

# FDA PRESIDENT ADDRESSES GENERAL ASSEMBLY

For the third year in a row, the President of the Florida Dental Association addressed the general membership of the Florida Academy of General Dentistry at our General Assembly Meeting in June. Dr. Dan B. Henry, a graduate of the University of Maryland, and newly appointed FDA President laid out his platform for the next year in Florida.



*FDA President, Dr. Dan Henry, addressing the FLAGD General Assembly*

Dr. Henry, a general dentist from the Florida panhandle, talked about ethical practice and the concept of mentoring. His idea of “home stays” for dentists being mentored went a step beyond the usual idea of offering advise to younger colleagues by inviting them into our homes, offering them a place to stay, and presenting a well rounded idea of what general dental practice is all about...including family.

The new FDA President was accompanied by Dr. Nolan Allen, President Elect of the FDA who is from the Clearwater area and active in Florida dental politics. It was clear from both men, that the needs and demands of the

general practitioner were high on their list and they would do whatever was needed to see that FLAGD interests were heard and served.

The FNDC Meeting in Orlando at the Gaylord Palms was a huge success again this year, and if you haven't attended in the past few years since the meeting was moved from the World Marriott Center, then you have missed a lot. Courses, including participation courses, were available every day. Shuttle parking at Disney was quite convenient and free, with buses running every 15 minutes.

The Florida Academy of General Dentistry General Assembly luncheon was well attended again this year, and the FLAGD Board believes this will become an annual event at the FNDC because so many general dentists attend the CE courses and enjoy seeing their colleagues at this luncheon. New officers of FLAGD were announced for the 2007 year, and many photos were taken (see pages 9 & 10).



*Dr. Dan Henry*

President Sam Hanania and President Elect Mel Kessler addressed the General Assembly with their thoughts and both men commented on the strong support the FLAGD now provides the FDA and organized dentistry in our state. Small Management Associates, our new management firm, coordinated the luncheon which went on without a hitch, and was enjoyed by all.

Plan on attending next June! Mark your calendars now.

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## President's Message



### I Have Been So Honored

By Dr. Sam Hanania

I am proud to report that our General Assembly was a success. This year we coupled our annual meeting with the FNDC to foster better relations with the FDA. In fact Dr. Dan Henry, the newly installed president of the FDA, was our keynote speaker. Dr. Nolan Allen, the FDA's president elect, also joined us for lunch. Much was accomplished including approving the budget and electing the officers for the upcoming year. Dr Melvin Kessler, our president elect, also presented his vision for the future of our organization. We are on solid footing and we are poised to take our advocacy to the next level. Next year we will be having our General Assembly with the FNDC and a free lunch will be included for all members.

I am pleased to announce that Ms. Christie Tarantino is the new Executive Director at the National AGD. I have worked with Ms. Tarantino in the past and she has assured me that Florida will not go unnoticed. I am hopeful that this will continue a very fruitful relationship with National.

I hope everyone has had a chance to meet or speak with Rosie Small, our new Executive Director. She has been a

wonderful addition to our team. She has handled the day to day operations of our organization with grace and efficiency. The Board and I thank her for her dedication and look forward to a long and productive time together.

As you know from my last report, our trustee, Dr. John Joffre, is stepping down and an election is planned for the Regional Caucus at the AGD meeting in Denver this summer. Dr. Lawrence Scheitler, our Editor, has thrown his hat in the race and we wish him well.

Dr. David Stillwell, our Vice President and I attended the Specialty Forum at the FNDC this year. Many new issues were discussed that directly affect general dentistry. Be assured we have your best interest at heart when we address these issues. In the future we will poll our members and formulate positions based on what you, the Florida general dentist, want.

We are in the midst of a membership drive. If you have not already done so, please ask a colleague to join. We only have strength in numbers and although we have been blessed with approximately 1600 members, 1601 would be better and 7000 would be ideal. As you can see we have a lot of work to do. Your help is necessary to the growth of this organization.

I would like to take a moment and thank the Board of the FLAGD. I have made many friends over the years through this organization and having those friends ask me to lead was both flattering and humbling. I have always known that very little is accomplished by oneself, and that describes this organization better than any other.

Lastly I would like to leave you with one of my favorite quotes:

*"Always remember we walk this path but once. The book of time uses permanent ink. Therefore control your passions. It builds your character. Increase your experience. It gives you wisdom. Harm no one in thought or deed. It will come back tenfold. Respect and honor all persons. Expect and receive the same. You do make a difference in the cosmic recipe. Never fail to exercise your thoughts and give your input for without it, the cement of destiny gives way the battering ram of fate."*

Paul I. Helzer

It has been my honor to serve you the membership and I am always available to help in any way I can.

#### FLORIDA FOCUS

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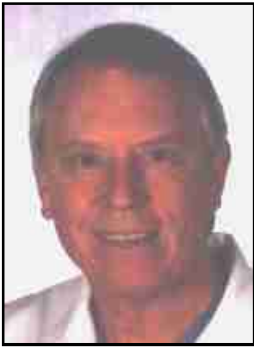
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## Editorial



### Are Ethics Really Worth It?

by Dr. Larry Scheitler

It would seem that we expend a lot of energy every year in the practice of dentistry, in the education of dental students and just living our lives day to day. And it would also seem that once that dental license is hanging on the wall, we as dentists can police ourselves in the practice of dentistry quite nicely, thank you, unless of course some irate and unappreciative patient turns us in to the Florida Board of Dentistry.

Of all the subjects taught in dental school, the one which is often wedged in between community dentistry and practice management is that short course on ethics. The one which says “above all do no harm”; or “treat your patients as you would like to be treated”; or “do unto others”. And it’s always on Friday afternoons at 4pm.

I think you get the picture. It’s kind of like going to church or temple, but on a weekday not a Saturday or Sunday. There is preaching and a lesson to be learned, but it really applies to the other guys in the room and not to me or you. And how do you teach someone ethics anyway? Aren’t you just born with the “ethics” gene? Apparently not.

When we enter the practice of dentistry, things get fuzzy. We’re now in the business of dentistry as well as the practice of dentistry, and often the two collide. Ethics may at times mean the difference between profit from a procedure, or loss. The difference between making the payroll that day or not. The Business of Dentistry may mean a short cut taken, but later regretted, or it may mean loss of a patient, a tooth or even a friend. It may mean veneering a tooth which clearly needs a simple restoration, or recommending a root canal because “we’re getting pretty close to that pulp, Mrs. Smith”. Yep, only 3mm away...

