be, overseeing the laws and regulations of our profession.

Part of the information that came out of this meeting is a new effort on BORID's part to define and codify our responsibilities so that we are more acutely aware of what I often think we should have learned in dental school. However, many things vary from state to state and priorities change over the years, so their experience as dental professionals allows the members of BORID to expand on and elucidate various definitions to help us in our practice.

I like to assume that we as dentists are always striving to achieve a higher standard, and for the most part, I think we do. But a timely review of what we should know never hurts, particularly in what has become a more hostile, self-centered social environment. To this end, BORID will be sponsoring a course at this year's Yankee Dental Congress—"Risk Management: BORID Interaction"—that should help take a lot of the uncertainties out of our responsibilities and hopefully give us a clear set of guidelines to follow. Also, we are all invited, as members of the public, to attend one of the Board's meetings at any time, which would certainly remove the mystery of the Board's proceedings and could prove to be a valuable learning experience for anyone who may have any concerns.

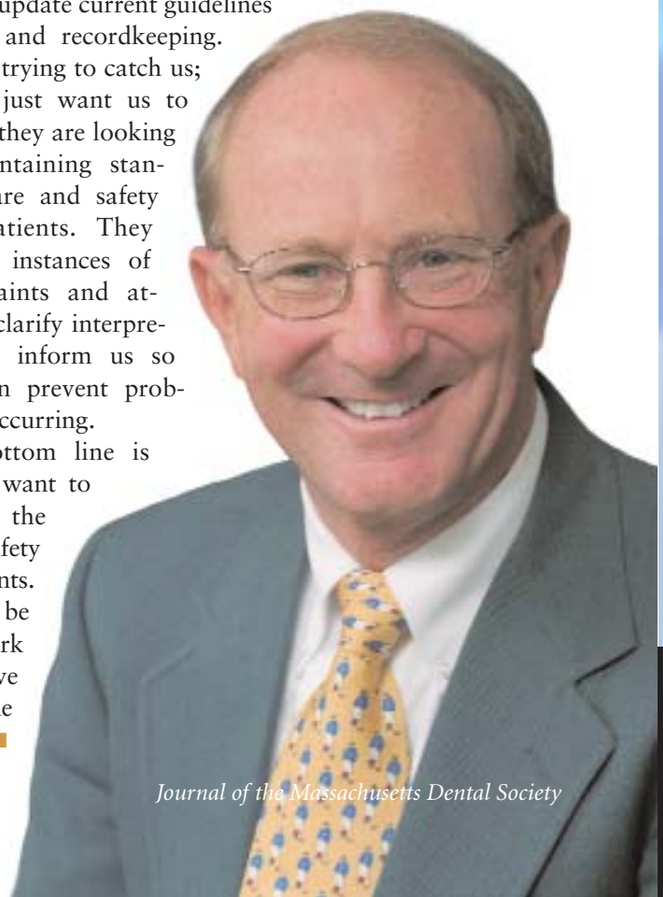
With that being said, I would like to expand on my initial mention of resistance to any kind of regulation. As dentists, we have a certain streak of independence. No one can do our job as well as we can, and no one should be able to tell us how to care for our patients. I admire this. Some of this stubborn independence is what makes us strong as a profession, but if we are not careful, this is what could also destroy us. Not literally, but it can add stress to our lives and reduce our sense of well-being.

Recently, rumors have been rampant relative to complaints filed with BORID. I have heard many different versions of what often appears to be the same story. If you are one of those affected, you may not agree with this, but if you are really trying to comply with the regulations, the odds are that you won't have a problem. Of course, part of this assumes you are well-grounded in the regulations, understand their application, and are meticulous in how you keep your records.

But sometimes we are a little casual in how we do things. If your continuing education credits are not current, you may have perjured yourself when you renewed your license. Did you read the small print? Who would ever neglect to renew their license? It happens. What if you haven't renewed your license? Is it fair that someone can make an issue of this? I'd like to think, "Hey, it's just an oversight," but it doesn't matter what I think; by law, those on the Board must bring such matters to your attention and impose a penalty if any of these situations comes up while they are responding to a complaint, even an unfair complaint, even one with no basis. And what about those illegible patient charts?

I find it difficult to believe any of this could happen to us—but it does happen. The members of BORID are attempting to rewrite and update current guidelines of practice and recordkeeping. They're not trying to catch us; they really just want us to know what they are looking for in maintaining standards of care and safety for our patients. They have taken instances of real complaints and attempted to clarify interpretations and inform us so that we can prevent problems from occurring.

The bottom line is that we all want to maintain the care and safety of our patients. We should be able to work together; we all want the same thing. ■



Women: Changing the Face of Dentistry

The face of the dental profession is changing. Each year, the number of women dentists in Massachusetts continues to grow. In the near future, our local dental schools will graduate more women than men. And this year, 50 percent of new members of the Massachusetts Dental Society are women.

In 2005, the MDS formed the Women's Leadership Task Force with the directive to examine the needs of women dentists, to encourage the active membership of women, and to ease their transition into leadership positions in organized dentistry.

As dentists, women share the concerns of our male colleagues, but as women, we have unique concerns as well. In this special issue of the JOURNAL OF THE MASSACHUSETTS DENTAL SOCIETY, we look at some of these aspects of practicing dentistry and organized dentistry from a woman's perspective. We hope that this information will be helpful to both female and male dentists as we look to the future of the Society and the profession.

Laura B. Glicksman, DMD, MS
Chair, Women's Leadership Task Force

The Evolving Role of Women in Organized Dentistry

ANDREA RICHMAN, DMD
Dr. Richman is a general dentist in Carlisle and president-elect of the Massachusetts Dental Society.

What does it mean to be a woman active in organized dentistry? My experience is that it has been the icing on the cake. It adds a level of involvement and interaction with colleagues that can make a difference not only in how you practice dentistry, but also in how you view yourself as a professional. As a member of organized dentistry, you have an opportunity to contribute your ideas, expertise, and talents. There are tremendous opportunities for women now in the Massachusetts Dental Society and its districts, in the dental schools, and in the Yankee Dental Congress. We are now sought after and our opinions are valued. It is vital that women, especially new dentists, feel connected to the profession. It is empowering to be so connected, and it says something about you as a professional.

Professional Perception

Nevertheless, while the number of female students at dental schools is rising at a faster pace than male students (first-year enrollment between 1995–1996 and 2004–2005 increased by 31.6 percent for females versus a drop of 3.6 percent for males),[1] this is not reflected in perception, which creates a problem both from within and outside the profession. Not only are women graduating in record numbers, with a 28.9 percent increase from 1995 to 2004;[1] they are entering private practice, academia, and public health dentistry in record numbers. In fact, the latest American Dental Association (ADA) statistics indicate that women comprise 48.6 percent of new employed dentists.[2] Why, then, are women not perceived as full partners in the profession? Around the tables at dinner meetings and in informal conversations, we hear the same theme: "Women only practice part-time and don't participate fully in the profession." Dentists are almost universally referred to as "he." However, there are women who have risen to become leaders in their state dental societies and in the ADA. They have worked tirelessly on behalf of *dentistry*—not just *women in dentistry*. Perception needs to catch up to reality.

The Times Are Changing

Let's look at some history. Twenty-five years ago, there were only four women delegates (plus two alternates) in the Massachusetts Dental Society House of Delegates; in 2006, there are 15 women delegates (plus six alternates) out of 145 voting members. Twenty-five years ago, there were three women delegates (plus two alternates) in the ADA House of Delegates; now there are 58 women delegates (plus 64 alternates) out of the total 464 delegates. Obviously, women are still woefully underrepresented. As women begin to filter into the organization as participants, it is inevitable that they will rise in proportional numbers as leaders.

In Massachusetts, 22 women have risen to leadership positions in 11 out of 13 districts, in YDC, and on the MDS Board of Trustees, and next year the MDS will be led by its first woman president. By next year, all the New England States in

As the next generation of women dentists comes along, dentistry should be seen as equally a male and female profession on both levels: caring for patients and being equal partners in the profession.

District 1 will have had a female president as well as a female trustee, Jeanne P. Strathearn, DDS. Also next year, the ADA will have its second female president, Kathleen S. Roth, DDS (the first was Geraldine Morrow, DMD, in 1991–1992). Since 1998, 40 women nationally have been elected president of their state district dental societies, and there are now four women on the ADA Board of Trustees. On our own Board, we have one female officer and just welcomed our third woman trustee, Janis Moriarty, DMD.

These statistics prove that the number of women practitioners is indeed rising. But the question remains: How do we address the need for more participation by women?

As women become more and more visible at district, study club, and continuing education meetings, the perception that dentistry is a "male" profession will change. According to the latest membership information, 111 out of 222 new member dentists who joined the MDS in 2006 were women. That is 50 percent of all new members. Our task is to keep these women engaged and connected. The most important link in the chain is the local district. It is imperative that all new members feel included and enriched at the district level.

We are fortunate in Massachusetts to have the Yankee Dental Congress, another vehicle for organized dentistry. This conference offers a multitude of opportunities for involvement based on expertise and interest. Members can participate by volunteering for one of the many and varied committees, participating in anything from Social and Cultural Events to Scientific or Allied offerings to Hospitality to Registration. The MDS has also formed the Women's Leadership Task Force, which has been charged with facilitating the movement of qualified women dentists into leadership positions in organized dentistry.

Public Perception?

Let's ask the question of the public: Is dentistry a female profession, a male profession, or a neutral profession? If you were to ask the average person, he or she would probably reply that dentistry is a male profession. If you ask the same question about medicine or law, the reply would probably be mixed. Why is this? Women have entered the medical and legal professions in significant numbers and have been there long enough to change public perception and acceptance. If one goes to see a physician in a hospital or private office, or a lawyer in practice, that client is as likely as not to see a female.

Of prime importance, the public seems to be accepting this reality and does not question the professionalism or expertise because of gender. If we return to that same average person, he or she will likely say that when seeking a dentist, he or she is more likely to find a male than a female but would be just as comfortable being treated by a female. Just as we have broken through the professional barrier in our offices for our delivery of dental care, perception needs to catch up with reality. As the next generation of women dentists comes along, dentistry should be seen as equally a male and female profession on both levels: caring for patients and being equal partners in the profession.

Conclusion

One of the qualities that made dentistry appealing to me when choosing a profession was the entrepreneurial possibility it held. I always wanted my own business, and a dental office fit the bill for my interests. Many women dentists have felt the same way and are in private practice. However, to reconcile perception with reality, more of us have to be visible within the dental community. We need to stand up and be counted, make our voices heard, and participate in the dialogue. If each of us could make a commitment to go to just one meeting a year, that would go a long way toward changing the perception within the profession.

There is a place for every woman dentist within the organization, no matter how much or how little time she has to invest. And that investment will pay off handsomely for the individual and for the profession alike. ■

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Mentoring: Leadership, Learning, Legacy

PAULA K. FRIEDMAN, DDS, MSD, MPH
Dr. Friedman is a professor and associate dean for administration at Boston University School of Dental Medicine. She is also currently serving as a guest board member of the Massachusetts Dental Society.

