PUBLISHED BY THE AMERICAN ACADEMY OF IMPLANT DENTISTRY / 2021 ISSUE 1

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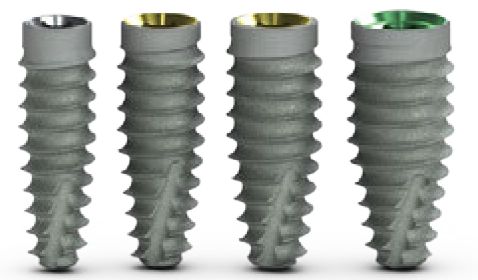

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EDITOR'S NOTEBOOK

Dennis Flanagan,
DDS, MSc, FAAID, DABOI/ID

Dental school should be six years ...it's time to raise the bar.

Since my graduation from Georgetown University School of Dentistry 50 years ago, the science that supports our beloved profession has expanded dramatically. There are technological advancements in basic sciences and clinical sciences. As well, dentistry has entered a digital phase that is revolutionizing the field. Dentists have become biomedical engineers who correct the ravages of biological disease and trauma.

The technological basis of dental treatment has expanded exponentially. Dental school education covers the biological, biochemical, and mechanical aspects of human oral treatment. For example:

- Basic sciences teach the rationale that underlies treatment.
- Anatomy teaches the location and structure of organs that we would alter or remove during treatment.
- Biochemistry teaches the basis of pharmacological therapies.
- Chemistry teaches us how to utilize therapeutic tools to alleviate pain and restore oral function.

For a young student with no experience in life science or oral clinical science there is much to learn. Once the basics are taught, it takes clinical experience to advance these skills so that a practitioner has the confidence to render a correct diagnosis and the most appropriate treatment. Dental school is a left and right brain experience. We learn the theoretical status of "normal" and conditions of pathology. Different patients can present with a non-uniform set of signs and symptoms for the same disorder. Clinical experience couches the didactic in real-life situations that include patient interpretations. Implementing our didactic left brain to treat pathologic conditions takes experience to understand the consequences of the treatment. It takes four years to learn the basis of "normal" and pathologic conditions. It may take an additional two years to implement that knowledge into excellent patient care.

Other things that could affect how patients are treated include technicians, or mid-level clinicians, who would perform routine dental procedures. A clinical technician's education may consist of two years of training in reversible procedures. (Of course, these technicians should be under the direction of a licensed practitioner.) This career could be an excellent choice for many people, but we must consider whether this is the best treatment for the patient. Additionally, insurance companies may decide that it is okay to pay lower reimbursements for these treatments. Another consideration is laboratory fabrication, which is becoming highly mechanized through digital technology. Dental technicians use guided automatons in the manufacturing of dental prostheses, surgical guides and more.

But will patients be okay with paying a lower rate for these treatments by a less educated clinician? For some the answer will be yes.

I believe that patients will continue to seek the care of a trained and licensed dentist. This is part of the reason that dental school should be extended. General dentists would be more highly trained and experienced. Advanced trained dental specialists, beyond six years, could perform complex surgeries and complicated cases. The general dentists would perform surgical extractions and other minor surgeries more effectively with a six-year education. It is time to raise the bar for dentistry. There are social and political pressures to make our beloved profession streamlined, efficient and cost effective. In fact, society is demanding it.

Access to care is another benefit that this extended education could address. Utilizing clinical mid-level clinicians may accommodate more patients in underserved rural areas and cities. A six-year trained dentist could treat most oral and dental issues with fewer referrals. This may be important when specialty care is unavailable or geographically inconvenient. Specialists will still be needed for complex cases that need true specialty treatments.

The two-year clinical education could be completed at approved hospitals, clinics, and universities. This is indeed an enormous undertaking, but such a change is much-needed. Funding could partially be defrayed with fees created by the post-graduates.

It is time for us to implement these changes now, before the political process forces change on us. Some dental schools are considering these changes, but the rank and file need to demonstrate an interest in these changes to provide an appropriate impetus. We should all be a part of this so as not to allow discomfortable policies to be instituted.

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PRESIDENT'S MESSAGE

I need a hug!

Duke Heller,
DDS, FAAID, DABOI/ID
2021 AAID President

COVID has changed the way I show affection to:

- My *children and my grandchildren* living outside of my house, who are either coming home from college or are married and coming home to visit with their families.
- My *friends* who I meet for breakfast or lunch. We both come into the restaurant wearing masks and can't wait to take them off so we can see each other's TEETH and smiles.
- My *patients*—some who are my really good friends—or new patients who I am limited to an "elbow touch" or a "fist bump." It really stinks because I prefer to get to know them before providing care.

We found out how much we really needed a hug from our mom, dad, sister, brother, or just a really good friend. And what about those with elderly parents who live alone or in nursing homes?

Some of us had to say goodbye through the window. I sure wish I could have *hugged* them goodbye!

COVID has brought me to experience **nomophobia**, fear of disconnectedness.

- Our kids and grandchildren would identify it as being without their phones more than ten minutes, even five minutes!
- I would identify it as being without a **Hug** from the people I so enjoy being with and truly do like to show my affection with a **HUG!**

Aloneness produces three things in our lives:

1. The disconnection of isolation: living a life of being alone. We are told 27 percent of people live alone in the United States. The other 73 percent live with others at home and/or interact with people at work.
2. The disconnection of infidelity… from friends/relatives…especially family members. I am not able to show my grandchildren my love because my grown children feel I could be bringing COVID home from the office….and giving it to them.
3. The disconnection of interference…. being treated as an enemy or "an invisible enemy." Staff members have left the dental office because they fear they will get COVID at the office and others because they refuse to get the vaccine to protect themselves or patients.

Has COVID brought any benefits?

One possible benefit is that COVID motivates us to come out of isolation and to start rebuilding our relationships and our practices.

One way to rebuild is to let people know that you are moving forward but doing so with "an abundance of caution" because it is important to get back to normal.