***“We’re now in the business of dentistry as well as the practice of dentistry, and often the two collide.”***

At the **American College of Dentists Annual Breakfast** this year it was a pleasure to meet with a group of dental professionals dedicated to one simple notion in dentistry, one common bond...ethical practice. Dr. Terri Dolan, the Dean of the University of Florida College of Dentistry was there, as was Dr. Frank Catalanotto, the previous UFCD Dean. Two student awardees were present to get their cash awards, and many other leaders in Florida Dentistry and the Florida Dental Association were enjoying a nice meal. Dr. Henrietta Logan and Dr. Larry Cook were honorably mentioned for their excellent course in Ethics, the one I mentioned above, for which they volunteer their time and efforts.

The many Florida dentists in attendance were all interested in discussing one central theme, one concept. No it was not the FNDC Meeting or the FLAGD General Assembly, or the CE Courses being offered. It was (to hear) Dr. Marcia

Boyd, the National ACD President, give her take on ethics in dental practice today. And what a speech that was.

Dr. Boyd opened her speech talking about history, and what brought her to that podium on that particular day. She outlined in a most capable way, her own personal history and the challenges through out her career at many levels.



*Dr. Betty Hughes addresses the American College of Dentists*

But the heart of the speech was ethics, and the soul of the speech was value. Because, she believes that an ethical practitioner is one who values him/herself as well as others. And then she began talking about the ethical changes in our profession today.



## Region XX Report



### News From Region XX Director

by Dr. Patrick Shepherd  
Region XX Director  
(shep5440@bellsouth.net)

The Florida and Puerto Rico constituents are doing well under the leadership of their respective presidents. Our fellow AGD members in Puerto Rico are especially pleased to now be receiving their own copies of the Florida Focus. I have heard rave reviews about our prize-winning journal from them.

You read elsewhere in Florida Focus where our long-time Regional Trustee, Dr. John Joffre, has reached his term limit and cannot run again for Trustee. Our Florida Focus Editor, Dr. Larry Scheitler, is seeking that position. The election will be held at the Region XX caucus during the upcoming AGD meeting in Denver.

Dr. Harvey Gordon has agreed to stay on as Region XX Secretary/Treasurer, and I will throw my hat into the ring for one more term as our Region XX Director. I have found this job to be extremely rewarding, and I am grateful to all of you for giving me this opportunity to serve.

If you are not involved with the leadership of your local constituent, please consider doing it. You will find that you get more out of it than you give, and you'll meet some really great guys and gals in the process.

Please take a moment to confirm that our FLAGD office has your correct phone number(s), fax number(s) and email address. It is often necessary that we reach you in a timely manner, but we can only do that if we have your proper contact information.

Don't forget that the AGD Annual Meeting will be held in Orlando in 2008. Please plan to volunteer.

Thank you for the trust you have placed in me. I hope to see you in Denver at our National Meeting.

### ARE ETHICS REALLY WORTH IT, *continued from page 3*

As Dean of a Canadian Dental School, she has faced ethical dilemmas, and she wonders why only 3% of the practicing dentists in our country are members of the American College of Dentists. That's not very many, really. Yet, it seems more dentists than ever are being brought up for peer review, for reprimand by the Board or for even loss of their licenses. The numbers are astounding nationwide.

A few issues ago, I reprinted an article written by Dr. Gordon Christensen. It was titled "I Can't Take It Anymore" or something like that. The premise was the trade our profession has made from ethical practice to esthetic/cosmetic practice. Dr. Christensen went way out on a limb and said that the profession has taken a turn down the wrong road, and clearly we were all going to pay for that change in direction. In fact, our profession which used to be ranked second or third in "respect by the general public" has dropped considerably in the rankings. We are seen differently now than we were ten years ago, and that's a

shame. But we're really good at veneers, bleaching and cosmetics.

He went on to say that there is room for cosmetic dentistry, esthetic dentistry, and ethical dentistry. But it takes ethics to balance dental practice and the business of dentistry. Is the cutting of good enamel on anterior teeth sound ethical practice?



Dr. Gordon Christensen

"Where has the professionalism of my profession gone? I have seen a major degeneration in the ethics of the dental profession over the past several years. In my opinion, the ethics of the dental profession have taken a real 'dive.' Over treatment in the name of esthetic dentistry without total informed consent of patients, primarily for dentist financial gain, is nothing less than overt dishonesty in its worst form."

That's for you to judge, not me. But according to Dr. Christensen, there's the rub.



## President-Elect's Report



### As I See Our Academy

by Dr. Mel Kessler  
FLAGD President-Elect  
(skesmkes@aol.com)

*"The mission of the Florida Academy of General Dentistry is to serve as an advocate for general dentists, to promote improved delivery of patient care by fostering continuing education and to increase public awareness of quality dentistry and those who provide it throughout the State of Florida."*

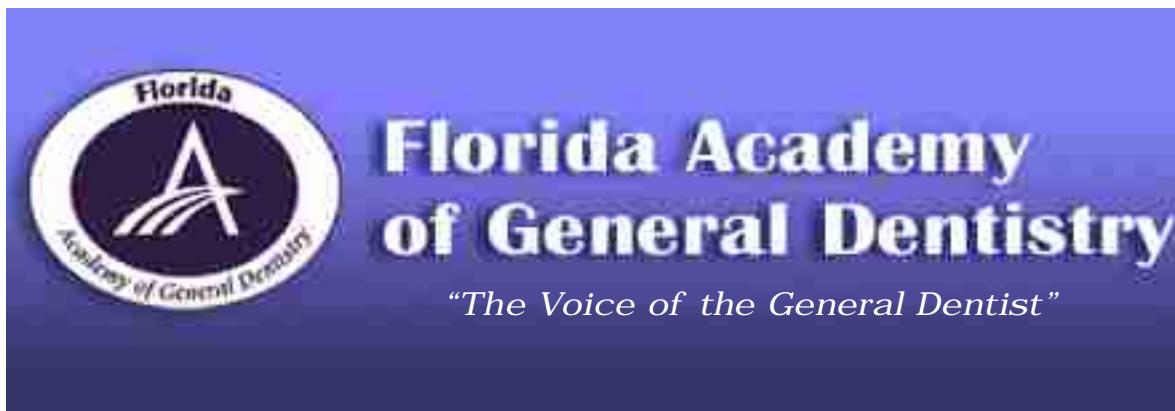
Okay, this is our new mission statement, as decided by your board on October 15, 2005. We may retune it at our next strategic planning meeting or keep it just as it is. What it does show is a dynamic organization that is willing to adapt and change as needed. We seek to serve the needs of the general dentist and to represent the general dentist. Thus we are the advocate for the general dentist. General dentists represent 75% of all dentists. Whereas I have been a member of the ADA for forty years, there are differences between the needs of the Academy and the ADA. The ADA must represent all dentists, specialists and general dentists alike. My concern is that at times specialists would be subject to their special interests, and may be in conflict with items of special interest to the GP. This is where the need for advocacy by the Academy is paramount.