Abstract

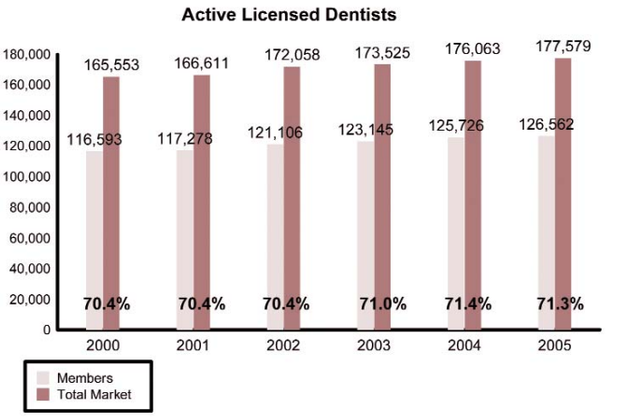
As the dental profession develops over the next few decades, there will be identifiable changes in the demography of the profession. Enrollment trends reflect a growing number of women in dental schools and in the dental profession. There is an increasing number of dentists—men and women—from countries and cultures outside of the United States. The profession must be prepared to address the question of how to engage women—as well as minorities—in more active and visible roles in organized dentistry. The challenge is clear, and the outcome will provide an indicator to the strength of our professional associations in the future. Mentoring of women dentists is one effective way of creating a pathway to participation.

Introduction

Spanish painter and sculptor Pablo Picasso once said, "There are painters who transform the sun into a yellow spot, but there are others who, thanks to their art and intelligence, transform a yellow spot into the sun." At some level, the process of mentoring—and of being a mentor—is about helping to transform potential into reality. The value of mentoring and being a mentor, and the potential that mentoring has for transforming more Massachusetts Dental Society (MDS) members and potential members into engaged, active participants in the organization, cannot be underestimated. And neither can the importance of recruiting and retaining more women members into organized dentistry.

In 2005, the American Dental Association (ADA) elected the second woman in its history to the office of president-elect, Kathleen Roth, DDS. In 2007, the MDS will inaugurate its first woman president, Andrea Richman, DMD. These two leaders represent the growing wave of women in dental schools and

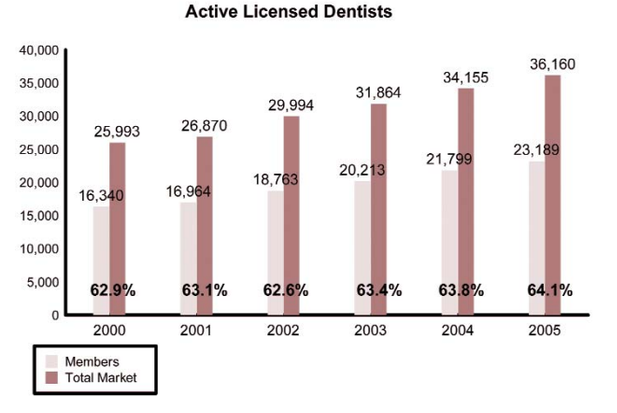
Figure 1
NATIONAL MARKET SHARE



Source: 2005 ADA Dentist Masterfile

NOTE: The market increase in 2002 is due in part to the addition of over 2,800 new records for foreign trained dentists.

Figure 2
WOMEN DENTISTS



Source: 2005 ADA Dentist Masterfile

dental practice. The enrollment of women in dental schools is approaching 50 percent of entering class membership.[1] While national market share of active licensed members of the ADA has increased slightly (by 0.8 percent) over the past five years, from 70.4 percent in 2000 to 71.3 percent in 2005 (see Figure 1), the market share of active licensed women dentist members has increased from 62.9 percent in 2000 to 64.1 percent in 2005 (see Figure 2).[2]

In 2003, Boston's three schools of dental medicine—Boston University, Harvard University, and Tufts University—reported a total of 355 graduates, of whom 153 (43 percent) were women.[3] While the percentage of membership for women lags behind overall membership, the growth rate for women exceeds that of overall membership.

And the fact that female enrollment in dental schools is approaching 50 percent provides compelling evidence that strategies for the recruitment and retention of women into organized dentistry needs to be a priority to maintain and grow the strength of the American Dental Association. The demographic imperative reflected in these data also speaks to the need for organized dentistry to create structure and opportunities for women dentists to be involved in activities and governance of the association to ensure the vibrancy and vitality of the organization in the future.

In 2005, under the leadership of then-President Dr. Alan DerKerzarian, the MDS initiated a new program to reach out to women dentists in the state—the Women's Leadership Task Force (WLTF). With the first initiative of its kind in the country, the MDS took a proactive stance in developing pathways for women to become active members of the Society. At its outset, the WLTF was comprised of women who had been in practice for less than 10 years, women who had been in practice for more than 10 years, and a dental educator. One of the first activities planned was a reception to welcome women members—current and potential—to the MDS, and to elicit interest in being mentored, as well as providing mentorship. At another recent program event on leadership sponsored by the WLTF, women participants were grouped by district for part of the day with the intent being to better develop networking and mentoring relationships. The WLTF has already been successful in propelling several women into leadership positions within the Society. One member, Janis Moriarty, DMD, the first chair of the WLTF, was recently elected MDS Trustee from the Middlesex District.

Leadership, Learning, Legacy

Why are mentoring relationships important and what is the role of mentoring for success in dental practice? Mentors provide leadership within the profession, present opportunities for bidirectional learning between the mentor and the mentee, and, through their investment in others, create a legacy for the next generation of leaders/practitioners/professionals. Mentoring is a form of "giving back" to the profession by sharing knowledge and experience with others. And mentoring is a way for the mentor to benefit from the current knowledge of a newer practitioner/graduate, and to stay engaged in lifelong learning and renewal.[4]

In 1992, the issue of mentoring in dental education was addressed, and a dual key question was posed: Who are mentors and do we really need them?[5] Mentors can be pivotal in providing guidance, sharing experiences, helping the mentees avoid pitfalls (or assisting the mentees in correcting the pitfalls once they have occurred), facilitating networking opportunities, and providing encouragement.

A mentor can bestow credibility on a mentee—the benefit of association with a successful practitioner, academician or politician can create opportunities that might not otherwise be derived. Warnock argues that it is essential to recognize the needs of surgeons (dentists) for mentorship throughout their careers, and that mentoring is inextricably linked to career development.[6] He discusses areas in which mentors can provide expertise and guidance, including personal organization, time management, effective oral and written communication, personal and professional goal-setting, information management, stress management, adaptation to change, and preparation for leadership.

Clearly, these tenets extend to and inform the practice of dentistry. And they may be of particular relevance for female practitioners who do not yet have an established network of seasoned role models as resources for information and advice.

Mentoring during the early stages of a career has been associated with high career satisfaction and may guide development of professional expertise.[7] Mentoring may also play an important role in bringing women into the fold of organized dentistry. It may be more comfortable for a relatively new member—male or female—of the MDS to attend his or her first district dental society meeting with someone who has gone to the meeting before, who invites the new member to sit with him or her, and who actively introduces the newer member to other attendees. Similarly, encouraging or sponsoring a newer member, or even a not-so-new member who has not been actively involved in the Society, to volunteer for committee activities within the district and to assist with the Yankee Dental Congress, for example, can provide important opportunities for the newer member to feel that he or she is contributing and is valued within the Society, as well as provide avenues to meet other MDS members and feel part of the established group.

The Report of the American Dental Education Association President's Commission on Mentoring compares a sponsor and a mentor in the following manner:[8]

- **Sponsor.** The sponsor serves as the advocate and champion for an individual's career advancement, nominating the individual for positions, committees, and projects that will help increase his or her professional exposure and develop the individual's career. The sponsor relationship is strictly professionally focused and limited to this function.
- **Mentor**. A voluntary and reciprocal interpersonal relationship in which an individual with acknowledged expertise shares his or her experience and learning with another (less-experienced) person. Mentoring relationships are typically long-term and are based on trust and mutual respect. The mentoring relationship goes beyond the role of professional advisor to focus on both the personal and professional growth of the individual. Mentoring may include aspects of advising, coaching, role modeling, and sponsoring.

Table 1. Benefits of the Mentoring Process

FOR THE MENTEE

- Supports professional growth and career development
- Supports personal growth and development
- Provides encouragement, direction, and promotion
- Increases job satisfaction and retention rates
- Supports socialization into the profession through networking
- Provides an opportunity to clarify goals, values, and choices—both personally and professionally
- Provides an opportunity to obtain new skills and strengthen existing skills
- Provides an opportunity to learn from the insights and expertise of a more experienced guide
- Provides a sounding board and a safe environment in which to test new ideas and discuss both personal and professional challenges

FOR THE MENTOR

- Increases personal satisfaction
- Provides opportunity for intellectual engagement and stimulation
- Provides an opportunity to stay abreast of new knowledge and techniques
- Provides an opportunity to "give back" by sharing expertise and knowledge
- Provides an opportunity to "create a legacy" by helping to prepare the next generation

Source: Adapted from *Report of the American Dental Education Association President's Commission on Mentoring*

Table 2. Desired Characteristics of Effective Mentors

INTERPERSONAL	PROFESSIONAL
• Professionally nurturing	• Knowledgeable
• Professionally focused	• Creative
• Interested	• Motivated
• Fair	• Honest
• Available	• Organized
• Flexible	• Decisive
• Generous	• Hardworking
• Friendly	• Attentive
• Communicative	• Responsive
• Supportive	
• Considerate	

Source: *Journal of Dental Education*

Engaging in the mentoring process provides benefits for both the mentor and the mentee (see Table 1).

Characteristics of an Effective Mentor

As our profession becomes more diverse in terms of race, ethnicity, and gender, the question of whether it is important and/or necessary to match a mentor with a mentee as to certain characteristics may arise. Research has shown that same race—or gender, it could be said—matching "may expedite the development of trust, but it does not guarantee a successful mentoring match." Why? Because "the qualities of a mentor, rather than race"—or perhaps gender—"are what matter the most."[9] Romberg identified a number of interpersonal and professional characteristics of effective mentors that distinguish between effective and ineffective advisors[10] (see Table 2).

Because entering private practice is generally the first opportunity to integrate the art and science of dentistry into the practice of the profession, a mentor can have exceptional influence on the success of a new graduate or a new solo practitioner transitioning from an associate position to an owner of his/her own practice, including influencing the practitioner's motivation, attitude, and integrity.[11] It may be helpful for the mentor and mentee to have a discussion regarding expectations of respective roles, responsibilities, and even timelines to avoid potential pitfalls in the relationship.

The Power of One

Mentoring is an opportunity for experienced practitioners to exercise the "power of one." One person can make a lasting and significant difference in the life of someone newer to the profession, not only in the practice of dentistry, but also in the "practice of the profession" through participation in organized dentistry.

Helping a colleague become active in the constituent and component societies will strengthen professional relationships. Having more practitioners become members of organized dentistry and having more members become active will increase our effectiveness in advocacy on the state and national levels and will increase our power in volunteer activities such as Special Olympics/Special Smiles and staffing of the MDS Mobile Access to Care (MAC) Van.