Here are some other ideas:

1. I will hug my children and grandchildren for a longer period of time and enjoy it much more.
2. I will have a greater appreciation for companionship; especially with my blood relatives, but also with my patients.
3. We live in a country that is producing a lot of vaccines for you, me, and our families, friends, and patients.
4. I think more often about how important it is for me to treat others the same way I want them to treat me.

Remember: Perhaps the most important way COVID has impacted all of us is to remind us that we are blessed to live in a great country and have so many dentist friends in other countries that are also blessed.

Tell me how COVID has made you more aware that ***you need a hug***.

We can all look forward to November 10 to 13, the AAID's Annual Conference in Chicago and our 70th anniversary. I look forward to seeing you in person.

You owe me a hug…
in person….be there!

Share with me some of the ways COVID has made you more aware of being isolated from your family, friends, and patients? Email me at *president@aaid.com*.

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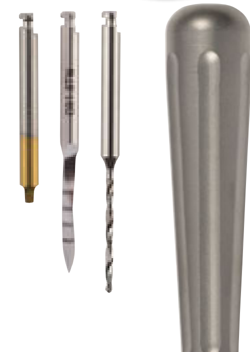

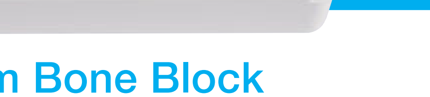

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Mandatory COVID-19 Vaccines for Dental Office Staff?

Considerations for Policy Implementation

By Katie Przychodzen, MA

Despite a frustratingly slow start, distribution and administration of the COVID-19 vaccine has been ramping up in recent months. According to the *New York Times*, President Biden Administration's latest update on vaccine availability confirms that there will be enough shots for every adult American by the end of May 2021. As the vaccine continues its rollout across the country and around the world, many business owners, including dentists, are wondering whether they should—or if they legally can—require their staff members to get vaccinated.

In addition to whether to require the vaccine, there are several other things practitioners are asking themselves: How do I develop a vaccination policy for my practice? What is the best way to communicate the policy to my staff? What are the potential risks involved? What happens if a staff member refuses the vaccine?

According to Amber Clayton, director of the Society for Human Resource Management's HR Knowledge Center, in Rasheeda Childress's March 2021 piece, "What To Consider When Crafting COVID-19 Vaccine Policies," the time is ripe for engaging in the process of drafting vaccine policies: "Employers should be thinking now about what's going to happen when the vaccine becomes widely available," Clayton says. There are several important issues to consider as you go about crafting your own in-house vaccination policy.

The Role of Federal and State Governments

Let's start with the basics: Is it legal to mandate any vaccination for U.S citizens? The answer is "yes" and these requirements are historically under the purview of individual states. For example, all 50 states require immunizations for children to enroll in public school (all have exemptions for medical contraindications), though specific mandates vary from state to state. It is the responsibility of the federal government—specifically the Centers for Disease Control (CDC) and the Food and Drug Administration (FDA)—to provide scientific recommendations and to regulate the safety of vaccines, respectively.

The next question then becomes whether states can require people to get vaccinated against COVID-19. When it comes to the three vaccines authorized thus far—Pfizer/BioNTech, Moderna, and Johnson & Johnson—the answer is "no." This is because so far all three have only been approved under an Emergency Use Authorization (EUA) and as such cannot be legally mandated. A November 2020 Occupational Safety and Health Administration (OSHA) report on the legality of

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mandated vaccines asserts that "Any COVID-19 vaccine brought to market under an EUA instead of the normal non-emergency approval process will, by necessity, lack long-term safety data." This long-term data is necessary to establish a mandate for any immunization.

The same report goes on to complicate the issue further, explaining that "…outside the context of EUA vaccine, employers *can* require vaccination as a term and condition of employment, but such practice is not without limitations, nor is it always recommended." According to Katharyn Edwards, RDH, writing for *Today's RDH* in January 2021: "It is clear that vaccination requirements will likely come from individual employers after assessing the risk level for their employees rather than federal or local governmental agencies." She adds that courts are likely to get involved in the coming months when they hear mandated vaccination cases and rule on their legality.

John C. Minichetti, DMD, FAAID, DABOI/ID, of Englewood, New Jersey, rightly points to yet another layer of ambiguity—namely, the still-limited supply of doses: "State laws may [eventually] allow some employers to require vaccinations, but even hospitals cannot consider enforcing now with such short supply of the vaccines."

So, what does all this mean for dentists and their staff? It might be helpful, suggests Shane Samy, DMD, FAAID, DABOI/ID, of Eugene, Oregon, to take a step back from the legalities and reframe the question of whether dentists can mandate vaccines for staff to *should* they make this a requirement. With this reframing, though, comes another set of considerations.

The Potential Risks of a Mandate

Dr. Samy believes that dental clinicians (especially dentists) have a moral and ethical obligation to protect their patients by getting vaccinated. "While dental offices have been taking proper precautions against the disease, including use of personal protective equipment (PPE), advanced air filtration systems, patient screening, etc., there is no doubt that the vaccine is key to reducing COVID-19 transmission," he says.

The benefits of vaccination obviously do not stop at dental patients. "COVID-19 poses a direct threat to employees in high-risk positions. Aerosols created during dental procedures place dental team members in this type of high-risk environment," writes Katharyn Edwards.

The CDC has confirmed that dentists, dental teams, and dental students will be among the first to receive the COVID-19 vaccine. Nevertheless, we must acknowledge that having access will not automatically translate to everyone rolling up their sleeves. Recognizing the hesitation of some to get the shot—even in the face of numerous scientific studies affirming and reaffirming its benefits and safety—might make it tempting for dentists to implement an across-the-board vaccine requirement for staff. Yet it is worth exploring the potential risks involved in instituting such a policy.

In February 2021, Rebecca Boartfield and Tim Twigg write in *Dentistry IQ*: "Employers with mandatory vaccine policies may be confronted with a backlash from employees for any number of reasons—everything from an employee being an 'anti-vaxxer,' to something more serious such as a medical condition that specifically prevents, limits, or restricts someone from receiving the vaccine."