Your board has been attending Dentist Day on the Hill for a number of years and has been working hand in hand with the FDA. This has been an excellent alliance and has served to cement better relations between both

organizations. In fact there is very little on which we do not agree. The FDA and ADA have sought the Academy's voice in speaking for the general dentist. Reciprocity and licensure by credentials are several of the more contentious issues nationally. If you are not attuned to politics, you have no idea how Tallahassee can impact your practice. Did you know that the hygienists, besides wanting a separate board, want to practice under physician supervision? Or that unlicensed dentists wanted to become licensed by merely working in an "underserved community"? Or that only dentists not signed up with CE Brokers would be audited? These are only a few of the items that politicians proposed. Every year brings something new. This is why we need to be diligent.

CE is still a major focus of our organization. Only through quality CE can we improve, becoming better dentists and thereby better serving the public. In fact, fear of earning the additional ten credit hours often stops many general dentists from joining us. This is unfortunate as we need them to improve also. As far as a state meeting, this is another issue. In the past we put too much money at risk for the low percentage of our membership that attended. We are constantly checking to see if there are other options. Currently we are relying on our Pace Program to see that the CE available meets the highest standards.

I would like to thank your board for having worked so long under adverse conditions. The members of the board are all exceptional. Special thanks for David Stillwell for stepping on line when we were short. And special thanks to Harvey Gordon, having survived the greatest adversity, and now stepping up to Vice-President. There is nobody else that spends so much attention to detail and deserves that position more than he. Looking forward to a great year serving our members.





## FLAGD Legislative Update



### Current Legislative Items of Interest

*By Dr. David Stillwell  
FLAGD Legislative  
Committee Chairman*

On the legislative front, there are some significant items of interest for our members:

l The Agency for Health Care Administration/Medicaid proposed a regulation on January 27, 2006 (FI 30570 2006) that would amend the incorporation rules to fold the Florida Medicaid Dental Services Coverage and Limitations Handbook within the Bureau of Medicaid.

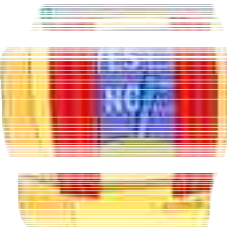
l The Department of Health/Board of Dentistry recently adopted a regulation (FL 30460 2005) that sets up new rules for administering conscious sedation. The rule became effective March 23, 2006.

l The Department of Health/Board of Dentistry has proposed a change in regulation slated to go into effect on September 9, 2006 (FL 30041 2005) that will significantly modify the State teaching permit language.

l HB 1157, dealing with charting by dentals hygienists, has passed both the House and Senate and has been sent to the Governor's desk for signature. FLAGD voted unanimously to endorse the FDA's position to "approve" this bill, and the Legislative Committee will continue to follow the impact of this legislation.

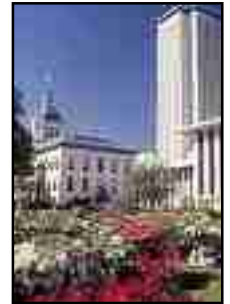
l HB 699, which changes the mandatory dental continuing education required for initial and renewal licensure, was passed and is currently waiting signature.

l HB 855 (the "Dental Lab Mandate" Bill) was temporarily postponed following first hearings on March 22, 2006. FLAGD voted unanimously to oppose HB855 as written. It is expected that a revised bill will be re-introduced in the next legislative session. Watch for future updates.



On May 23, 2006, an AGD "Advocacy Training Tool" conference call was conducted for the purpose of assisting all participants in the use of our national advocacy website (Capwiz) for communicating action alerts and crafting letter mailing campaigns. This powerful software interface, found on the AGD Web site ([www.agd.org](http://www.agd.org) -click on "Advocacy") will make it extremely easy for members to get involved in grassroots advocacy. If you have a personal opinion or position, this is the site to use for maximum impact. Check it out!

On June 14, 2006, the Florida Dental Association held its annual "Specialty Group Forum" in conjunction with the FNDC at the Gaylord Palms Resort in Orlando. Attending to monitor the interests of general dentistry, FLAGD State President Sam Hanania and State Vice-President David Stillwell participated in an excellent discussion of dental issues with 24 other representatives from most of the recognized specialties. Some topics discussed were:



*Florida Capitol*

- ✓ Specialty Licensure Update
- ✓ ADEX National licensing examination
- ✓ CE Broker developments
- ✓ Botox and other esthetic/cosmetic therapies
- ✓ Certified Dental Assistant expanded function regulations and "DanbyCertification"
- ✓ Agency for Health Care Administration (AHCA) and Medicaid reform
- ✓ Florida Board of Dentistry budget deficit and possible assessment to all current dental license holders

For more information on the "2006 Specialty Group Forum" topics mentioned above, contact the FDA lobbying office (Ron Watson or Jo Anne Hart). The next FDA "Specialty Group Forum" is tentatively scheduled at the Tampa Airport Marriott, Jan 26, 2007. President Hanania has recommended that FLAGD piggyback our Board of Directors meeting at same time so that our membership can continue to attend this important event.



## The Job of a Successful Leader

by Dr. Robert Willis

In every business, there is someone who is leading. In some businesses, the clients, patients, shoppers or customers are running the show. In others, the staff, team, workers or employees are in charge. In a few businesses, the owner, president or CEO is leading. Regardless of what your title or how high up the organizational chart your name appears, someone is really pulling the strings. The good news is that it really doesn't make any difference who's leading if you are unconcerned with what the results produce.

Now, if on the other hand, you do have a preconceived notion of what results you would like to see from the business you are in (in our case, that would be our dental practices), it would make sense that you be determined to become very good at leading your practice in the direction you really want to go so that the results you get support the ones you want.

Here are some time tested steps to make sure that the results you want from your practice come to fruition:

1. Begin formulating your vision for the practice. Start with the answer to this question, "What do you want your practice to look like?" Don't dwell on where you are now, focus on where you are going.
2. Evaluate your people. Make sure that each person is willing and capable to do what it takes to get you to where you want to go. If you allow people to stay on board who do not support your direction, people who have their own personal agendas, or people who do not bring energy to the practice, you will fail and be frustrated. Attitude trumps aptitude every time.
3. Start implementing with yourself first. When the team sees you are serious, it is far easier for them to buy in to your Vision. Set a shining example by what you do, the pleasing attitude you have when you do it and the energy you bring to the practice.