Knowing that one person can contribute to the growth and development of a colleague through mentoring can provide great personal satisfaction. Being a mentor can create a win-win-win situation: for the mentor, the mentee, and the profession as a whole. ■

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Health and Wellness for Women in the Profession

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"I felt overwhelmed and alone . . . feeling depressed and . . . where was I to turn? I was a smart, hardworking, loving mother of two wonderful children looking forward to advancing in a bright productive future in dentistry. My intelligence, education, and training and my position in the community did not make me immune to the reality that I was addicted to opiates and I could not stop using. What I feared most was being judged by my peers, being rejected by my patients, and being punished by the dental board." —Anonymous

Abstract

Regardless of gender, dentists can and do experience illness and other problems that may disrupt or impair dental practice, including substance abuse involving alcohol and/or other drugs. As part of the ethical obligation to maintain public confidence through responsible and effective self-governance, the American Dental Association (ADA) and state dental components offer health and wellness resources to members through programs such as CDAD–Dentist Well-Being Committee. Though the percentage of women entering the dental profession has consistently increased, utilization of CDAD resources by female dentists remains low. In order for the profession to fully address the needs of its changing membership, dentists need to understand gender differences associated with risk for abuse of alcohol and other substances; related physical, emotional, and professional effects; and other aspects of professional health and wellness. As more information on substance abuse in female and male dentists emerges, CDAD is prepared to support, educate, and advocate for the health and wellness of all colleagues in the dental profession.

Dentists can and do experience illnesses and other problems—including alcohol and/or other substance abuse—that may disrupt or impair the ability to practice. In 1980, with the help of volunteer members, the Massachusetts Dental Society formed a standing committee to provide health and well-being assistance and support to MDS members.[1,2]

The CDAD–Dentist Well-Being Committee (see "CDAD" sidebar, at right) currently works with the dentist quoted above and more than 50 others, all of whom cope with substance use with or without coexisting mental health disorders and/or stress related to such issues as the burden of clinical practice, chronic pain management, long-term disability, and litigation. As noted in a 2002 *ADA News* article, "While the incidence of chemical dependency among health professionals seems to be no higher than the general population, the stakes are much higher."[3]

Gender Disparity in Seeking Help

Despite the increasing number of women in the dental profession, few female dentists have sought assistance from CDAD over the past 10 years. According to Linda Keating, manager of Dentist Health and Wellness at the American Dental Association, the majority of active statewide health and wellness programs such as CDAD report that only 10 to 25 percent of the dentists they assist are women.[4] The disproportionately low number of female members seeking assistance is a concern to the Society and CDAD. The purpose of this article is to explore the prevalence and characteristics of alcohol/substance abuse for dental professionals, and the risk factors and support systems for these practitioners, with a focus on the female dentist's health and well-being.

Most information about the behavioral health of health care professionals comes from research on physicians and nurses. Because information on substance abuse by female dentists is limited, research targeting female physicians may provide the dental profession with some basis for comparison. In studies of physicians with a primary diagnosis of substance use disorder, heritability and environment were shown to be significant risk factors. In one study, 17 percent of female physicians had alcoholic mothers, 36 percent had alcoholic fathers, and 8 percent had both alcoholic mothers and fathers.[5] A study on heritability of alcoholism in boys was duplicated in girls with results that corroborate these findings.[6]

Students and Abuse

Both male and female dental students enter dental school with a number of health and well-being risk factors. In a six-year survey conducted at a Midwest dental school in the mid-1990s, 35.8 percent of the students reported a positive family history for alcoholism (parent, grandparent, or sibling), 30.7 percent admitted binge drinking in the last month, 72 percent had been drinking since high school, and 24.2 percent got drunk monthly, weekly, or daily. The students reported past-month use of alcohol (73 percent), marijuana (12.4 percent), nitrous oxide (2.4 percent), opiates (2.1 percent), and stimulates (1.7 percent). Women made up 33.8 percent of the respondents, though the results were not broken down by gender.[7]

In 2005, Kenna and Wood reported: "There is little evidence that dentists are at greater risk of developing alcohol or other drug-use problems than the general public."[8] Current literature supports this parallel among physicians, with estimates of prevalence of drug and alcohol abuse (7 and 14 percent, respectively) to be no higher than in the general population.[9] In a self-report survey of 9,600 physicians, Hughes and colleagues concluded that "a higher prevalence of alcohol use among physician respondents was more an artifact of socioeconomic class than of profession." However, the researchers noted "a high rate of reported self treatment with controlled substances."[10]

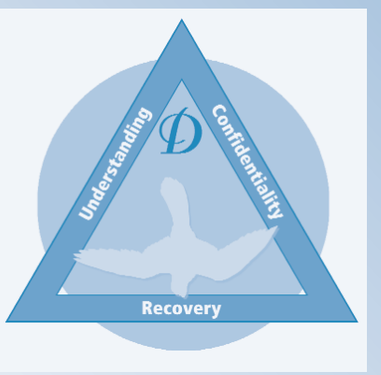
Of the psychoactive drugs used by dentists, alcohol is the most common as well as the one about which there exists the most recent research data and treatment outcome information for women.[11] At-risk drinking for women is defined as having more than seven drinks per week or more than three drinks on any one occasion (see "NIAAA Guidelines" sidebar).

A woman will become more intoxicated than a man of equal size drinking the same quantity of alcohol. Because alcohol is water soluble, initial blood alcohol level is higher on intake due to increased fatty tissue in females. Alcohol is also metabolized differently because women produce lower levels of alcohol dehydrogenase, resulting in a higher percentage of alcohol entering the bloodstream from the stomach. Alcohol abuse is defined as repetitive, long-term use that causes impaired psychosocial functioning and health. Dependence is characterized by loss of control of alcohol intake, with evidence of tolerance (requiring an increasing volume to achieve the desired effect) or addiction (evidence of withdrawal when the use of the substance decreases or ceases).[12]

Women who use sedatives, antianxiety drugs, or hypnotics are nearly twice as likely as men to become addicted to these substances.[13] Women of all ages become addicted to prescription and illicit drugs more quickly than men and suffer more severe physical, psychological, and social consequences.[14] In addition to various medical problems, women substance abusers are at increased risk for psychological problems: comorbid psychiatric disorders, such as depression, anxiety, bipolar affective disorder, phobias, psychosexual disorders, eating disorders, or post-traumatic stress disorder.[15]

Risk Factors for Substance Abuse

For the health care professional, the temptation to self-medicate is a major risk for personal health and professional status. The misuse, illicit use, or criminal behavior involving controlled substances can result in serious legal problems with state and federal officials. As mental and physical impairment of the clinician progresses, the risk of harm to the patient increases, along with the threat to the profession and the public at large.



CDAD

How CDAD Can Help You

Like many other health care professionals, dentists are subject to extreme job stress, have access to controlled substances, and are often faced with the temptation to self-medicate. Additionally, dentists often work in isolation, creating an environment in which an addiction can flourish.

As defined in the Massachusetts Dental Society bylaws, the CDAD–Dentist Well-Being Committee was created "to develop informational and educational programs to aid and assist the dental membership who voluntarily seek out its services for a better understanding and improved quality of lifestyle at a confidential and peer level; and to provide assistance, education and information on issues related to dentists' well-being and substance abuse."

CDAD operates quietly, under the strictest rules of confidentiality, protecting members' anonymity at all times. The committee motivates dentists to seek treatment voluntarily and assumes an advocacy role on their behalf, helping them to retain their practices and self-esteem.

Call **(800) 468-2004** for more information about CDAD or to discuss a problem that you, a colleague, or a family member may be experiencing. All calls are kept completely confidential.

No formula exists for accurately identifying who will engage in substance use or if that behavior will lead to dependence or addiction, regardless of the age or circumstances of the individual. Protective factors and risks for substance use constitute a multifactorial pathway influenced by an individual's personality, family history, peers, community, and culture. Joseph A. Califano Jr., chair and president of the National Center on Addiction and Substance Abuse at Columbia University, states, "Addiction is an equal-opportunity disease. It does not discriminate on the basis of race, educational achievement, economic status, ethnicity, or geography."

Professional training and licensure in the health care professions does not confer immunity from the realities and anxieties of a busy life and professional practice—in fact, quite the opposite. The stress associated with dental education segues directly into professional practice. In the American Dental Association's 2003 Dentist Well-Being Survey, 13 percent of respondents reported feeling "very stressed." A sense of control in the work environment was strongly related to work satisfaction, and vice versa.[16]

Potential risk factors for substance abuse by dentists with or without coexisting mental health disorders include:

- Positive history of familial alcoholism
- Access to controlled substances, including nitrous oxide
- Opportunity to self-medicate
- Potential for excessive workplace stress
- Isolated working environment
- Pressure of family/work integration

The Female Dentist: Special Considerations for Health and Wellness

The "dual-role" responsibilities of women in all professions present unique challenges. Balancing a professional career with family life can juxtapose ongoing financial and other pressures of dental practice against the roles of wife, mother, and daughter. In addition to the desire and need to build, grow, and maintain a rewarding career in dentistry, a female dental professional is likely to face concurrent "homeside" challenges associated with bearing and rearing children, partnering for a healthy relationship, coping with divorce and its consequent financial pressure, caring for aging parents, and facing family illness or parental death.[17] Along with the risk factors listed in the previous section, female dental professionals face additional gender-related societal and familial expectations that may predispose them to substance abuse.

Because of social pressures and the desire to maintain a professional image, dentists are reluctant to seek help, regardless of gender. According to the American Dental Association's 2003 Dentist Well-Being Survey, 37.6 to 44.8 percent of dentists surveyed agreed or strongly agreed that they would have difficulty seeking professional help—i.e., counseling or psychotherapy—because they believe they should be able to solve their own problems[16]—a belief echoed by nearly all the female dentists the authors have personally interviewed. When women do seek treatment, they tend to ascribe their problems primarily to depression, anxiety, or family stress, and are more likely to seek help from primary care practitioners and mental health counselors. When the "doctor-patient" sees her health care provider, she may be hesitant to discuss drinking and drug use patterns even if she suspects a problem exists.[18]

Another barrier to treatment is the enduring stigma attached to substance use and mental health disorders. Reminiscent of the traditional double standard, men are still more likely to be regarded with humor and compassion—"the poor guy can't help but . . . "—whereas an alcoholic woman is considered "disgusting."[19] This prejudice toward mental health and substance use disorders remains a roadblock to countless people who would benefit from early diagnosis and treatment.[20] Though medicine and counseling practices are evolving to better differentiate signs and symptoms and apply appropriate treatment, health care providers as patients—and women in particular—are often misdiagnosed, leading to treatment that may contribute further to a substance abuse problem.[21]

Finally, a common problem for the female dentist is the supposed or actual lack of support within the dental community. Women in the profession are less likely to have established practices of their own to return to, are more likely to be unemployed, are less likely to have adequate health insurance, and are more likely to have parental responsibilities. The 38-year-old dentist quoted at the beginning of the article articulately summarizes her perceived alienation when she states, "What I feared most was being judged by my peers, being rejected by my patients, and being punished by the dental board."