Recognizing the hesitation of some to get the shot—even in the face of numerous scientific studies affirming and reaffirming its benefits and safety—might make it tempting for dentists to implement an across-the-board vaccine requirement for staff. Yet it is worth exploring the potential risks involved in instituting such a policy.

Boartfield and Twigg explain that having a mandate does not mean the employer can ignore employee concerns; in fact, each concern must be examined, and the employer will have to decide whether the employee is entitled to an exemption. For example, exemptions can be made based on religion or medical/disability accommodations. Reasonable accommodations may include allowing an employee to work remotely or take a leave of absence. In addition, employers cannot retaliate against any employee for bringing up their concerns. Even the appearance of retaliation can be problematic and have legal consequences.

According to the American Dental Association's *COVID-19 Vaccines in the Dental Workplace: FAQs for Employee Dentists*, updated January 2021, "If the practice has 15 or more employees, any staff vaccination requirement would be subject to federal legal requirements to accommodate disabilities, including pregnancy-related disabling health conditions… under the Americans with Disabilities Act (AwDA), as well as genuinely held religious beliefs and Title VII of the Civil Rights Act of 1964 (Title VII)."

Any vaccine requirement must be job-related, critical to the functioning of the business, and as minimally intrusive as possible. While healthcare workers normally meet this standard as it relates to the COVID-19 vaccine, accommodations must be made under the AwDA unless the employer can demonstrate that such an accommodation would cause undue hardship,

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COVER STORY
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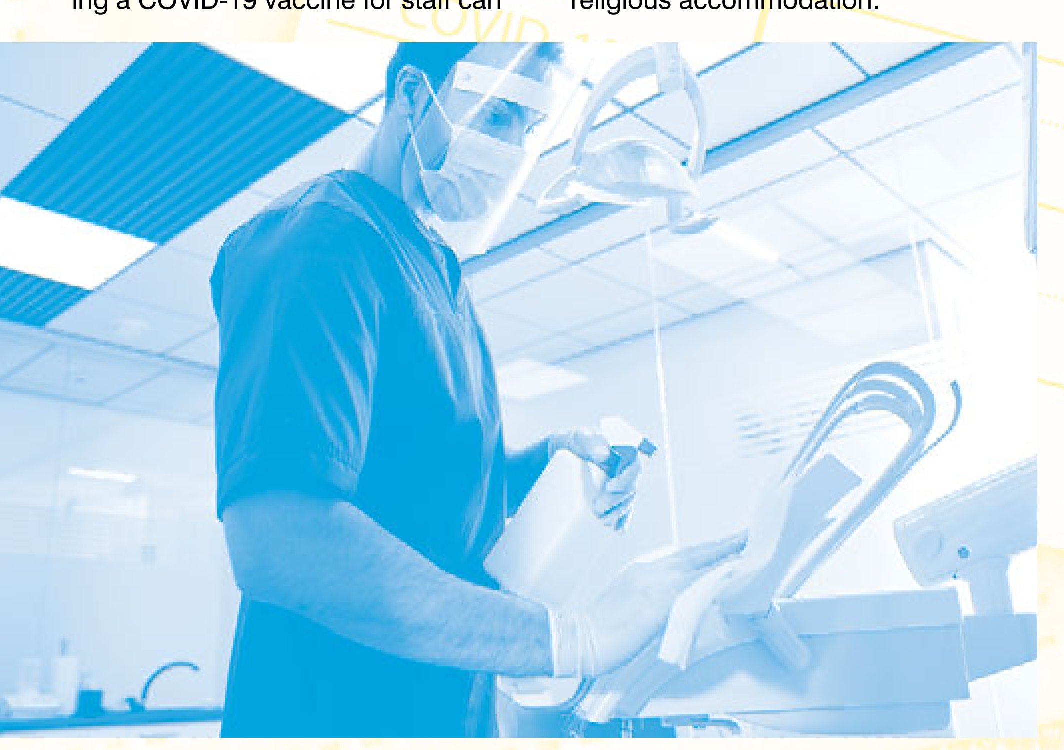
in the form of significant difficulty or expense, and that there are no feasible alternatives. Additionally, per the California Dental Association (CDA) in January 2021, employers who require their staff to get vaccinated must consider the possibility of negative health outcomes: "Should an employee experience health complications after receiving the vaccine, this would likely be considered a workplace injury under workers' compensation."

Finally, an examination of these standards necessarily brings up the issue of which office roles require direct patient contact and which do not, and how this difference will inform vaccination policy decisions.

Taking all of this into account, mandating a COVID-19 vaccine for staff can lead to tough decisions and even legal repercussions. But what if you weigh all these challenges and still want to require a vaccine?

Center for Drug Evaluation and Research (CEDR) Compliance officer Nora Gustafson, writing for the CEDR HR Solutions *HR Basecamp* newsletter in February 2021, says that in addition to being responsible for the cost of employees' vaccines and their time spent getting the vaccine, employers must enforce their vaccine policy consistently; keep all employee vaccination records in a separate, confidential medical personnel file; and "[c]reate a written policy that explains the compelling reason for requiring the vaccine, the process, confidentiality measures, and how to seek a medical or religious accommodation."



The Case for Educating Versus Requiring

In the January 2021 issue of Society for Human Resource Management *Employee Relations* newsletter, Daniel Kadish, an employment attorney at Morgan Lewis, recommends that employers avoid instituting COVID-19 vaccination requirements until the FDA grants them full (non-emergency) approval. By waiting for full FDA approval, employers can decrease risks associated with employees' fears about the vaccines' emergency status.

Whether you as an employer decide to postpone a vaccine requirement for staff or decide that navigating all the challenges posed by a vaccine mandate is too risky, there is nothing wrong with doing your best to encourage staff members to get vaccinated.

Amber Clayton points out that some employers are offering encouragement in the form of financial incentives such as paid time off, bonuses, and even gift cards. She cautions employers that, while these might prove popular among staff, these sorts of incentives might not be entirely appropriate, adding that we should wait for the Equal Employment Opportunity Commission (EEOC) to issue guidance on the subject.