4. Communicate the vision and your chosen direction to your team. Make sure ask each team member to tell you what the vision is and how they contribute to it. Ask them often.
5. Be a leader. Don't be one of the group. When you are a leader, you are not a team member. Be excited and inspired about going to the office. Leading requires movement and energy. Stagnancy causes lethargy, indifference and poor habits.
6. Set high standards. The Doctor is the only one who can do this. The team watches what you do and emulates you. An example would be: I want everyone who enters this office to be treated as an honored guest or being on time. The team watches and observes your behavior. Your practice is a reflection of what you tolerate.
7. Have a game plan. Then take action. Stress in practice is caused by not having a plan, not knowing what to do next and waiting to take action.

*The Job of a Successful Leader, Continued on Page 8*



**T**he Academy of General Dentistry endorses Chase as its preferred Visa card, with low interest rates and an optional value Miles feature that can help you to earn travel miles on every purchase. Premiere Value Miles are good on major U.S. air carriers, with no blackout periods. Expanded destinations include Hawaii, Alaska and Europe.

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8. Delegate and get out of the way. You have to do 1 through 7 first. Management is implementation of the policy, it is not leading. The leader must be very clear about the vision and the game plan and make sure that the people who shouldn't be there aren't. You can do well with the approximately right people, but never will you do well with negative people or people who are not on board. With the right attitudes on board, management is easy and you will spend little time managing.

9. Rip off limitations of people around you. Dentists operate out of what is reasonable and practical. Be willing to be unreasonable; raise the bar. Cross training is critically important. Set up training programs with committed teachers and students. A person can learn anything if committed. Remove limitations from your own mind about what your team can do or remove team members if they have preset their own limitations so as not to infect the other team members.

10. Treat the people around you with respect and dignity. If you expect the team to treat your patients kindly and respectfully, you must treat the team the same way. Don't be in your office if you can't be joyful and bring energy to the office. Don't allow team members who bring negativity to the office or are whiners, complainers, nay-sayers, etc. to exist in your practice.

Please note that in order to be a Successful Leader, you will find that you will periodically need to review or evaluate:

1. Your practice direction
2. Your personal performance
3. The performance, attitude and contribution of each of your team members
4. The practice monitors and financials

I find that Dr's who are most successful re-evaluate their practice direction, personal performance and team performance, and review the practice monitors financials at least every quarter. They have a handle on what is going on with their practices so that things don't get too far off line.

The team assessments are not those that are done annually for each individual team member; these quarterly assessments are to determine how well each team member is contributing and how that affects the practice. These are done for the purpose of continuing to lead effectively using the facts.

By following these steps you will find that your practice is far more enjoyable, easier to run and a better place for all to work. If you would like to see where your practice stands and what is possible for you, email us today at [DrWillis@dentalcoach.com](mailto:DrWillis@dentalcoach.com) for your Free Practice Evaluation.

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## ANNOUNCEMENTS & NOTICES

### A Service to FLAGD Members

Beginning in this issue of Florida Focus, we are offering FLAGD members to place an announcement, notice, or even classified advertisement.

If you have recently moved your office and would like to let all of our FLAGD members know your new address and phone numbers, send the information to the FLAGD office at [rsmall@flagd.org](mailto:rsmall@flagd.org) for the next issue of the Florida Focus. Have you brought in a new partner or associate? Do you have a new baby or a grandchild? Have you recently married, as did our FLAGD delegate at-large and assistant editor, **Dr. Kelly Peters Halligan**? If you will send that information to our FLAGD office, we will include your information in the next issue of the Florida Focus.



*Dr. Kelly Peters Halligan,  
Newlywed*

Perhaps you are seeking a new associate or other employee, and know the value of hiring an FLAGD member. You may have a dental office to rent or equipment to sell. Starting in our next issue, the FLAGD will include a section of classified ads - from FLAGD members only, for FLAGD members only.

The FLAGD would like to congratulate **Dr. Harvey Goron**, former Treasurer of the FLAGD, who will become FLAGD Vice-President in November 2006. Dr. Gordon will move up the line and serve as FLAGD President in 2008-2009, following Dr. David Stillwell.

Additional congratulations go out to **Dr. B. Laurel Casey** who has been elected to serve as a new Delegate at-large to the FLAGD and the AGD.



## From the Executive Office



### What We're Doing... and What You Can Do To Help

by *Rosie Small*  
*Executive Director*  
([rsmall@flagd.org](mailto:rsmall@flagd.org))

Have you had a chance to check out the FLAGD website lately? There is a plethora of useful information about the FLAGD, our calendar, membership, new members, PACE providers, Continuing Education, meetings and events, and a whole lot more. And you can also read each issue of the *Florida Focus* online, several weeks before you receive it in the mail. You can access the FLAGD website at [www.flagd.org](http://www.flagd.org).

Periodically, we have information that we need to get to our members on a timely basis, especially during the period that the Florida Legislature is in session. Unfortunately, we do not have access to all of our members' email addresses. If you would like to receive current information from the FLAGD, please make sure we have your correct email address. You can do this by sending an email to me at [rsmall@flagd.org](mailto:rsmall@flagd.org), indicating the email address you would like us to use for you. I can't begin to tell you how helpful this would be for us.

As Dr. Mel Kessler begins preparing for his year as President of the FLAGD, he is looking for interested, committed FLAGD members willing to serve on committees. We currently have vacancies on the Membership Council, CE Council, PACE Committee, and Bylaws Committee, among others. If you are willing to help out by serving on an FLAGD committee, please send an email (to that same email address, [rsmall@flagd.org](mailto:rsmall@flagd.org)) and I will pass your information along to Dr. Kessler. Or you can contact him directly at [skesmkes@aol.com](mailto:skesmkes@aol.com).

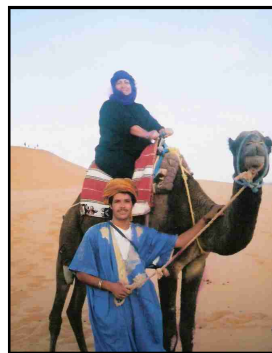
Here's some great news! The *Florida Focus* won the AGD's ACE Award again this year. To win this award ONCE is an honor, to win it four years in a row is downright AMAZING! Congratulations to the editor, Dr. Larry Scheitler, for his excellent work on our FLAGD publication.