Accessing Help

The Well-Being and Assistance Program of the ADA is available to help dental professionals "at the first sign of problems, with the goal of assisting the dentist toward optimum help" in continuing in current practice or returning to practice.[22] The national program provides personal assistance and extensive resources regarding treatment facilities,

NIAAA Guidelines for Maximum Drinking Limits

It may be difficult for you to determine if you have developed a drinking problem. How do you know if the amount of alcohol you are drinking is potentially problematic? The National Institute on Alcoholism and Alcohol Abuse (NIAAA) has determined maximum drinking limits, listed here. If your alcohol intake exceeds these limits either daily or weekly, you should contact CDAD at **(800) 468-2004**.

For healthy **men up to age 65—**

- No more than **4 drinks** in a **day**

AND

- No more than **14 drinks** in a **week**

For healthy **women** (and healthy **men over age 65**)**—**

- No more than **3 drinks** in a **day**

AND

- No more than **7 drinks** in a **week**

Source: National Institute on Alcoholism and Alcohol Abuse. Helping Patients Who Drink Too Much: A Clinician's Guide. NIH Pub. No, 05-3769. Rockville, MD: 2005.

ongoing evaluation, and state well-being committee contacts, such as CDAD.

For any dentist who suspects that she or he may have a substance abuse disorder, contacting the ADA (***www.ada.org/prof/resources/topics/wellbeing.asp***) and CDAD (***www.cdad.org***) is an important first step toward accessing confidential help and resources, including information about treatment options.

Therapeutic program selection for treatment is especially important for professionals. Most health care professionals have a difficult time being seen as patients and are likely to take on the role of co-therapists, especially in groups. Local and nationally recognized treatment centers offer residential treatment programs that help dentists and other professionals prepare for reentry into practice, establish contact with professional support groups, and aid in documentation of treatment and compliance records. These programs provide intensive multidisciplinary assessment and treatment plans tailored to help the dentist best address her or his individual issues and prepare a structured aftercare plan. Some women may feel more comfortable attending facilities exclusively for women or those programs that have resources to help women address specific gender-related problems.

Treatment Works

Professionals who seek assistance, receive appropriate diagnosis, and complete treatment thrive both personally and professionally. This is the area where professional peers, in recovery themselves, prove to be of great assistance in helping colleagues who have struggled with similar problems.

Peer assistance programs like the Massachusetts Dental Society CDAD–Dentist Well-Being Committee provide a confidential gateway into therapy with peer support and acceptance. Weekly participation at statewide peer-facilitated professional support group meetings composed of dentists, physicians, hygienists, and nurses provide important collegial support and networking. Professional treatment, along with ongoing empathic supportive aftercare, works to restore health to the dentist and her family, and maintain the integrity of the dentist's practice and the profession.

CAGE Screening Test for Alcohol Dependence

The CAGE screening test—CAGE is an acronym for "cut down, annoyed, guilty, eye-opener"—is used to screen for alcohol use problems in adults. However, it cannot be used to diagnose the disease; it only suggests that the disease may be present. Other tests are needed to diagnose alcohol dependence.

Screening Test Questions:

- Have you ever felt you ought to Cut down on your drinking or drug use?
- Do you get Annoyed at criticism of your drinking or drug use?
- Do you ever feel Guilty about your drinking or drug use?
- Do you ever take an early-morning drink (Eye-opener) or use drugs first thing in the morning to get the day started or to eliminate the "shakes"?

Answering "yes," "sometimes," or "often" to two or more of these questions may indicate a need for more in-depth assessment.

Sources: JAMA 1984;252:1905-7 and Am J Med 1987;82:231-5.

Conclusion

In addressing dental professional health and well-being, gender does impose some different biological, psychological, and societal conditions and challenges with accompanying potential obstacles. By expanding the membership of the CDAD–Dentist Well-Being Committee to include female colleagues, the committee is prepared to better address the needs of all MDS members in substance abuse prevention education, early intervention, timely assistance, referral, and advocacy. ■

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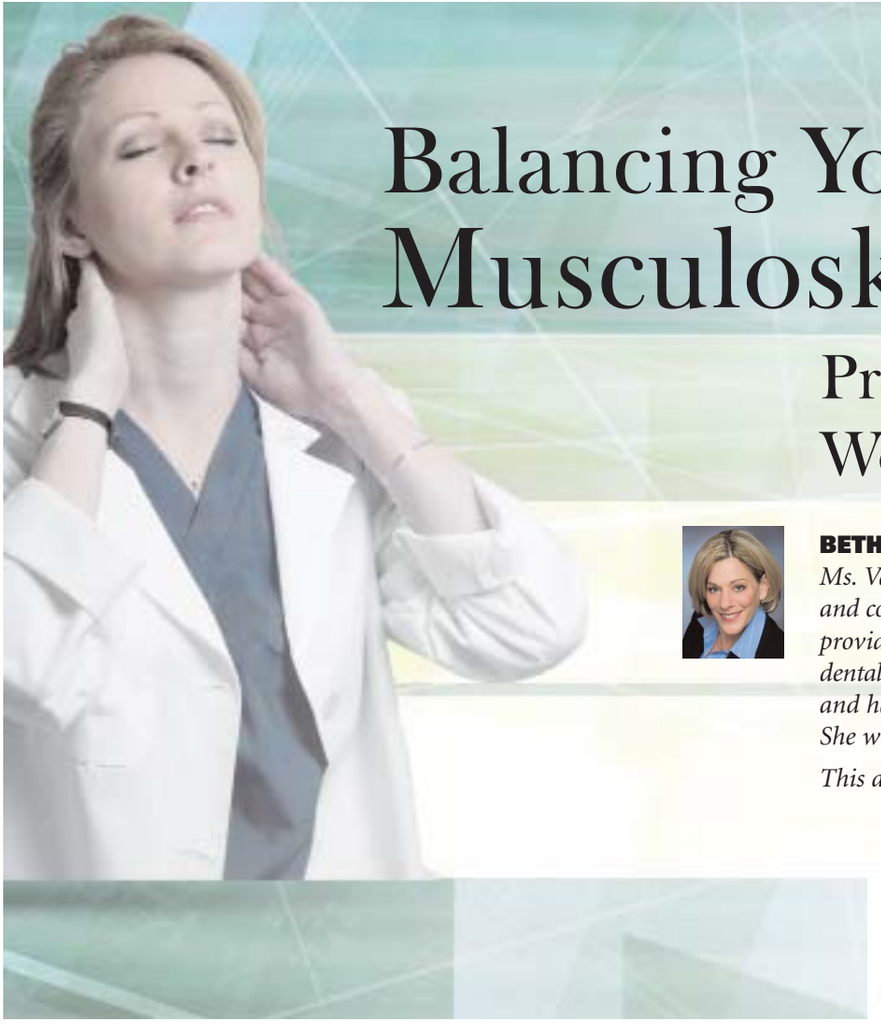

Balancing Your Musculoskeletal Health:

Preventing and Managing Work-Related Neck Pain

BETHANY VALACHI, MS, PT, CEAS

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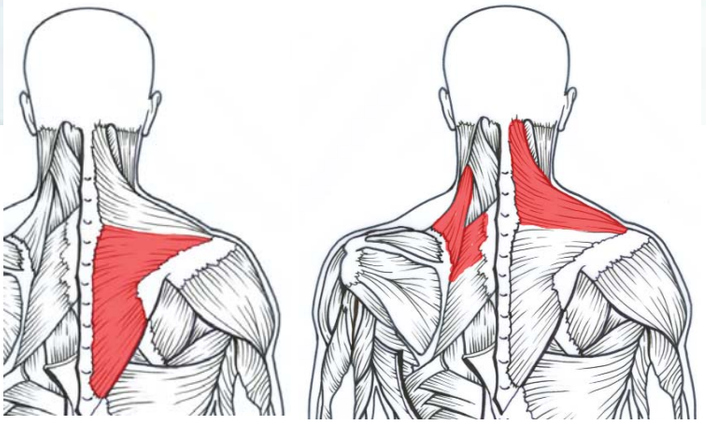
Whoever coined the phrase "My job is a pain in the neck" could have been a female dentist. For in few careers can this phrase be interpreted more literally than among women in dentistry.

Compared to the average female worker, female dental professionals experience two to four times more musculoskeletal pain.[1] Studies reveal that female dentists in particular tend to be more prone to neck and shoulder pain than their male counterparts.[2-4] Female dentists face a unique set of musculoskeletal challenges when delivering dental care that can result in muscle imbalances, ischemia, nerve compression, and joint or disc degeneration.

Dentists tend to hold one posture for a longer period of time than hygienists, meaning that dentists must have excellent endurance of the stabilizing muscles of the neck and shoulder in order to have optimal hand and arm function and to avoid musculoskeletal dysfunction. On the average, women's muscles can exert only two-thirds the force men's can.[5] What this means for female dentists is that when the head moves forward, out of neutral position, there is generally less muscle to stabilize the neck.

Maintaining optimal neck and shoulder musculoskeletal health for female dentists means understanding the unique muscle imbalances to which they are prone and how various working postures, positions, exercise, and adjustment of ergonomic equipment can positively or negatively affect the involved muscles.



Figures 1a and 1b. For dentists, the middle and lower trapezius muscles, left, can become fatigued. When that happens, other back and shoulder muscles such as the upper trapezius, levator scapula, and upper rhomboids, right, have to compensate and can become overworked.

Muscle Imbalances

The delivery of dentistry requires substantial endurance of the shoulder girdle–stabilizing muscles, especially the middle and lower trapezius muscles (see Figure 1a). These shoulder-stabilizing muscles tend to fatigue quickly with forward head, rounded upper back, and elevated arm postures commonly seen among female dentists. When these muscles fatigue, other muscles (upper trapezius, levator scapula, and upper rhomboids) must compensate and can become overworked, tight, and ischemic[6] (see Figure 1b).

This muscle imbalance may result in a "tension neck syndrome" and is one of the most frequently diagnosed musculoskeletal disorders (MSDs) among female dentists.[7] Symptoms include pain, tenderness, and stiffness in the neck and shoulder

musculature, often with muscle spasms. A typical symptom among female dentists is pain that may radiate between the shoulder blades or up into the occiput. Headache is also a common symptom. Two contributing factors to tension neck syndrome in dentistry are forward head and elevated arm postures.

Forward Head Posture

Optimal posture of the head is ears-over-shoulders when viewed from the side. Unfortunately, dentists do not achieve this neutral position while working in the operatory unless they are using a microscope. Even with telescopes, the best head posture that dentists can attain is about 25 degrees of forward head tilt.[8] However, when compared with postures of their colleagues who do not wear scopes (40–60 degrees of forward head tilt), the ergonomic advantage of scopes becomes clear.