The safest bet, according to many experts, is to provide encouragement to staff in the form of meaningful education on COVID-19 vaccination. CEDR HR Solutions, in its February 2021 post, "Can I Make Vaccines Mandatory

For My Employees?" suggests: "Inform your employees about the importance of being vaccinated and the safety of the vaccine during team meetings, and provide them with convenient ways to get more information, should they need it."

Childress also suggests that, as you start developing a comprehensive educational program, it might be helpful to conduct an anonymous staff survey to gauge their willingness to get the vaccine and assess the reasons for any possible hesitations. You can then use their survey answers to inform the framework of your educational program, rather than trying to guess how to make it most effective.

Another form of education is leading by example. You, as an employer, can encourage your employees to model your behavior by communicating to them your own vaccination plans, as CEDR HR Solutions points out: "The more your team members see individuals in their inner circle getting vaccinated safely and moving on with their lives, the more the stigma surrounding the vaccine will diminish, which will make your skeptical employees more inclined to get vaccinated themselves."

As for what happens if an employee still refuses to get vaccinated, even after you encourage them to do so through comprehensive education, Dr. Samy suggests that all employers consult an employment law attorney in their respective state.

There are many important factors to consider when developing and implementing a COVID-19 vaccination policy for your dental practice. This article addresses some of these considerations, yet more will surface in the coming weeks and months as the vaccine becomes more widely available and additional guidance is issued. Visit the AAID COVID-19 Information and Resources page at *aaid.com/membership/AAID-Update-and-Resources.html.*

Katie Przychodzen, MA, is the AAID's Marketing and Communications Coordinator.

You, as an employer, can encourage your employees to model your behavior by communicating to them your own vaccination plans..."The more your team members see individuals in their inner circle getting vaccinated safely and moving on with their lives, the more the stigma surrounding the vaccine will diminish..."

Additional COVID-19 Vaccine Resources

The CDC has created the very useful *Customizable COVID-19 Vaccine Content for Essential Workers* (updated February 2021). This toolkit is designed to provide employers of essential workers with customizable templates of different types of materials to share with employees—including letters, newsletter posts, FAQs, a slide deck, posters/flyers, and more—to encourage COVID-19 vaccination. You can access the CDC toolkit at *cdc.gov/coronavirus/2019-ncov/vaccines/toolkits/essential-workers/newsletters.html#employers.*

According to Becker's Dental + DSO Review in February 2021: "Dentists in at least 20 states are approved to administer the COVID-19 vaccine, helping the U.S. health care system curb the spread of the pandemic, according to the American Dental Association."

Check out the interactive map (*success.ada.org*) created by the ADA, showing which states have authorized dentists to administer the COVID-19 vaccine. The map also shows the vaccination plan phase during which dentists in each state will have access to the vaccine.

Learning How to Manage Risk Management

By Frank R. Recker, DDS, JD
Chief Counsel, First Amendment,
Specialty Matters

As one might expect, I receive countless telephone calls from dentists throughout the country, asking questions related to a host of issues, most dealing with risks they encounter in their own dental practices. The other day I encountered such an inquiry, dealing with a subpoena issued by the practitioner's state dental board. The subpoena commanded him to appear at a certain date and time and to bring six specific months of his appointment book to the board office. He asked if that was a normal procedure for a dental board and whether or not he should comply with the subpoena.

Most state dental boards are given a broad array of disciplinary tools to deal with a multitude of dental matters. Some include as a basis for discipline, the failure to cooperate in a board investigation, such as responding to a subpoena.

What rights do you have if you want to challenge the legality of a subpoena? It is important to note that this could put you at risk and you might be accused of failure to cooperate in an investigation. Dental board might ask for your appointment book if they have received a patient complaint about a crown.

A subpoena for an appointment book that notes scheduled procedures could lead to an additional request for all patients who might have had the same procedure performed during a certain period. The appointment book subpoena sometimes is a start if the board is looking for additional information.

When I address any board in a disciplinary proceeding, in looking through anyone's patient records, I could find a multitude of deviations from the standard of care. They might include an endo that was short 2 mm, a third canal not sufficiently obturated, a patient chart that did not contain adequate notes about medications being taken, a failure to note precisely the local anesthetics used, quantity, mgs, or the rationale for any prescription dispensed. Or, a third canal not obturated to the end, a chart that did not make sufficient notes about meds being taken, a failure to note precisely the local anesthetics used, quantity, mgs, or the rationale for any prescription dispensed.

There are wide variations in how states process complaints they receive. Some will accept, and act upon, anonymous complaints taken over from phone calls. Others may require a written statement by the complaining party, signed and notarized. And the rights of the dentist being investigated are disparate among the states.

There are wide variations in how states process complaints they receive. Some will accept, and act upon, anonymous complaints taken over from phone calls. Others may require a written statement by the complaining party, signed and notarized. And the rights of the dentist being investigated are disparate among the states. In Ohio, for example, you have very limited rights to discovery. The biggest loss without discovery is knowing what witnesses are going say about the issues against you, the basis for them, and what connections (if any) they have had with any board members or dentists.

Most insurance companies have a provision that covers regulatory agency defense (at least up to $25,000), they will choose the law firm and typically you are unable to have a say in the attorney selection process. Those who choose retain an experienced dental malpractice defense attorney will do so out of their own pockets, but in so doing choose an expert who understands the issues at hand.

There are so many facets related to risk management. The first tenet of dental risk management: Know what you're doing before you do it. When you give treatment plan options, think about what you should be referring out and what you can competently do yourself. If you want to learn more, read several depositions from dental malpractice suits, as they are almost always public records. When you put yourself in the chair of the defendant/dentist, you will see the defendant is asked to describe the purpose and dosage significance for each medication the patient was taking, as described on the medical history, the significance of the dosage, the potential relationship to what you eventually prescribe, the procedure you performed, and so on. Especially important are medications related to the heart or any chronic condition, control of diabetes, and smoking.

In short, (if it's already not too late) remember the words of a wise Clint Eastwood: "A man's got to know his limitations." Amen, Clint.