Here's another volunteer opportunity . . .

Are you aware that the AGD Annual Meeting will be held in Orlando, FL in 2008. That's only two years away. Whether or not you have attended the AGD meetings in the past, you will have the chance to participate in one close to home in 2008. If you were to check the FLAGD 24-month calendar of our website, you would see that the dates of this AGD meeting are July 16-20, 2008. The local chair of the AGD's local arrangements committee is Dr. Marc Tindell. He will be asking for volunteers to serve as local hosts, room monitors, and other functions. Consider being a volunteer at the AGD Annual Session. Let's use this opportunity to showcase our magnificent state, and our excellent constituent AGD. By now, if you have read this far, you know the email address to send information about your interest in participating. Here's a clue - [rsmall@flagd.org](mailto:rsmall@flagd.org).

Will the two FLAGD members who attended the General Assembly luncheon in June and requested information from me about starting a component in Central Florida - the Orlando area - please contact me. I have put together a list of members for you to contact, but I need your help.

The FLAGD's Continuing Education Committee is planning a major CE program next year, very likely in the Palm Beach area. We're also looking into planning some



*Rosie in the Sahara  
with Omar the camel driver*

CE vacations, and I would love to get your input on that. Do you have any interest in an FLAGD CE Seminar on a cruise ship? If so, how many days would you consider? How about a ten day trip to exotic Morocco, with eight hours of CE included. For around \$2,000 per person, we can provide transportation (to and from Morocco plus in-country guided tours), five star hotels, and CE programming. Our

itinerary would include Casablanca, Fez, Marakkech, Ouazerzate, Agadir, and maybe even a camel trip into the Sahara to see the sun rise over the Merzuga Dunes. I've done this trip, and I can tell you, it is amazing. Great shopping, too! I would love to share this experience with my friends at the FLAGD.

If any of these CE travel opportunities interest you, please send me an email (you know where). If I get enough interest from our members (you are welcome to bring your friends and relatives also), I will start investigating it.

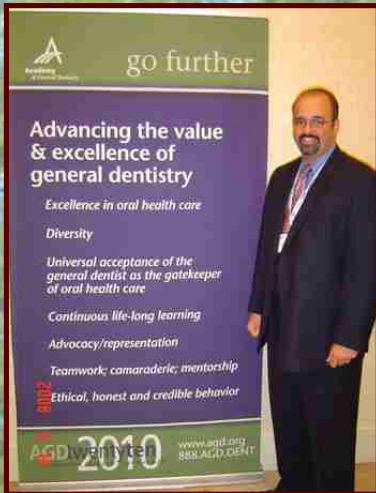
# Photos from the FLAGD General Assembly



*Drs. Tassi, Collins, Scheitler, Casey and Stillwell*



*Coast Dental provided financial support for luncheon*



*President Hanania outlines AGD 2010*



*FDA President, Dr. Dan Henry*



*Drs. Rod Shaw and Bob Gehrige*



*Dr. Irma Tassi awards gift certificate to winner of raffle drawing*



*Director of Comprehensive Dentistry Program at UFCD, Dr. James Haddix provided an update*



*Dr. Charles Ross (R) and other members enjoyed the luncheon*

# June 16, 2007 Gaylord Palms Hotel, Orlando



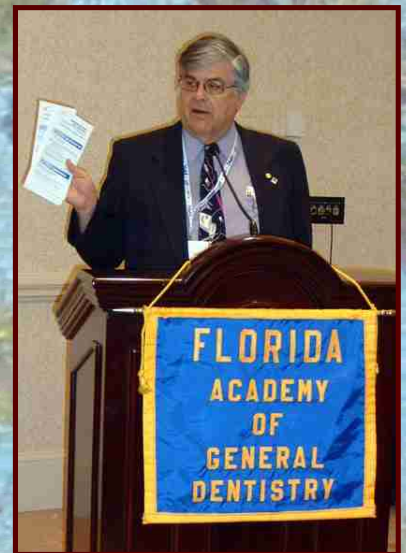
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## Guest Editorial



# Dentists Talking Negatively About Dentists

by Dr. Richard Mufson  
President, FMSOM  
(muffyrich@aol.com)

**If you don't have anything nice to say...  
... then don't say it!!**

That's what my mother used to say throughout my years of growing up. And although she's not with me any longer, I can still hear her voice saying this very same phrase to me in my right ear, if ever I should fall from grace and forget to exercise this important golden "do-unto-others" rule of respecting other's feelings.

Also as a child, I remember reading the favorite children's magazine, Highlights, in which one of my favorite cartoon segments was that of "Goofus and Gallant". I'm sure many remember this creative, simplistic, yet effective monthly teaching aid for children, in which we learned by example the basic differences between right and wrong. Goofus would always show us how to do things the selfish, self-centered, wrong way, and Gallant, of course, would show us how to do it the right way, in being more thoughtful, courteous, and considerate of others' feelings.



Well, I know the world's not perfect (and Lord knows, I'm certainly not either), but in the twelve years I've been practicing dentistry, it has become evident to me that not everyone was raised by my mother. Or more likely, perhaps they *were* raised by someone with at least similar values or teachings - but somehow just simply chose to forget. Did they read and learn from Goofus and Gallant, as I did? Maybe so - but again, may have simply forgotten that important lesson of childhood.

The sad fact is, that talking bad or saying negative things about our colleagues, whether down the street, across town, or even across state lines, is a pervasive sickness which has infected our so-called "profession" for years, if not probably decades. And like a chronic infection, or even a

low-grade cancer, it continues to linger on and fester in a way that threatens us, our patients, and the health of our profession with a far-reaching impact that so few of us may stop to consider.

I'm sure that right now, as you're reading this, in fact, that somewhere, probably within a 5-mile (or perhaps even 1-mile) radius, there is a dentist remarking to his/her patient that their fixed bridge restoration has open margins with some recurrent decay, and therefore "was done improperly", and that "...if you had only come to me in the first place, I could have done a better job, and you wouldn't be having this problem right now."

Another conversation is probably also taking place in another area of town, or perhaps hundreds of towns throughout the country, in which a dentist is answering an all-too-familiar question posed by a patient as to why a particular tooth, treated several months or years ago, has recurrent infection. "The root canal fill is too short", I can hear the dentist say, "...and it does not appear as if it was performed very well." And "the post within the tooth is too long and was placed improperly". Sound familiar?

Yes, unfortunately, we all know it does. And frankly, we should be ashamed. More importantly, we should be asking ourselves, quite literally, "Why are we doing this?"