Women dentists' first line of defense against neck and shoulder pain is to learn how to attain optimal head posture and shift the muscle workload throughout the workday. Next, dentists should address muscle imbalances to which they are prone by stretching specific tight muscles, strengthening shoulder-stabilizing muscles, and avoiding exercises that stress the already-overworked muscles. Properly adjusted scopes can reduce muscle strain in the neck and upper back by promoting proper neck and shoulder posture.[9] Two of the most critical factors to consider when purchasing scopes are working distance and declination angle. The working distance is the distance from the operator's eye to the working area. Measure the working distance in your own operatory, if possible, with arms relaxed at your sides and forearms approximately parallel to the floor.

From an ergonomic and musculoskeletal standpoint, the declination angle of the scopes is your most important consideration. The declination angle is the steepness of the downward viewing angle the scopes allow. A good declination angle will allow you to work with a more upright, neutral neck posture, about 25–30 degrees of neck flexion, or head tilt (see Figure 2). Even then, however, working in postures of greater than 20 degrees of neck flexion has been associated with increased neck pain.[10] This means that dentists must not only address the ergonomic magnification component, but the muscular component as well, by strengthening the shoulder girdle–stabilizing muscles.

Correct Height

Possibly one of the biggest contributing factors to neck and shoulder pain among female dentists is positioning the patient too high. This causes elevation of the shoulders and abduction of the arms, leading to prolonged, static muscular tension in the neck and shoulders. Magnification enables operators to position patients lower, thus maintaining a greater working distance from them and keeping shoulders relaxed and forearms approximately parallel to the floor.

To maintain optimal head posture, however, you must be able to get close to the patient. A common problem among shorter female dentists is the inability to get their legs under the patient chair without lifting the arms away from the sides. A tilting seat may enable closer positioning to the patient by opening the hip angle. Then you can position the patient slightly lower to decrease "chicken-winging." Additionally, tilting the seat pan 10–15 degrees forward has been shown to help maintain the practitioner's low back curve and reduce low back disc pressures, which can help reduce low back pain.[11,12]

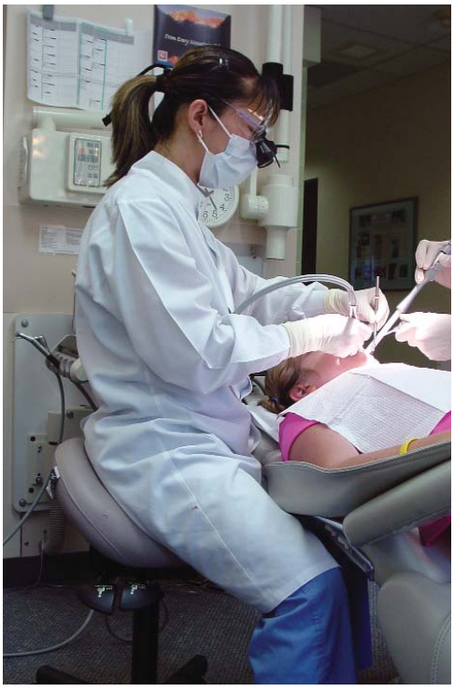


Figure 2. A good declination angle enables a more upright, neutral neck posture, about 25–30 degrees of neck flexion, or head tilt.

A saddle-style stool will allow the closest positioning to the patient by placing the operator in a position partway between standing and sitting. This opens the hip angle up to about 140 degrees, helps promote the spine's natural curves, and shifts the workload to different muscles than those used with traditional seating. For this reason, it may be desirable to have one of each type of stool in the operatories to alternate working postures and prevent overworking the same muscles. Ask if you can have a trial period for operator stools prior to purchasing them.

Some female dentists may have modesty issues, and thus prefer a comfortable distance between their chest and the patient's head. This will cause them to either lean forward, which will increase forward head posture, or sustain a forward reach with the arms, causing neck strain. Opening the hip angle and using magnification will enable lower positioning of the patient and help address this common problem.

Armrests Improve Stability

Among dentists who are already experiencing neck pain, the weight of the arms hanging unsupported at the sides may often perpetuate that pain.[13] Armrests can reduce such strain by providing an operating fulcrum at the elbow, which also improves instrument stability. Dentists who suffer from neck pain and who have short arms should consider using support under the elbows at home as well as in the operatory, including when driving, sitting on a couch, or working at the computer.

The weight of large breasts can cause bra straps to dig into the upper trapezius muscle, exacerbating the muscle imbalance, and can cause headaches. A sports-type bra with wide straps that connect in the middle of the upper back can translate this weight to a wide support band under the breasts and may help reduce pain when worn during work.

Out of the operatory, a large shoulder bag may also compress the upper trapezius in a similar manner. A backpack-style purse, which distributes the weight more evenly, should be considered by female dentists. Additionally, the upper trapezius muscle is susceptible to the effects of emotion, and during times of emotional stress may be held elevated and tense.

Female dentists should learn to sense this tension and release it throughout the day. One method is with frequent shoulder rolls, each time returning the shoulders to a relaxed, neutral position.

Strengthening

All exercise is not necessarily good exercise for female dentists. Due to their susceptibility to the muscle imbalance described earlier, most women dentists should focus on specific strengthening of the shoulder-stabilizing muscles and steer away from exercises that strengthen the upper trapezius, levator, and upper rhomboids, muscles that are already prone to tightness, ischemia, and pain.

The middle and lower trapezius muscles may be strengthened by utilizing an elastic exercise band and pulling diagonally downward, squeezing the shoulder blades downward and together (see Figure 3). Always use a very light resistance when strengthening postural stabilizing muscles and seek professional guidance from a health care professional to ensure good technique.

Using an exercise band in the reverse manner of Figure 3 (i.e., pulling diagonally upward toward the body) may overstrengthen the upper trapezius, worsening the muscle imbalance. Instead, focus on aerobic health of the upper trapezius and choose aerobic activities that swing the arms, like walking, cross-country skiing, or working out on an elliptical machine.

Additional target areas to strengthen include the shoulder external rotators, transverse and oblique abdominals, multifidus, and deep postural neck muscles. Strengthening exercises should only be performed when there is no musculoskeletal pain and full range of motion is present. Tightness, ischemia, and trigger points in the upper back and neck muscles should also be addressed daily with specific chairside stretching and trigger point self-therapy.[14]

Figure 3. Proper use of an elastic exercise band can help strengthen the middle and lower trapezius muscles.

Conclusion

The possible etiologies of neck and shoulder pain among female dentists are numerous, including neurological, spinal disc, joint, ligamentous, and other pain mechanisms. Most frequently, however, neck and shoulder problems originate from postural problems that lead to muscle imbalances. If these imbalances are not addressed, they can eventually compress nerves and discs and cause joint dysfunction.

Education of this type in dental schools may help dentists develop healthy postural habits, make wise ergonomic decisions, and maintain balanced musculoskeletal health before they sustain a permanent musculoskeletal injury. Addressing and preventing muscular pain early on can make the difference between a satisfying, lengthy career in dentistry, or painful early retirement. ■

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Techniques, Tools, and Tricks—

A Leadership Retreat for Women Dentists

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Editor's Note: This article is adapted from the outline of a seminar Dr. Scheele presented to women members of the Massachusetts Dental Society at a seminar sponsored by the MDS Women's Leadership Task Force on April 7, 2006, in Natick, Massachusetts.

Developing greater expertise is the conscious and ultimate goal for most dentists and other health professionals, both male and female, whether in public organizations or in private practice. While technical, or clinical, expertise is essential and always in demand, it is only half of the twin skill set that is required to become a leader within a profession. In order to become a truly successful leader in your profession, you must fully exhibit both technical and interpersonal skills.

As a practicing dentist, there are many avenues available to you to sharpen your clinical skills and learn new techniques and technology; however, there is little opportunity to learn and practice the other, more external skills of self-presentation, connecting, and positioning. These interpersonal, or social, skills embrace many areas of expertise: learning how to discover opportunities; becoming a protégé to respected professionals; risking the development of a network of colleagues for support and as an avenue by which to contribute your talent; acting as a mentor to others; helping shape your profession; and, of course, receiving deserved recognition. This entire set of developmental skills requires you to acknowledge their power and then dedicate yourself to a lifetime of practice.

Yet the challenge for learning these nontechnical skills multiplies for professional women, whose acculturation renders them nearly invisible despite their often-real talent and ambition. This completely and directly contradicts the way that many women are raised to not brag, to not toot our proverbial horn. Women are taught to be modest to such an extent that we are left without any voice. This process can be changed, however, by retraining women to proudly tell about the good work they do, ask for recognition and compliment others' work, and thereby begin to participate in the long process of developing their leadership skills.

Developing Self-Presentation

Studies reveal that we size each other up in less than 30 seconds. In the blink of an eye, we immediately determine the status and ability of another professional based only on what we perceive. This is certainly not fair, but still, first impressions are hard to undo. Therefore, how we present ourselves serves as an essential signal to others about our own worth. That is why I opened a recent retreat seminar for the Massachusetts Dental Society's Women's

No one achieves anything solo, no matter how excellent one's independent work is. We all need support for our own work . . . that requires risk to make vital connections to people, groups, and ideas.

Leadership Task Force with an experiment to do just that—change the impact of that first impression. It was an experiment about the essential but oftentimes overlooked behavior of delivering appropriate self-introductions. Each attendee was asked to take one minute to come to the stage, take the microphone, and state her name, title, and area of responsibility as clearly and vividly as she could.

Deceptively simple, yet few could introduce themselves very effectively, despite their talent and professional accomplishments. I coached each participant to become more courageous in front of her peers so that they would understand her name and, more importantly, remember it, which is not easy, particularly if one's name is uncommon. Too many of the participants resorted to turning the statement of their name into a question, their soft, higher-than-normal-pitched voices rising at the end, as if they themselves weren't sure of who they were.

Their colleagues interpreted what sounded tentative and questioning as weak or childlike. Each speaker reported being unaware of the faint power of her own voice, until she practiced, retraining herself to sound so much more self-confident, as if she wanted to be known in the same voice she would utter the name of those she admires. But after the speakers were willing to be coached a few times to be more vivid, more powerful, and stronger in their own introductions, the audience responded back so positively. Self-presentation coaching lasted for a few rather intense hours during the morning as we practiced claiming ourselves with voice and description work to match our identities—our names, titles, and a sentence about our work, accomplishments, or goals.

Stage Fright

This exercise tapped into one of our most profound fears: speaking in public. Like stage fright, it doesn't make rational sense; we are in no mortal danger, yet we feel paralyzed by the emotional anxiety of being judged. The women participants at this seminar admitted to sweating, shaking, or feeling cotton-mouthed. But we are not alone. What we don't know is that, before taking the stage, opera singers gently bite the tips of their tongues to cause enough saliva to well up in their mouths in order to begin singing. Most public speakers talk out loud backstage to find their voice before they appear and then have the requisite glass of water beside the podium. Many actors confess to vomiting before their entrance onstage, even though they have already memorized their lines and rehearsed their parts. While you as a dentist are not a public performer, you need to be able to be present and known in your profession, and so you need to practice these skills of self-presentation.

Appearing before others, especially one's peers and superiors, and introducing oneself only looks easy for successful professionals, but the art of appropriate self-presentation requires constant practice to reach that feeling of ease. Listen to your leaders, who have developed these skills, and recognize both what they say and how they say it. The dual process of speaking and listening to other attendees in a safe environment helped the Women's Leadership Task Force seminar group bond as colleagues in realizing how much they needed such coaching for their professional lives, as well as learning more about each other.