Editor's Note:

Dr Recker's article reminds us to appropriately document each patient encounter, including telephone calls. Details are good but some details may be inappropriate. Patient quotations are appropriate and may become important. Keep calm even if a patient becomes hysterical or argumentative. Stoicism is an excellent strategy to embrace. Keep abreast of the technological advancements in dentistry but it may be best to not be the first clinician to use it nor be the last. Keep in mind that attorneys have little or no knowledge of dentistry and thus their opinions and defense may be inadequate. There are dentist/attorneys who would be willing to help if trouble arises.

By Roger P. Levin, DDS

Dental Implant Case Acceptance: Helping Patients See the Value

Dental implants are an interesting service from a case presentation standpoint. Some patients feel they're absolutely essential while others believe they are completely elective. Some patients make decisions based on being able to easily afford implant dentistry, while others work hard to pull together the funds. Finally, some believe they are for the wealthy and others believe they benefit everyone equally. Since their introduction in the middle 1980s, implants have continued to make progress as a standard of care but are viewed differently from other dental services and, as such, should be treated differently from a case presentation standpoint.

The Four Challenges with Dental Implants

1. **Single-tooth treatment.** Based on Levin Group's observation, about 80 percent of general dental appointments are for single-tooth treatment. While we believe that an optimal rate for single-tooth treatment (to maximize total practice production) is more in the 55 percent range, the main point is that most practices rely on smaller procedures because patients easily and frequently accept them. Psychologically this often leads the dentist and team to pat themselves on the backs because the practice ends up achieving a high case acceptance rate. And while this may be *technically* accurate, their case acceptance is only high because the procedures aren't costly, time-consuming, uncomfortable, or based on a certain amount of recovery time. This is all great for patients, but it offers much lower revenue for the practice.

   Presenting a case to an implant patient is a completely different scenario. First, the costs are simply higher. Although dentists often feel that their implant-related fees are fair and reasonable, and something a patient would benefit from and should accept, many patients look at the expense and not the benefit. Even if most practices reduce their implant fees by 20%, it's unlikely that they would have higher implant case acceptance *if that were the only step taken*.

2. **Knowledge and familiarity.** If you ask most patients what an implant is made of, how it works biologically, how long it will last, or the benefits of implants, they will probably look back at you with a blank face. Most people know that implants replace teeth, but most don't know the extensive benefits and quality of life enhancement that implants provide. This leaves them believing that getting full dentures, having a partial, or even doing nothing are all options that may be acceptable, less expensive, and have similar benefits.

3. **Dental insurance.** Most implants aren't covered by dental insurance. One of the reasons that so many dental appointments are single-tooth procedures is that most single-tooth procedures have

If you want a patient to spend more than they expected, to go out-of-pocket if there is no dental insurance, and to go through the time, trouble, and relative inconvenience of having implant treatment, then you need to provide them with good reasons. Those reasons can be accentuated in an extremely positive manner if they are presented with enthusiasm.

some level of dental insurance coverage. Patients have been conditioned by their medical insurance provider to only take advantage of a treatment covered by their insurance plan and that everything else is a luxury. As a result, this mentality extends to dental insurance and many people will ignore or postpone other procedures that would benefit them. The problem with this postponement mentality is that they often never get back to it.

4. **Case presentation.** There are some people who will automatically demand an implant to replace a missing tooth, but they don't represent most of the population. Most patients must be approached with the right level of information, value building, compassion, financial options, and support. They have questions that often go unasked and unanswered in an implant case presentation. One of the main reasons for this challenge is that dental practices often approach the implant case presentation in the same way they would

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Business Bite

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Dental practices often approach the implant case presentation in the same way they would present a restoration, crown, periodontal treatment, or other basic service. However, implants for many patients are not a basic service, and this leads to the challenge of patients not understanding why they should go through the time, trouble, inconvenience, and expense of having dental implants placed.

present a restoration, crown, periodontal treatment, or other basic service. However, implants for many patients are not a basic service, and this leads to the challenge of patients not understanding why they should go through the time, trouble, inconvenience, and expense of having dental implants placed.

The Two Most Important Factors in Implant Case Presentation

It is beyond the scope of any one article to go through every step of an implant case presentation. There are numerous important components to the process. Most implant treatment coordinators or doctors have no training in this area and don't map out their entire approach to presenting implant cases to patients. In reality, it requires two to three full business days to fully understand and be trained in implant case presentation, but there are two things you can do right away that will make a difference.

1. **Listen carefully.** You should start by understanding the patient's knowledge base and perspective before jumping in with any presentation. Ask questions that will tell you how much the patient knows about dental implants, the benefits of dental implants, and the consequences of not having them. It will make them feel good to be understood, but in this case the understanding is more for the benefit of the doctor or implant treatment coordinator presenting the case. You can approach dental implant patient education from many angles, but the angle selected should be based on what the patient knows. How would you respond to the following comments from a patient?

   - I want an implant to replace this tooth.
   - How much are they?
   - I really don't like surgery.
   - I hear they only last about 10 years.
   - How many of these have you done?

   These and other questions and comments are very common. By asking questions first and understanding their perceptions, then talking with the patient about those questions, you can tailor the case presentation to meet their needs in order better motivate them to move forward.

2. **Enthusiasm.** Enthusiasm is a critical component when presenting treatment for more expensive and possibly elective procedures. If you want a patient to spend more than they expected, to go out-of-pocket if there is no dental insurance, and to go through the time, trouble, and relative inconvenience of having implant treatment, then you need to provide them with good reasons. Those reasons can be accentuated in an extremely positive manner if they are presented with enthusiasm.

   In a nutshell, be excited for the patient. Pretend this is your mother having an opportunity to improve the quality of her life. You would be excited for her and make comments about how great it will be and that it will be worth it—and in the end, a patient must believe that it is worth it.

   Enthusiasm can overcome many deficits in case presentation and one of the biggest is being flat or robotic. Not that I recommend it, but you can probably get away with being flat and robotic when presenting most single-tooth procedures—not so much for dental implants.