Let's explore for a minute the reasons why many of us feel the need to engage in such destructive and condescending talk. It really does not take a rocket scientist, nor even a clinical psychologist, to understand the basic theories:

(1) **The basic need to put someone down:** The very competitive marketplace in which dentists practice, especially within major metropolitan areas where larger numbers of dentists practice per square mile, motivates a number of us, either consciously or subconsciously, to do or say things designed to make another dentist look bad in a patient's eyes, and to literally cause the patient to want to think, "Why did I go to that doctor, instead of coming here first?"

(2) **Which, in turn, boosts our own ego:** For similar reasons of a competitive atmosphere, where many dentists

may have questionable self-esteem, or feel too much like a “small fish in a large pond”, many see the opportunity to spew out negative commentary against one’s own peers as a means of boosting one’s ego and feeling of self-worth.

(3) **The desire to win-over a new patient:** There are those among us, who take great pleasure at the site of a new patient coming into the office for a “second opinion”, particularly if they may be disgruntled over previous dental treatment. In this situation, dentists may all-too-frequently find themselves conveniently “agreeing” with a patient’s negative comments about another dentist (which is itself an indirect form of negative commentary on the part of the doctor), and the dentist may then join in and commiserate with negative comments of his/her own, in hopes of increasing the likelihood of pleasing the patient, and having them be more likely to stay in the new practice.

(4) **Direct monetary gain:** There are many situations in which a dentist need only convince a patient that their previous dental treatment was inferior or substandard (whether founded or unfounded), as a means of helping to legitimize their own new extensive treatment plan to “correct the problem” and/or have a third party feel obligated to pay for the treatment.



And finally, a more complex and bizarre set of medico-legal reasons:

(5) **The desire to incite litigation:** The motivational and behavioral factors behind this category are quite complex, and may run the gamut from being very obvious and deliberate, to the more subconscious and subtle. It is widely known that a small percentage of dentists take gratification in seeing another’s misfortune, and revel at the thought of playing the role of “savior”, while demonstrating to the world, preferably in court, that it took such an expert as them to recognize, correct the problem, and to have known the right way to have handled it in the first place.

Sadly, however, two other “sub-categories” of reasons are responsible for this behavior, and include the following:

(a) **the desire to punish or “teach someone a lesson:”** - There are those who may feel that another dentist (or dentists) may be either practicing at an inferior level to

their own, or below standard, or doing procedures with less training than they should have, or otherwise “doing bad things” to people - and that the best way to “send them the message” and “teach them a lesson” - is to create a lawsuit, if possible. If enough emotional or economic misery is incurred in the process, they would then hope that the defendant will realize what they are doing is wrong, and then abandon such methods or procedures (or better yet, perhaps their entire practice), and change their evil ways.

***“We may not stop to realize, that even the most subtle of “digs” may have the same potentially hurtful effect as any another.”***

The realization may unfortunately never set in, however, that this warped and misdirected method of involuntary forced “continuing education” usually does not work, nor does it ever actually produce such an ill-intended desired end result.

(b) **the desire to see another person suffer the same ill-fate that they once suffered (the “misery-loves-company” reason)** - There are also those who have had a very negative experience with one or more previous legal actions, and in the same noble spirit of the typical “soap-opera mentality”, wish the same bad fortune upon someone else, as if to legitimize their own past history, while allowing them to feel that, “Hey, I’m not alone in this”, and “I must not be so bad after all”.



Sound ridiculous? Well, it should. But I’m only the messenger, and this is simply what has been occurring within our own profession (and admittedly others too) for years. Are the above reasons a reality, or simply a cynical exaggeration? Unfortunately, as repulsive as it may all seem, **yes** - it is a reasonably accurate representation.

**From the most subtle of comments:**

I truly wonder if there are any among us (myself included) who, at one time or another, has not faltered nor fallen prey to the temptation of speaking negatively to a patient - if only in the most subtle or subliminal of ways - about another practitioner or their respective prior treatment.

And in reality on an daily basis, it may only be in the most subtle of ways that we speak in many cases, with the desired implication nevertheless being (whether conscious or subconscious) that we position ourselves just a notch or two higher, in the patient’s eyes, than another practitioner.

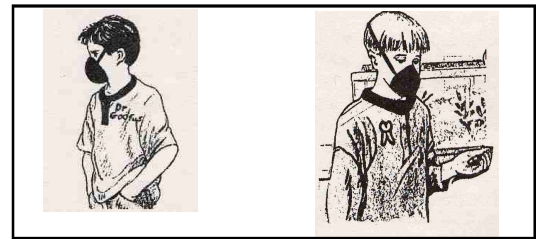
“Yes, I would have used a slightly different shade to match the adjacent tooth.” “Our office uses a different material that will look more natural and probably last longer”. “The root of your tooth appears very shortened, and is most likely from the previous orthodontic treatment you had.” “I would normally have placed a different type of implant in this area. The type of implant you have hasn’t been used for many years.” “Yes, the swelling you have is normal after having a tooth out, although it is a bit more than I usually see with most of my patients.” “Yes, the clicking noise in your joint could be related to the recent bridge you had placed. Was your bite checked afterwards?”

We may not stop to realize, that even the most subtle of “digs” may have the same potentially hurtful effect as any another. It is said, it is heard, it registers, and it somehow sticks just the same - as a permanent negative fixture in one’s mind. I must admit, from my own experience, if ever a negative comment regarding another dentist befalls my ears (whether via a patient or another dentist), that as much as I try and ignore it in most cases, or try to let it travel in one ear and out the other - a part of it unavoidably remains, and somehow has a lingering effect on my future impression or image of who that person is.

**To the more obvious and flagrant:**

Then, of course, we have the more obvious, the more spiteful and more sharply-directed commentary: “This bridge was done all wrong, and I agree with you, Mrs. Plaintiff, they do look like horse’s teeth”. “You would not have the hole from your mouth into your sinus if your dentist had removed the tooth using the proper technique (or if you had only come to me from the beginning).” “This is the wrong type of implant, and was placed incorrectly.” (By the way, these are all real comments - but this next one is a precise quote from just last week - a comment made by a dentist on referring a patient to my oral surgery office). “She has implants that are failing and look like they were placed by a horse’s ass.” (The implants, although placed at slightly odd angulations, were actually doing quite well.) “The dentist probably missed a canal.” “The tooth wouldn’t have fractured if the post was placed right”. “I could have made this bridge look a lot better.” “Where was this bridge made, anyway (i.e., as if implying that another planet may have been a distinct possibility)?” The list could go on forever.