No Woman Is an Island

No one achieves anything solo, no matter how excellent one's own independent work is. Such independence is one of life's great myths. We all need support for our own work, including access to new ideas and to other professionals at our own or higher levels. That requires risk—overcoming the fear of saving face if we are wrong or feel like a fraud—to make vital connections to people, groups, and ideas. We need to connect with others without even knowing what the end goal might be.

A professional association, such as organized dentistry, is a splendid example of a safe environment within which to practice meeting colleagues, brainstorming ideas, and exchanging information about new techniques and opportunities. Your state or local dental society can be a network or support group, but it requires mutuality; it requires you to support your colleagues in good times in order to receive support in bad times. Way beyond just showing up at meetings and exchanging cards, this skill requires commitment through active voluntary participation that is one sure way of getting to know and trust others.

Serving on a council or committee is an ideal way to forge these connections. Look at your Society's committees and choose one based on your own interests and abilities. If you are new in your practice or area, you might choose the membership council or committee in order to meet members. If you have an interest in public relations, offer yourself to the communications council. Join the committee and fulfill your obligations to it. Don't wait to be asked. Find yourself an experienced colleague within that committee to act as your mentor and develop a relationship.

Eventually, after you have gained more experience on that committee and have learned more, ask to chair that committee. You'll learn many of the leadership skills that were invisible beforehand: motivating members to act, settling conflicts, envisioning new plans, encouraging your committee members, and, of course, doing more public speaking than you may have experienced before. Serve the chair well and ask questions about the process of making the best choices. Then, to continue challenging yourself, consider switching to another committee and learning as much as you can about its role within the Dental Society.

You may also want to consider getting involved in your local district as an officer. Take a look at your abilities and interests, and run for the office that best suits you, matching your skills to the office of treasurer, secretary, editor, or perhaps, eventually, district chair or MDS president. Get support from past officers on how to campaign, to get votes, and to serve your district in the best way possible. It may be that your own talents and abilities fall more in the number-two role, tracking progress

and supporting the president, or it may be the number-one role itself. Either way, be true to yourself.

Getting Involved

All professional associations need a variety of roles to be in play in order to run. And not only professional roles, but also social events, which create strong bonds as well. Golf, the prime choice for dentists with great hand-eye coordination, has functioned as an enormous support group. Women dentists might consider taking golfing lessons as a means of joining in another network of fellow dentists to become more visible and make more connections.

But some cautions to these social events: Don't act like a "guest," waiting at a dinner table, a lecture hall, or a golf green for others to offer you a hand, a drink, or an introduction. You'll wait forever and find yourself moving to the sidelines or sitting by yourself until someone rescues you. Instead, have the courage to be proactive and put yourself on the line. Exhibit gracious behavior, start conversations, ask questions about the people you are conversing with, making sure to introduce yourself. Be enthusiastic; don't be negative. Meaningful participation takes time, but it is the greatest investment for your future success.

Even if you are not ready to admit it, you are ambitious. You have chosen a prestigious profession without any limits. No matter where you are in it today, you could make the next year far more fulfilling if you were to reflect on your own goals, allow yourself to be inspired by those professionals you admire, and recognize that opportunities are right under your nose since change is always inevitable. Whether you find a mentor to guide your progress or you forge connections with other like-minded professionals whose mission is to encourage each member's career, you will be amazed at the difference in your life that focus and direction can make.

Consider what you might want and need: how to improve your office, train and encourage your staff, grow your practice, hire more dentists, form a partnership, write a journal article about your research, be recognized and promoted. To find answers and encouragement and to access that which you might not have had, form what is called a "Strategy Group." Find up to five colleagues—savvy and intelligent professionals—to meet once a month. If you can, plan to meet 90 minutes before your monthly district meeting or on some other kind of regular basis, such as the first Monday of the month, in a conference room where you won't be disturbed.

But this Strategy Group isn't about socializing; it's about learning about yourself and problem solving. For the group to be successful, you should follow some rules:

1. Pledge confidentiality.
2. Commit to meeting for at least six months. Do not skip a meeting because you did not do your homework. Your group needs your attention and will also inspire you.
3. Divide the time equally among all members.
4. Each person divides her turn in half, first describing her dilemma or her goal with the obstacles she sees and then turning her issue over to her group, who acts as her brain trust and mentors, thinking carefully and positively about what she needs, how she might proceed, who she might contact, what else she might try. That advice becomes her homework to start during the next month.
5. At the end of the meeting, each member, round robin, compliments the member sitting on her right. We need validation from each other, for the course of changing is difficult yet worthwhile.
6. Calls might be made during the month for more feedback and encouragement. Take care that it is not a casual conversation, but a mutually supportive act.
7. Each succeeding meeting opens with each member taking a turn and updating the group on her progress—or sometimes the lack thereof—and care is given to think through whether the goal is doable but needs time and experimentation. Some goals will be reached, others strived for with steps made toward it.

You are on the road to changing what you do, expanding your horizons, improving your social behavior, and developing leadership skills. In the process, you will launch your ambition. It takes courage—but it will make your life more purposeful and enjoyable. ■

A Clinico-Pathologic Correlation

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Dr. Lucca is a first-year resident in oral and maxillofacial surgery, Dr. Shastri is an attending maxillofacial surgeon, Dr. Kahn is chair of the department of oral and maxillofacial pathology, and Dr. Papageorge is a professor and the chair of oral and maxillofacial surgery at Tufts University School of Dental Medicine.

History

A 37-year-old male was referred to the oral and maxillofacial surgery department at Tufts University School of Dental Medicine with a firm swelling in the right preauricular region. The swelling was first noted over 10 years prior to his presentation, with no reported history of facial trauma. The patient complained of periodic discomfort in this area exacerbated by cold weather, but no functional limitations were present. His condition had been previously addressed overseas in both 1996 and in 2005 with computed tomography (CT) and a needle biopsy. Separate CT scans obtained in 1996 and 2005 revealed multiple opacifications in and around his right temporomandibular joint (TMJ), and in 1996 a preauricular biopsy was consistent with parotid gland tissue, a finding not uncommon with biopsy of some TMJ pathologies.[1] *The patient's past medical history was without significance; he reported taking no medications and had no known drug allergies. His social history was positive for light recreational use of alcohol and tobacco.*

Clinical examination revealed a palpable, nontender fullness in the right preauricular area. The patient exhibited an adequate 42 mm of jaw opening with slight deviation to the right. Good right and left lateral excursions were noted, a stable occlusion was exhibited, and there appeared to be no tenderness or spasm of the muscles of mastication. Neurological findings were within normal limits with no report of cranial nerve (CN) 7 deficit, hearing loss, or tinnitus on his affected side. Computed tomography revealed multiple radiopaque areas in the right TMJ (see Figure 1). A comparison review of the CTs obtained in 1996 evidenced a similar entity but to a lesser degree.

The treatment recommended was a right open joint surgical procedure with exploration of the right TMJ and biopsy of representative areas, performed under general anesthesia.

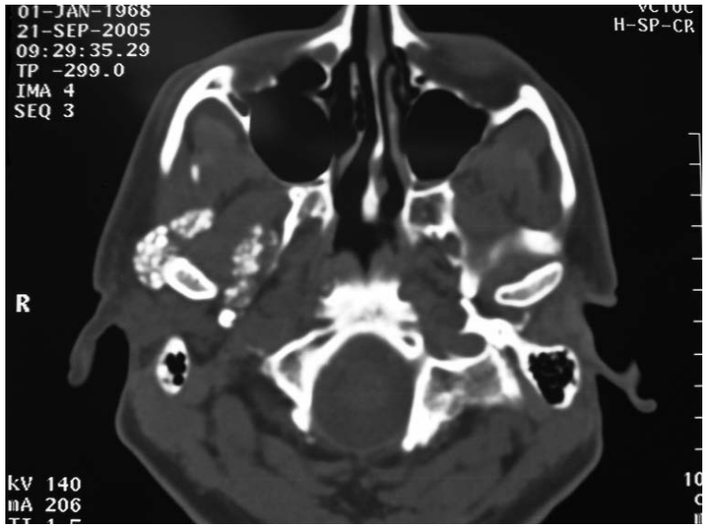

Figure 1. Axial computed tomography with radiopaque masses appreciated proximal to right temporomandibular joint medially and laterally.

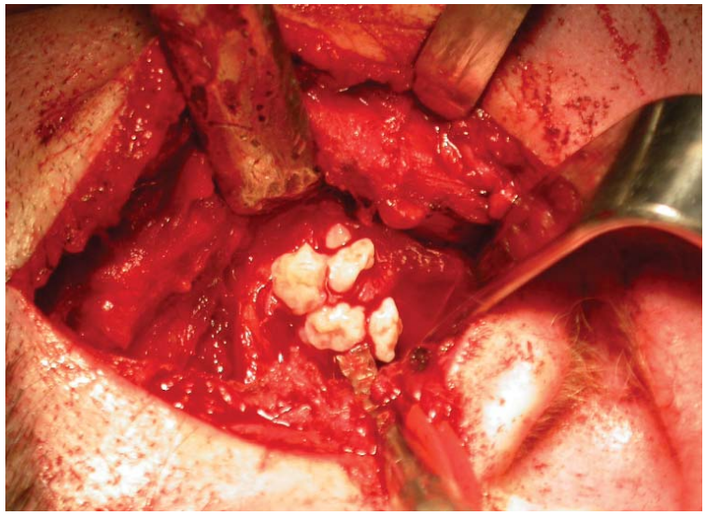

Figure 2. Intraoperative digital photograph of calcifications exposed through preauricular incision approach to temporomandibular joint.

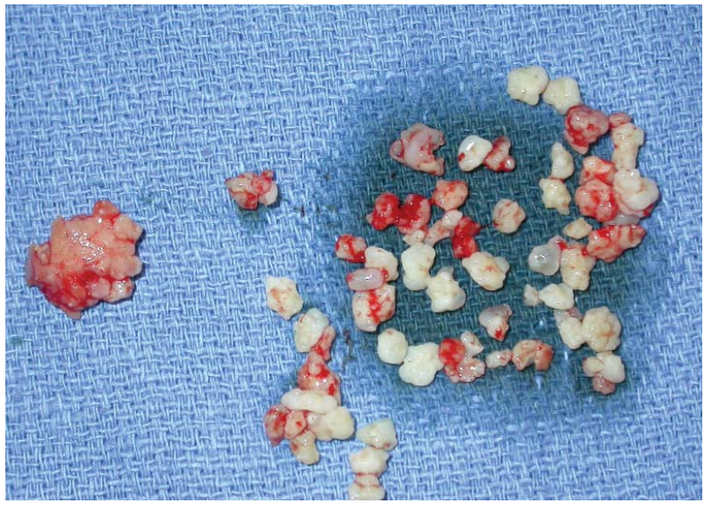

Figure 3. Retrieved calcified bodies of varied shapes and sizes.