There are challenges that should be considered regarding implant case presentation and understanding these challenges will help you view these presentations in a new light. By listening carefully, asking questions, and giving enthusiastic answers, you'll end up with patients believing implants are worth it and your case acceptance will rise.

Roger P. Levin, DDS, is the CEO and Founder of Levin Group, a leading practice management consulting firm that has worked with over 30,000 practices to increase production. A recognized expert on dental practice management and marketing, he has written 67 books and more than 4,000 articles and regularly presents seminars in the U.S. and around the world.

To contact Dr. Levin or to join the 40,000 dental professionals who receive his Practice Production Tip of the Day*, visit* levingroup.com *or email* rlevin@levingroup.com.

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Editor's Note: Because of busy schedules, you may not have time to read the dozen or so articles in each issue of the *Journal of Oral Implantology*. In this section of *AAID News*, we selected a few articles that have broad applicability to the daily practice and provide a brief summary of key points so you can decide if you wish to read the complete article. The following articles are from Volume 46, Issue 6 (2020).

RESEARCH ARTICLE

Cleaning Efficacy of Poly-ether-ether-ketone Tips in Eliminating Cement Remnants Around Implants With Different Abutment Heights

Screw-retained or cement-retained restoration types are preferred for fixed implant prostheses. In a recent systematic review, it was concluded that no statistically significant difference in survival or failure rate was found between these 2 types of restorations. However, cement-retained restorations are commonly preferred over screw-retained devices because of their lower cost, technical sensitivity, and superior esthetics. Furthermore, dentists are generally more familiar with cementation procedures. In contrast, cementation procedures present inevitable problems such as difficulties eliminating all entire cement remnants from peri-implant soft tissues. Excess/residual cement was established as a risk factor for multifactorial peri-implant diseases by the American Academy of Periodontology. Cement remnants can cause peri-implant inflammation/infection and bone resorption because of foreign body reactions. Residual cement may also become a mechanical irritant or a reservoir for bacteria because of the rough material surfaces. Novel cementation methods or effective cleaning techniques and materials may prevent the problem of excess cement. Poly-ether-ether-ketone (PEEK) was commercialized in the 1980s. Since then, it has been used for different

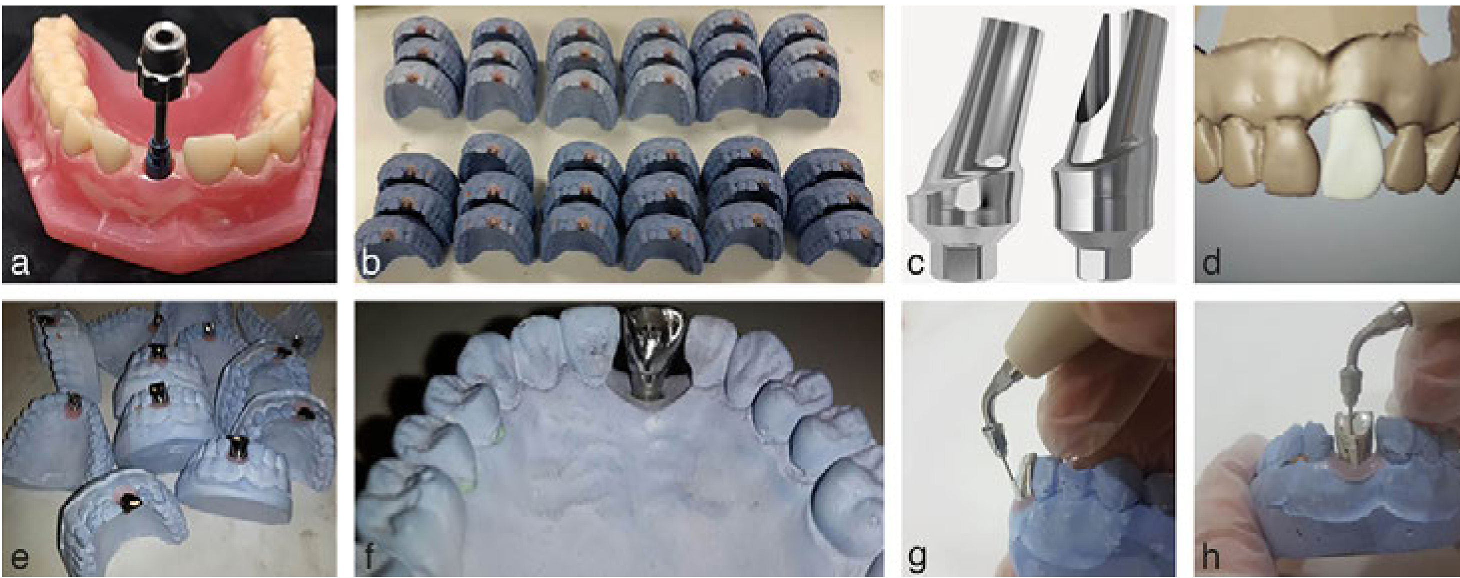
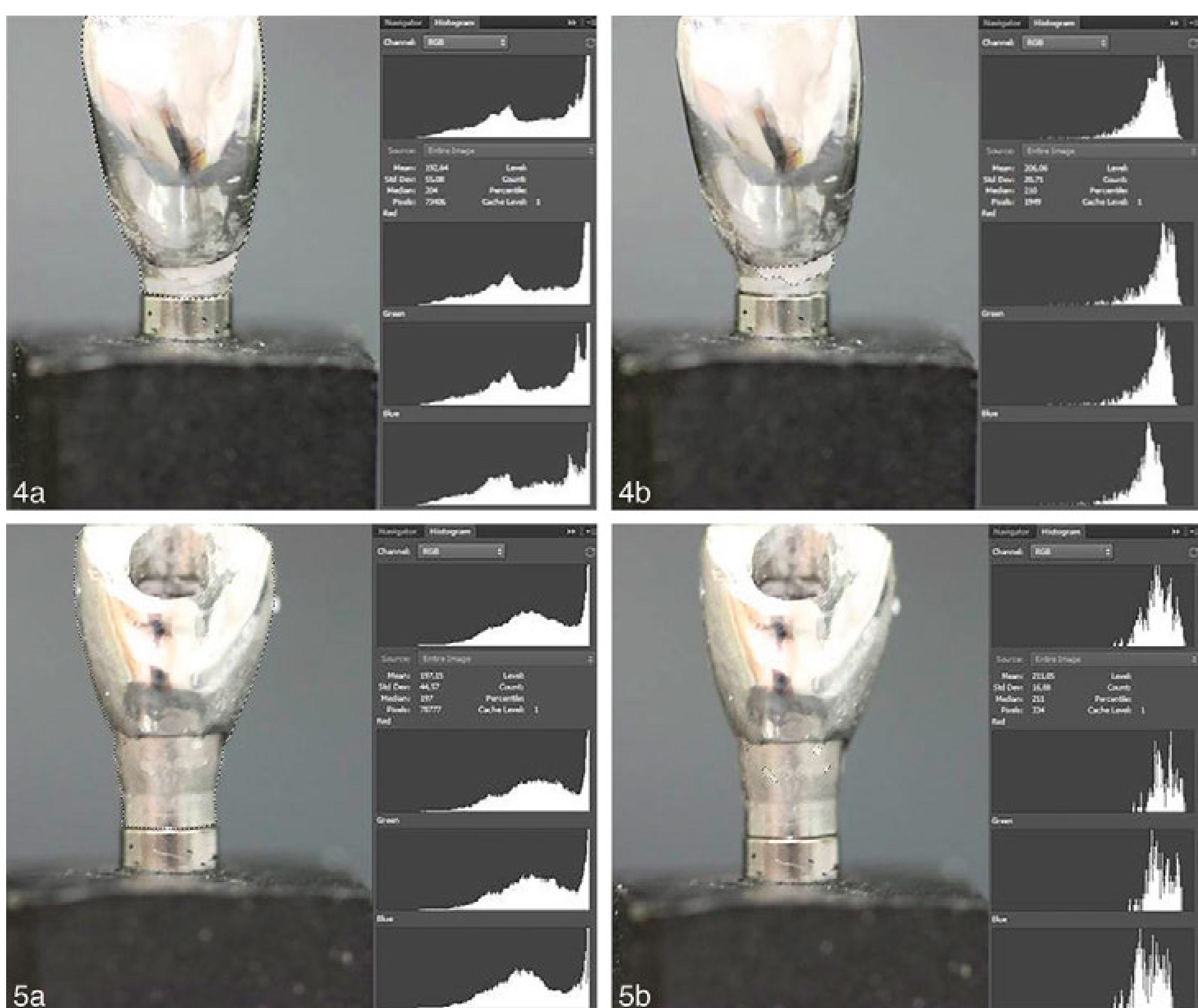