**We admittedly have a problem:** So what’s wrong with all this? Well, it’s abhorrent, reprehensible, repugnant, and a



*"The bridge your dentist made looks way off, and has to be remade"*

*"The bridge your dentist "made looks fine"*

lot of other bad words, but most of all, very destructive to ourselves, our profession, and our patients. The sad part is that such negative commentary and behavior toward others results in so many negatives, and among them - the potential to hurt others’ feelings, hurt another’s practice, one’s reputation, and as mentioned, incite possible litigation.

However the most significant negative of all, by far, and the one which hurts both our patients and our profession more than any other - is that it constantly and repeatedly feeds the ever-increasing and downwardly-spiraling problem of cynicism and distrust which patient’s already have regarding physicians, dentists, and their overall ability to obtain good and trustworthy medical/dental care. And the fact is, that a patient coming into our office who mistrusts us - is less likely to be responsive to our findings, undergo recommended treatment, follow our post-treatment instructions, keep follow-up appointments, or accept reassurance that certain outcomes or symptoms are “normal” - and hence, the advent of the “second opinion”- and, more likely sue us if things do not go well.

What would Goofus and Gallant say to all this? Coincidentally, I have since learned that both young boys are “grown-ups” by now, and believe it or not, chose to become dentists, and are now practicing (although not as partners - they didn’t quite see eye- to-eye on most things) in a small town in Northern Idaho.

Well, not surprisingly, Dr. Goofus tells his patient, “The lower molar that Dr. Jones treated is still infected, because the root canal was done improperly”. Dr. Gallant tells his patient, “Even if a root canal is performed very well, and in the best of hands, infection may still remain or recur in a

***"We need to choose our words carefully, think before we speak, and truly ask ourselves what goals we are trying to accomplish by speaking in such ways about others?"***

Well, not surprisingly, Dr. Goofus tells his patient, “The lower molar that Dr. Jones treated is still infected, because the root canal was done improperly”. Dr. Gallant tells his patient, “Even if a root canal is performed very well, and in the best of hands, infection may still remain or recur in a small percentage of cases”. Dr. Goofus says, “The tooth fractured because the post was too large.” Dr. Gallant says: “A tooth with a root canal can sometimes be very weak and brittle, and in a rare case, may fracture, even if everything was performed with the best of skill and intention.”

We need to heighten our awareness. We need to heighten our professionalism.

We need to choose our words carefully, think before we speak, and truly ask ourselves what goals we are trying to accomplish by speaking in such ways about others?

In situations where we may only be the unwilling listener, we also have a choice of “taking the high road” and pressing the pause-button in the conversation, while attempting to raise another’s awareness level of right versus wrong in talking negatively about others. It really gave me a good feeling recently when, in the middle of a sentence,

in which a patient was pouring their heart out to me with negative comments about their previous dentist, I just stopped - and said, “Excuse me, but does any of that information have any relevance to your treatment today? If not, I really do not feel the need to hear about it.”

We need to weigh our own selfishness and ego against what we truly derive by hurting others’ feelings, harming a practice or one’s reputation, helping to incite a lawsuit, or further erode the public’s trust in the delivery of dental or medical care.

Every day of our professional lives, we must ask ourselves, “Do we want to be a Dr. Goofus, or a Dr. Gallant?” The answer is simple. It takes a much bigger person in this world to be a “Dr. Gallant”.

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Dr. Richard Mufson is an oral and maxillofacial surgeon in private practice in North Miami Beach, Florida. A graduate of Temple University School of Dentistry in Philadelphia, PA, and post-graduate residency training program at Georgetown University Medical Center in Washington, D.C., he has published numerous articles, and has lectured extensively on the topic of HIV/AIDS and other infectious diseases. He is also Past President of the South Florida District Dental Association and current President of the Florida Society of Oral and Maxillofacial Surgeons.



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## A FUNCTIONAL IMPRESSION METHOD FOR DISTAL EXTENSION CASES

by *K. David Stillwell,  
DDS, MAGD*  
*University of Florida  
College of Dentistry*

**\*\* EXERPTED FROM A COMPLETE ARTICLE  
CURRENTLY UNDER REVIEW FOR PUBLICATION  
ENTITLED "DISTAL EXTENSION RPD FABRICATION  
EMPLOYING A FUNCTIONAL BILAMINAR  
IMPRESSION METHOD**

(\*\*Watch the 2006 AGD Journal General Dentistry for the full text article)

### THE PROBLEM-AND A POSSIBLE SOLUTION

A prosthodontic trend observed in recent years has seen many clinicians abandon border-molded custom impressions in favor of simplified final impressions using stock trays and alginate. In 1992, Leupold, Flinton, and Pfeifer completed a study which compared vertical displacement movements occurring during loading of distal extension removable partial denture bases made by three impression techniques. The impression techniques studied were 1) control casts generated from stock tray impressions made with irreversible hydrocolloid, 2) an altered cast impression made with light-bodied polysulfide rubber, and 3) a border molded custom impression tray made with light-bodied polysulfide rubber. Their research data revealed that the non-customized stock impression technique produced 187-247% greater vertical displacement than either of the customized impression techniques.

This study concluded by suggesting that the border molded custom impression tray provided comparable results to the altered cast impression technique for distal extension partial dentures, remarking that a one piece master cast made from a border molded custom tray could preclude many of the potential problems inherent with the multiple clinical and laboratory procedures required by the traditional altered cast impression technique. (1)

The Leupold study indicated that the currently popular technique of impressing distal extension areas with stock trays and alginate typically produces an RPD with inadequate soft tissue support. In clinical observations, a removable appliance constructed in this manner will demonstrate varying degrees of unacceptable

anterior-posterior rotation around the primary fulcrum line. These rotational movements are translated into traumatic leverage forces applied to the key abutment teeth and unfavorable compressive forces applied to the supporting mucosalveolar tissues. In this excerpted article, an alternative custom impression tray design is advocated for improving support in tooth-tissue borne RPD designs. The following description delineates the simple, predictable, clinically effective, and readily teachable Functional Bilaminar Impression (FBI) method for achieving functional and anatomic support for the distal extension removable partial denture.