Intraoperatively, free-floating calcified lesions were noted but limited to the superior joint space in anterior, lateral, posterior, and medial locations (see Figure 2). All accessible calcifications were removed (see Figure 3) along with the synovial lining of the joint. The meniscus appeared normal and was left in place. The inferior joint space was not violated. The patient tolerated the procedure well and had an uneventful postoperative course.

Differential Diagnosis

Synovial chondromatosis
Chondrocalcinosis (pseudogout)
Synovial chondrosarcoma
Degenerative joint disease

Histological Findings

Histological examination of specimens submitted from the right TMJ revealed fragments of metaplastic cartilage in apposition with mature lamellar vital bone. The cartilage exhibited chondrocytes located in groups and surrounded by an acellular matrix of hyaline cartilage with no free chondroid fragments (see Figure 4).

Diagnosis

Synovial chondromatosis

Discussion

Synovial chondromatosis (chondrometaplasia) is a benign progressive joint disorder of unknown origin. It is marked by the proliferation of cartilaginous nodules within the connective tissue of a joint's synovial membrane.[2] According to Koyama, the disorder was first described by Auhausen in 1933 and is exceedingly rare in the temporomandibular joint.[3] Ishii's 20-year review of the English literature documented only 51 cases of TMJ-affected chondromatosis.[4]

With regard to this disease's incidence, this patient is particular. Synovial chondromatosis of the TMJ is a disorder with an age and gender predilection that favors middle-aged females.[2] At a ratio of 4:1, this statistic specific to synovial chondromatosis of the TMJ deviates from disease incidence with other joints that carry a 2:1 male predilection.[2,5]

Synovial chondromatosis can be asymptomatic but can often present with preauricular swelling, facial asymmetry, pain, crepitus, and limited joint function.[2,5] Traditionally, there is no reported history of trauma or rheumatoid arthritis in cases of synovial chondromatosis.[3]

The progression of this disorder develops and is characterized in three histologically numbered stages. The first stage shows histological evidence of metaplasia in the synovial membrane with no distinguishable detached cartilaginous particles.[3] The second stage reveals a histological picture that includes metaplasia with freestanding or detached cartilaginous entities.[3] The third and late stage is evidenced by only free particles, and manifests clinically with particle size ranging from 1 mm to 10 mm in diameter.[2,3]

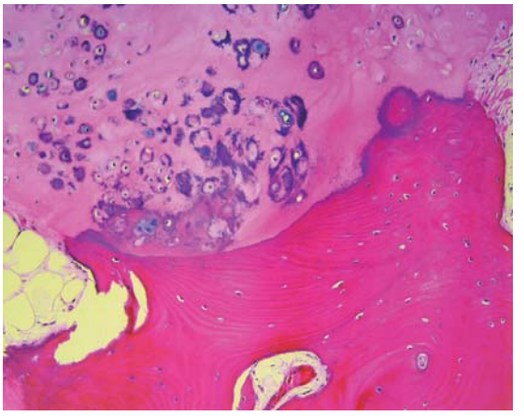

Figure 4. Hematoxalin- and eosin-stained slide. Low-power photomicrograph of fragments of metaplastic cartilage in intimate apposition with mature lamellar vital bone. Chondrocytes localized in groups and surrounded by an acellular matrix of hyaline cartilage are appreciated.

These particles are foci of metaplastic cartilage known as "loose bodies." Although the absence of these particles does not preclude the diagnosis of synovial chondromatosis, the fragments are a dramatic radiographic and intraoperative feature of this disorder. (Figures 2 and 3 clinically illustrate loose bodies extirpated from the patient.)

Loose bodies are appreciated radiographically as round, irregularly sized radiopacities often visualized in and proximal to the joint (see Figure 1).[2] Again, these radiopacities are cartilaginous nodules that form and detach from the synovial membrane and often exist freely in the synovial fluid, where they are nourished and gain in size.[2] But Koyama reminds us that many other types of loose bodies or fragments in the joint space can result from disorders including, but not limited to, intracapsular fracture, avascular necrosis, and degenerative joint diseases such as osteoarthritis and rheumatoid arthritis.[3] None of these entities were representative of the patient.

Osteoarthritis of the TMJ accounts for 10 percent of TMJ-associated pain. Osteoarthritis is a chronic degenerative and destructive inflammatory joint disorder marked by progressive aching, pain, crepitus, and joint stiffness, which is often most severe in the morning. The disorder can present with pain in the muscles of mastication. Radiographically, osteoarthritis of the TMJ presents in a variety of ways that can include a diminishing joint space, exostoses, osteolysis, subchondral cyst, synovial membrane thickening, and/or multiple chondral bodies appreciated in the joint space.[2]

Rheumatoid arthritis (RA) is also a chronic degenerative inflammatory joint disorder. However, rheumatoid arthritis is thought to be an autoimmune disorder. RA affects women significantly more than men, at a ratio of 3:1. Signs and symptoms indicative of RA are progressive and are relapsing and remitting. The joint is affected by swelling, stiffness, pain, ankylosis, and deformity. TMJ appears in 40 percent of patients with RA, is bilateral, and can result in malocclusion and micrognathia from severe destruction of the condylar heads. Approximately 80 percent of patients with RA demonstrate diagnostic markers for the autoantibody rheumatic factor and 50 percent manifest antinuclear body.[2]

Synovial chondromatosis is similar in its physical appearance to chondrocalcinosis (pseudogout). Chondrocalcinosis is characterized by the precipitation of calcium pyrophosphate dehydrate crystals into the joint space.[5] These crystals appear similar to the cartilaginous foci appreciated in synovial chondromatosis. TMJ involvement in this entity is similarly rare, but this diagnosis is distinguished from synovial chondromatosis histologically and by its particle composition.

The histological appearance of synovial chondromatosis is characterized by cartilaginous nodules included within

the synovium and sometimes freestanding in the joint space. Calcification and ossification are not uncommon features. In addition, the cartilage can sometimes assume areas of cellular atypia and hyperchromatic features suggestive of chondrosarcoma. It is important to note that synovial chondromatosis does not exhibit malignant behavior; malignant transformation has never been reported with this disorder.[2] However, chondrosarcoma is a critical inclusion in the differential diagnosis. Koyama states that "multiple and short interval recurrences" might present a possibility of a synovial chondrosarcoma (as opposed to chondrometaplasia) that should be carefully investigated.[3]

Chondrosarcoma is a malignant tumor of cartilaginous origin. Chondrosarcoma has no gender predilection and commonly is first diagnosed in patients during the fourth to fifth decade of life. Chondrosarcoma rarely occurs in the jaws, but when present, it most commonly affects the maxilla.[2] The presentation of this malignancy rarely involves a complaint of pain. Signs and symptoms can include nasal and sinus congestion, epitaxis, and visual disturbance, with loosening of the teeth another common finding.[4]

The signature radiographic features of chondrosarcoma often manifest a mixed radiopaque-radiolucent entity with ill-defined borders. Chondrosarcoma is distinguished from chondrometaplasia clinically and radiographically, where chondrosarcoma is characteristically accompanied by severe bone destruction, trismus, and abnormal joint function.[2] However, this is not to suggest that synovial chondromatosis can not also exhibit locally destructive behavior. Mupparapu reports a case of glenoid fossa perforation with extension of chondrometaplasia into the middle cranial fossa.[1] Cranial extension is a rare but serious development. Careful diagnostics with computed tomography and magnetic resonance imaging, combined with close long-term follow-up, is useful to rule out this occurrence.

Conclusion

Surgery to remove loose bodies in synovial chondromatosis is the treatment of choice and delivers a good prognosis with low recurrence rates. Synovectomy and meniscectomy may be indicated if recurrence occurs and/or if the disk can not be fully repaired.[2]

The patient has recovered well during his postoperative course. He has resumed over 40 mm of jaw opening and exhibits good lateral excursion of his mandible. Continued clinical and radiographic assessment has been recommended for this patient. ■

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PATHOLOGY SNAPSHOT

VIKKI L. NOONAN, DMD, DMSC
GEORGE GALLAGHER, DMD, DMSC
SADRU KABANI, DMD, MS
Dr. Noonan is an assistant professor, Dr. Gallagher is a professor, and Dr. Kabani is a professor and the director of oral and maxillofacial pathology at Boston University School of Dental Medicine.

COMPOUND AND COMPLEX ODONTOMAS

THE ODONTOMA IS A COMMONLY ENCOUNTERED ODONTOGENIC hamartoma (a tumorlike mass representing anomalous development of tissue native to the region) characterized by an aberrant proliferation of tooth structure composed of variable amounts of enamel matrix, dentin, cementum, pulpal tissue, and odontogenic epithelium. Because this typically asymptomatic lesion represents a developmental anomaly, odontomas are frequently discovered on routine radiographic examination or in patients presenting with the chief complaint of failed tooth eruption. While most lesions are small, odontomas occasionally grow to a diameter of 4 cm or more and cause cortical expansion.

Odontomas can be classified into two types based on the degree of differentiation appreciated in the lesion. Compound odontomas are composed of multiple small, calcified, grossly identifiable rudimentary toothlike structures typically presenting in the anterior regions of the jaws. Complex odontomas consist of an amorphous mass of toothlike tissue lacking appropriate odontogenic configuration, and are most often located in the posterior jaws.

Treatment for odontomas that prevent the eruption of teeth, or that present with a mixed (opaque-lucent) radiographic appearance causing expansion or other symptoms, consists of local excision with a favorable prognosis. ■

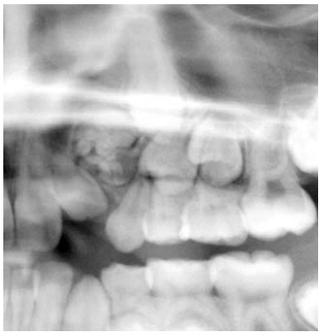


Figure 1. Cropped panoramic radiograph showing a cluster of toothlike structures preventing eruption of the maxillary canine in a 10-year-old female. (Image courtesy of William Bontempi, DMD)

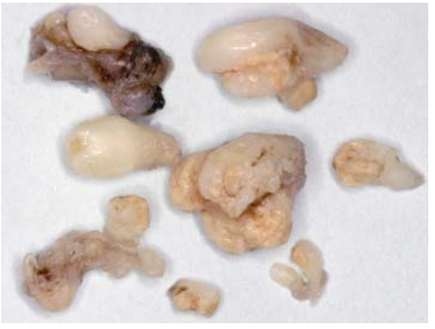


Figure 2. Surgical specimen showing multiple rudimentary toothlike structures.

CLINICAL CASE STUDY

ROBERT MEHANNA, DMD, CAGS
Dr. Mehanna is a periodontist with practices in Boston and Winchester.

ORAL PLASTIC AND RECONSTRUCTIVE THERAPY

ORAL PLASTIC AND RECONSTRUCTIVE THERAPY HAS SIGNIFICANTLY IMPACTED the way we practice dentistry today. Health, function, and then esthetics, in that order, have always been the driving paradigm supporting treatment planning and sequence of therapy. Treatment of gingival recessions caused by trauma, inflammation, or a combination of both is highly predictable with the use of different grafting modalities. Using autologous or allogenic grafts, guided tissue regeneration, or tissue engineering products, the surgeon can reestablish the harmonious, natural-looking periodontal tissues without the rugged, thick, and scarred appearance of the free gingival graft. Although the indication for the classical free gingival graft seems to somehow differ from that of the connective tissue graft, one may find very limited clinical application for an epithelialized graft should esthetics be the primary concern.