FIGURE 1. (a–h) Laboratory steps of the study.



FIGURES 4 AND 5. FIGURE 4. (a) Total surface area of buccal site of the abutment/restoration is marked. (b) Cement remnants on buccal site of the area in group 1. FIGURE 5. The 2 types of prosthetic abutments with different location of cementation margins. (a) Total surface area of lingual site of the abutment/restoration is marked. (b) Cement remnants on lingual site of the area in group 4.

medical purposes such as orthopedic and spinal implants or as prophylactic instruments for dental implants. The effectiveness of ultrasonic plastic tips (PEEK) was tested for implant prophylaxis with superior results compared with classic plastic curettes.

Therefore, the objectives of this study were as follows: (1) to evaluate the amount of residual cement at various abutment margin locations and (2) to test the cleaning efficacy of PEEK tips after cementation.

Cenker Zeki Koyuncuoglu, DDS, PhD, Haluk Baris Kara, DDS, PhD, Sinan Akdemir, CDT, Becen Demir, DDS, PhD, Nadin Al-Haj Husain, Mutlu Özcan, DDS, DMD, PhD, *Journal of Oral Implantology*. 2020 December; 46(6):548-544.

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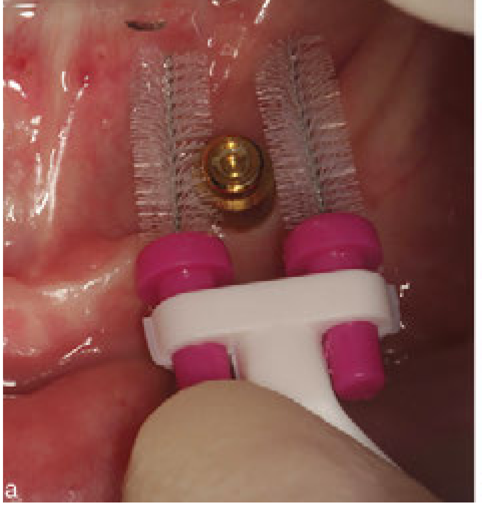
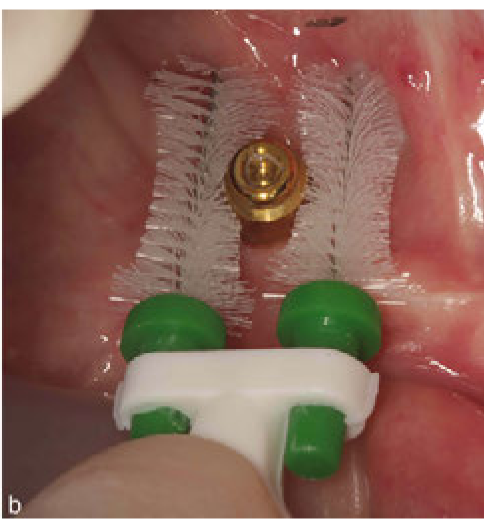
CLINICAL ARTICLE