### CONSTRUCTING THE FUNCTIONAL BILAMINAR IMPRESSION TRAY

This method, as with any custom technique, is contingent upon the generation of an accurate, well-extended preliminary impression in order to produce an exacting diagnostic cast. Begin the tray fabrication by outlining the proposed border extensions of the final RPD base on the diagnostic cast with pencil. Use the muco-buccal folds, top of retromolar pad area, height of the lingual frenum and 1 mm posterior to each terminal tooth abutment as a guide for the proper extensions. Block out any posterior alveolar ridge undercuts by flowing on a thin layer of baseplate wax. Thoroughly soften one piece of baseplate wax. Carefully adapt a double thickness of the wax over the dentate portion of the cast, extending it from the muco-buccal fold on the buccal to the muco-lingual fold on the lingual and 1 mm distal to each posterior abutment. This will create a uniform relief space of approximately 2mm around the anterior dentate portion of the cast. Carefully cut out 3mm, square definite tooth stops on the non-functional cusp tip areas of three widely separated teeth. Lightly coat any visible anatomic portion of the preliminary cast with a suitable gypsum release agent.

Apply aluminum foil over the baseplate wax, remove the foil covering the tooth stops, then very lightly lubricate the foil with petroleum jelly. Place one layer of light-cured base plate resin over the completed wax block out and the posterior edentulous portion of the cast, adapting it carefully and avoiding the tendency to thin the material. Placing a handle on the tray is optional but not advocated. Use excess light-cured base plate resin to thicken, and therefore strengthen, the first molar to first molar lingual aspect of the tray; the occlusal surface may be thickened but do not make it more than two layers in bulk.

Cure the light-cured base plate resin for 2 minutes. After the external surface has been cured, carefully lift the tray off the cast, remove the foil and any residual baseplate wax, then thoroughly cure the intaglio surface of the tray. After complete curing, trim back and assure that the peripheral borders are smooth and extended to the proper length and thickness. The internal tissue side of tray must be completely debrided and slightly roughened so that the adhesive and impression material will properly adhere to the impression tray. Preserve the internal tissue stops. The

completed tray should be carefully checked on the preliminary cast to insure that the tray demonstrates complete stability and exhibits sufficient rigidity in order to resist flexing during the final impression adaptation and removal procedures.

## **MAKING THE FUNCTIONAL BILAMINAR IMPRESSION**

### **A. FUNCTIONALLY RECORDING THE EDENTULOUS ZONES**

At the tooth modification appointment, evaluate the functional bilaminar custom impression tray intra-orally. Correct any under-extension of the tray flanges as necessary with stick compound, self-curing acrylic resin, or light-cured base plate resin. If desired, selective pressure can be applied to the primary support areas by application of compound, acrylic, or light-cured resin. Next, trim all distal extension tray flanges 1 - 2 mm short of the ideal vestibular depth and proceed by applying a polyvinylsiloxane (PVS) elastomeric impression material liquid adhesive to the intaglio surface of the impression tray that covers the posterior edentulous areas only. Apply a layer of heavy bodied PVS impression material, covering only the posterior edentulous areas of the tray. Quickly and completely, seat the impression tray into the proper intra-oral position, guided by the internal stops within the tray. Hold the impression tray in place while conducting "border molding" of the tray periphery.

After hard set, remove the impression tray from the oral cavity and cut back any material that extends beyond the buccal and/or lingual extent of the tray. Relieve any undesirable tray "show through" areas carefully with an acrylic bur. Remove any material that extends anteriorly into the anterior dentate portion of the impression tray. At this time, there should be no heavy bodied PVS material in contact with any tooth surface or tooth-containing alveolar ridge surface (where the major connector will reside) in your tray. Use acrylic burs and handpiece to carefully remove the internal stops completely from the inside of the anterior portion of the tray, taking care not to excessively thin out the tray in these areas. Apply PVS tray adhesive to the inside of anterior portion of the tray. Do not apply liquid adhesive to the initial layer of heavy-bodied impression material in the distal extension area of the tray. Instead, carefully dry the distal extension areas so as to minimize the risk of de-lamination of the secondary impression material.

### **B. RECORDING THE SECONDARY ANATOMIC IMPRESSION**

If necessary, block out all unfavorable tooth anatomy and severe soft tissue undercuts with a suitable material. Proceed to isolate and dry the oral cavity. Load the anterior and posterior segments of the tray with medium viscosity PVS impression material, inject the rest seat preparations and all significant axial tooth contours with medium (or light) viscosity PVS, then insert the loaded impression tray into the oral cavity. Maintain balanced seating pressure on the elevated dentate portion of the impression tray while assuring good contact in the distal extension areas of

the tray until the material has polymerized. Conventional border molding movements should again be executed during the secondary impression setting reaction. Upon removal and inspection of the finished impression, note any areas of "show through" of the heavy bodied preliminary PVS material as areas of probable excess tissue pressure, indicating the need for internal relief of the completed prosthesis. Box the final impression, and pour the master cast using die stone. After the appropriate setting interval, carefully recover the final master cast. To avoid master cast damage in difficult or delicate situations, soak the cast/impression tray assembly in very hot water in order to reduce resistance to removal; occasionally, it is necessary to section the impression tray into multiple segments to free the master cast so as to avoid breakage. Trim the recovered cast, preserving proper horizontal and vertical land areas along with all functional and anatomic regions registered by the functional bilaminar impression.

At this point, a decision must be made to: 1) construct record bases on the new master cast in order to obtain interocclusal recordings to allow accurate mounting of the case prior to construction of the RPD framework, or 2) construct the RPD framework, then appoint the patient for a framework try-in immediately followed by application of record bases for the purpose of obtaining the appropriate interocclusal recordings. The clinician will be required to properly assess the patient's current condition and needs and then make a clinical decision as to the proper sequencing of events on a case-by-case basis.

## **CONCLUSION**

Dental educators and practicing clinicians have access to many dental texts, reference journal articles, and continuing education courses that define excellent prosthodontic techniques for RPD fabrication. These procedures normally provide very acceptable clinical results, but the techniques are often considered to be too time-consuming and difficult for routine use in practice. A new practitioner, often lacking experience and having background knowledge in only in those time-consuming and often technique-sensitive methods, may find removable prosthodontics frustrating and costly, leading one to abandon a badly needed patient-centered clinical procedure. It has been observed that the functional bilaminar distal extension custom tray impression is routinely manageable at the chairside, the tray can be readily produced by a trained dental auxiliary or dental laboratory, and the technique produces a master cast with excellent functional and anatomic detail which typically results in a properly supported final prosthesis.

## **REFERENCES**

1. Leupold, Richard J., Flinton, Robert J. and Pfeifer, David L. Comparison of Vertical Movement Occurring during Loading of Distal-Extension Removable Partial Denture Bases made by Three Impression Techniques. *J Prosthet Dent* 1992: 68 (2), 290-293.



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