This case reflects the effectiveness of the use of autologous connective tissue grafting in the treatment of multiple Class II recession (using the Miller Classification). Figure 1 reveals chronic marginal inflammation, a complete lack of attached keratinized tissue, frenum tension, and limited mandibular vestibular depth. Treatment includes initial therapy with scaling and root debridement, followed by proper home-care instruction and physiotherapy.

The surgical procedure includes sulcular incision with sharp periosteal dissection and adequate flap relaxation with mobility. A subepithelial tissue graft is harvested from the palatal area of teeth numbers 2–5 with the single incision approach to ensure optimal postoperative healing and minimal discomfort. This is transplanted and secured over the recipient periosteum subadjacent to the facial recession. Careful root surface preparation includes root reshaping and conditioning, which precedes graft fixation. Closure is free from tension.

Such an oral plastic procedure is dependent on the selection and control of proper magnification, the use of a microsurgical blade, root biomodification, selected suturing material (monofilament or braided), and technique. With these controls, healing is tension-free. The integrity of the marginal gingival contours has been developed along with coverage of the exposed roots. The vestibular depth is now adequate. Figure 2 shows the successful treatment of the mandibular anterior teeth. ■

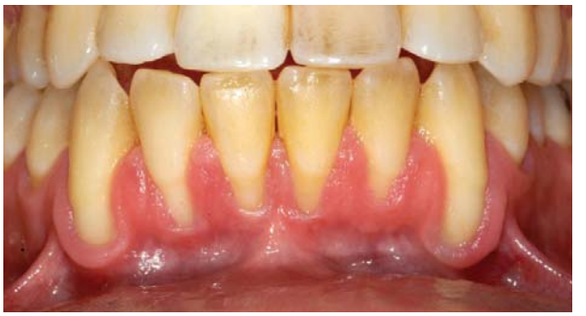


Figure 1. Pretreatment photograph reveals chronic marginal inflammation, a complete lack of attached keratinized tissue, frenum tension, and limited mandibular vestibular depth.

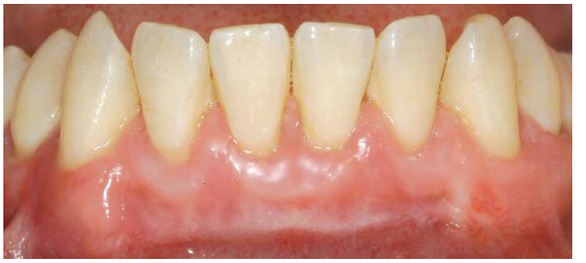


Figure 2. Posttreatment photograph indicates successful treatment of the mandibular anterior teeth.

About Clinical Case Study

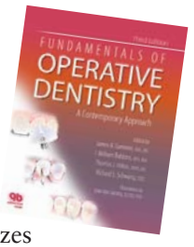
A clinical case study is defined as a written and visual assessment of a clinical case wherein the author presents before-and-after radiographs and/or photographs as a means to discuss the diagnosis, treatment plan, and actual treatment of a particular situation. The purpose of this study is to encourage JOURNAL readers to contribute a clinical response to the cases presented. It is our hope that many practitioners will contribute their ideas and treatment approaches, with the end result being a means for communication and learning.

Please address your correspondence to Clinical Case Study, JOURNAL OF THE MASSACHUSETTS DENTAL SOCIETY, Two Willow Street, Suite 200, Southborough, MA 01745. Responses may be published in a future issue of the JOURNAL.

BOOK REVIEWS

NORMAN BECKER, DDS, EDITOR EMERITUS

Fundamentals of Operative Dentistry, Third Edition



JAMES B. SUMMITT, WILLIAM J. ROBBINS, THOMAS J. HILTON, RICHARD S. SCHWARTZ

Quintessence Publishing

The preface of this text perhaps best summarizes the editors' goals for this book: "The many advances in materials and instrumentation, linked with the development of reliable dental adhesives, have allowed us to modify many of Black's original concepts to more conservative, tooth-preserving procedures, and to offer a much wider range of restoratives options."

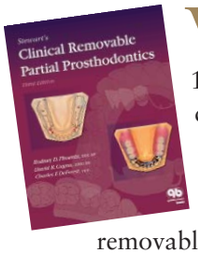
Utilizing the illustrations of Jose dos Santos Jr., as well as the insights of 36 internationally recognized contributors, the editors have created a textbook that presents current concepts and the latest scientific evidence in restorative and preventive dentistry. The treatment modalities reflect conservative dentistry, techniques for the restoration of health, function, and esthetics of individual teeth, as well as the overall dentition.

The text covers a broad range of topics, such as caries and pulp management, as well as dental materials and restorative techniques. The illustrative photographs and drawings, along with the well-written text, make this book a valuable tool for students and practitioners alike.

Stewart's Clinical Removable Partial Prosthodontics, Third Edition

RODNEY D. PHOENIX, DAVID R. CAGNA, CHARLES F. DEFREEST

Quintessence Publishing

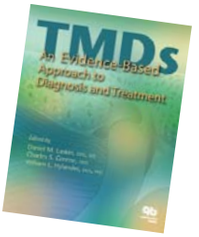


Written for students, residents, and practitioners, this update of Dr. Kenneth Stewart's 1983 textbook presents a chronological procedure and sequence for treatment modalities for removable partial denture service in contemporary dental practice. It builds on itself with logical steps to provide a clear understanding of removable partial denture concepts and construction.

The introduction of a series of definitions and terms used throughout the text helps the reader understand and follow the teaching principle and goals of the authors. These well-presented definitions also aid in clarifying prescriptions written or discussed while designing cases. For example, the Kennedy Classification System of design is described with words, as well as clear photos.

This textbook assumes nothing and teaches all. With the additional contributions of James S. Brudock, Raymond G. Kowpin, Michael A. Mansueto, and Ronald G. Verrett, the authors succeed in making this a valuable, all-inclusive text.

Temporomandibular Disorders



DANIEL M. LASKIN, CHARLES S. GREENE, WILLIAM L. HYLANDER

Quintessence Publishing

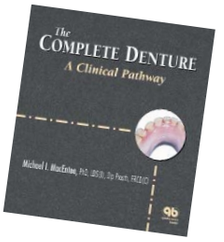
By adopting an evidence-based approach to the diagnosis and treatment of temporomandibular disorders (TMDs), the editors have integrated "the expertise of multiple basic scientists and clinicians to address the biologic complexity of the temporomandibular system, as well as the clinical challenges of diagnosis and treatment."

The text is divided into two parts: The first addresses the biologic basis of TMDs while the second covers the management of these disorders. In each case, the editors asked eminent researchers and clinicians to base their presentations on evidence-based knowledge. They were asked to highlight the areas of agreement and disagreement within their discipline. As a result, this textbook indicates recent advancements in the behavioral dimensions of both diagnosing and managing TMDs, significantly changing the current landscape for understanding the affected patient.

In addition, the section on guidelines for obtaining and using biobehavioral assessment data is notable, as it may prove to be a valuable adjunct when obtaining health histories of your patients.

Do not let the book's title appear to limit its scope. It is a text that will help give the practitioner a better understanding of what appears as chronic pain, and thus help in the many phases of your practice.

The Complete Denture: A Clinical Pathway



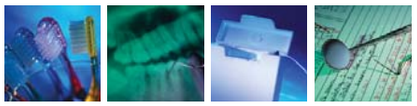
MICHAEL I. MACENTEE

Quintessence Publishing

Although the edentulous patient is on the decline, a percentage of our patients still requires full dentures. And while full-denture prosthesis may have been placed somewhat on the back burner, treatment involving complete dentures in the elderly population is not simply a mechanical skill. According to MacEntee, it demands an accurate diagnosis of systemic and local problems before any attention is paid to the design of the prosthesis.

Using clear photographs to help illustrate each phase of the procedure, MacEntee has designed a step-by-step manual to help practitioners provide effective treatment for the edentulous patient, including the necessary materials for each appointment.

Chapters devoted to complete denture relining, immediate denture construction, and implant overdentures are just a few examples of why this manual should be in the library of both the experienced practitioner and the student. ■



CYNTHIA K. BRATTESANI, DDS

Dr. Brattesani is a dentist based in San Francisco and previously served as chair of the ADA Council on Membership.

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THE JOURNEY TOWARD EXCELLENCE

WOMEN HAVE MADE A BIG IMPACT ON DENTISTRY, ADOPTING a new management style with a radically different, yet dramatically enhanced, dentist-to-patient and dentist-to-dental team dynamic. The dentist, dental team, and patient all benefit from this change. We now see positive work relationships, energized dental teams, and more caring and effective patient care.

This change is occurring across the nation. Women's leadership encourages the dental team to contribute and to feel powerful and important. We know this is good for the dental team and better for the practice. In this environment, the improved health dividends to patient care are clear.

Women thrive in this profession, and the profession thrives with the inclusion and active participation of women. With the ever-increasing number of women graduating from dental school today, this management style will become even more pervasive in our profession. We are proud to be dentists and dental health professionals, and we are excited about our future—a future increasingly reliant on the woman's perspective and the woman's touch in dental management and dental care.

The Journey Toward Increased Excellence

To continue the journey toward broader visions and increased excellence in dentistry, these three concepts will help nurture and develop women's dental practices:

Do what comes naturally. Women are natural leaders. So, do what comes naturally; always provide an environment of growth and development using compassionate, empathetic leadership. Empower your team at every step. Understand your team, so they can understand you. Coach, support, and offer guidance, but help them find their own answers. Do not dictate a result; ask them to find a solution. Tell them that they must offer a solution, no matter how ridiculous it may seem, with every problem they present. Encourage creative, independent, solution-oriented thinking. You will be amazed by the results.

It's a team business. If you want your team to take care of the practice as if it were their own business, make it their business. Demonstrate to your team what it means to run the business. Show them the numbers. In many cases, dental teams have no idea what it takes to keep an office healthy and running effectively. People will rise to the challenge when it is *their* challenge. Remind your team members of their successes. Celebrate every single time the team members meet their goals. Do not take for granted their efforts at making the business—your practice—a success.

Communicate and listen. Understand communication as a dynamic circle between sender and receiver. Hear and talk to your team. Together, you and your team collectively create more than either of you can conceive alone. Ask yourself: What procedures can keep the lines of communication open? What can you do better to open the lines of communication? But avoid the temptation to communicate too much. We also need to listen. Listen with your third ear: your heart. The ability to listen carefully and to pay attention enables us to seek the truth, to learn, and to lead.

As women dentists, our insights and learning do not end here. The empowerment, inspiration, and lessons learned every day in our practices and in our lives will no doubt have a ripple effect on our patients, our colleagues, our organization, and our profession. ■