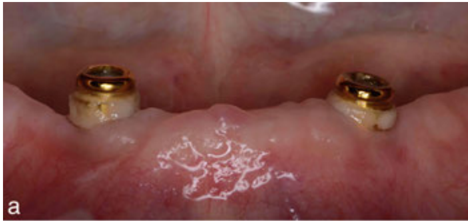
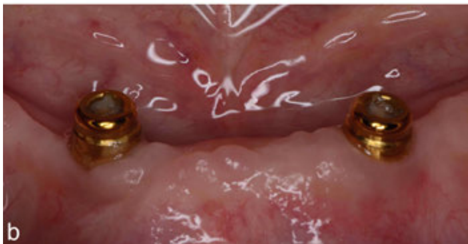
The Effectiveness of Waist-Shaped and Straight-Shaped Interdental Brushes in Cleaning Implant Overdenture Attachments: A Self-Controlled Clinical Trial

Mandibular edentulous patients often suffer from severe alveolar bone loss and are not always satisfied with using their conventional complete dentures. Compared with conventional complete dentures, implant overdentures (IODs) can improve denture retention, stability, and chewing efficiency. They can also result in greater patient satisfaction. According to the McGill consensus and York consensus statements, the use of 2-implant–retained mandibular overdentures is recommended as the standard of care for edentulous patients. However, accumulation of a plaque biofilm is a risk factor for peri-implant mucositis and peri-implantitis. Further, it has been found to be challenging for edentulous patients, most of whom are elderly, to control plaque accumulation on the IOD attachments owing to decreased hand dexterity. It is common to find that the implant attachments of elderly patients with IODs are often covered with abundant debris and, in some cases, calculus. Plaque that forms a biofilm on the attachments and neck of implants not only causes peri-implant disease but also results in the accumulation of pathogenic organisms, which may lead to the development of respiratory diseases from the perspective of systemic health. It is of the utmost importance for patients with IODs to remove plaque biofilm from around the attachments and to maintain the health status of the tissue surrounding their implants. However, few studies have addressed the efficiency of instruments in cleaning IOD attachments. Therefore, the purpose of this prospective randomized controlled clinical trial was to evaluate the cleaning effectiveness of the waist-shaped interdental brush (WIB) and straight-shaped interdental brush (SIB) in removing plaque biofilm on IOD attachments, with the aim of collecting evidence to help provide appropriate instructions on hygiene maintenance to patients with IODs. The null hypothesis of this study was that there is no difference in cleaning effectiveness between the WIB and SIB.

FIGURES 1. (a) Straight-shaped interdental brush with holder cleaning the locator. (b) Waist-shaped interdental brush with holder.

Qiuwen Chen, DDS, PhD, Yanjun Ge, DDS, PhD, Jinyou Chai, DDS, PhD, Hailan Feng, DDS, PhD, Jianzhang Liu, DDS, PhD, Shaoxia Pan, DDS, PhD, *Journal of Oral Implantology*. 2020 December; 46(6):594-601.

FIGURES 4. The plaque on the attachments before (a) and after (b) brushing (dentist brushing). The attachment on the right side was cleaned using the straight-shaped interdental brush, and the attachment on the left was cleaned using the waist-shaped interdental brush.

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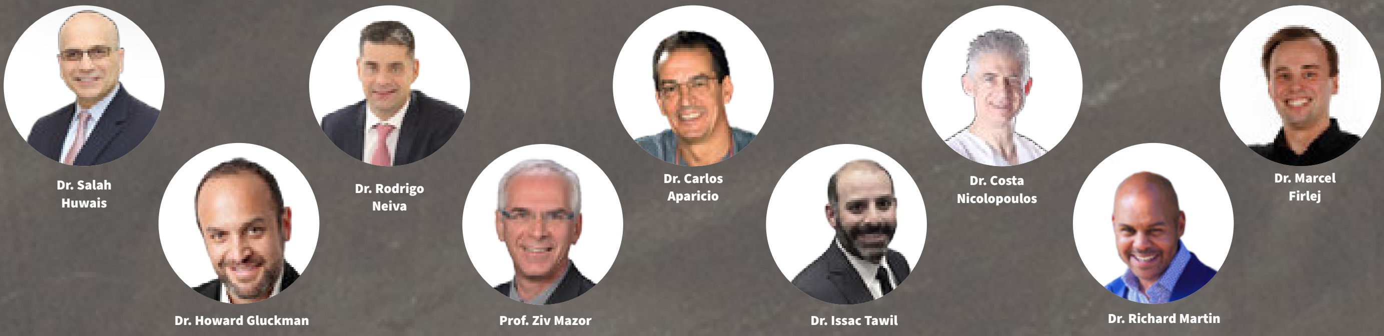

Osseodensification: Optimize the Site - Optimize the Outcome

Dr. Salah Huwais
September 24, October 22, November 5, November 12, December 3

Contemporary Strategies for Soft Tissue Development

Dr. Rodrigo Neiva
September 25

Guided Bone Regeneration Surgical Modalities

Dr. Howard Gluckman
September 25

Partial Extraction Therapy (PET)

Dr. Howard Gluckman
September 26

Osseodensification with Zygomatic Implantology utilizing the Zaga Surgical Concept

Dr. Costa Nicolopoulos and Dr. Carlos Aparicio
October 8-9

Digital Guided Surgery with Osseodensification

Dr. Issac Tawil, Dr. Marcel Firlej and Dr. Richard Martin
November 13

Advanced Osseodensification Level II

Dr. Salah Huwais and Prof. Ziv Mazor
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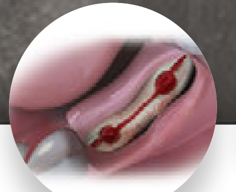
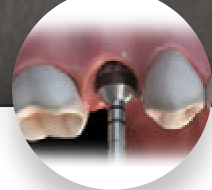
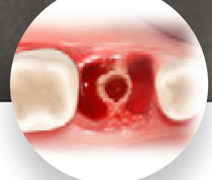
Ridge Expansion



Immediate Implant Placement

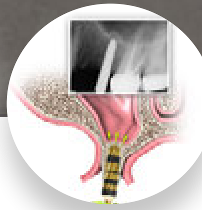


Molar Septum Expansion

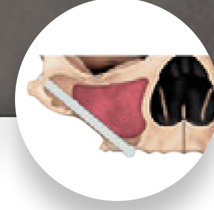


Universal Guided Surgery

OD Sinus Lift



OD Zygoma



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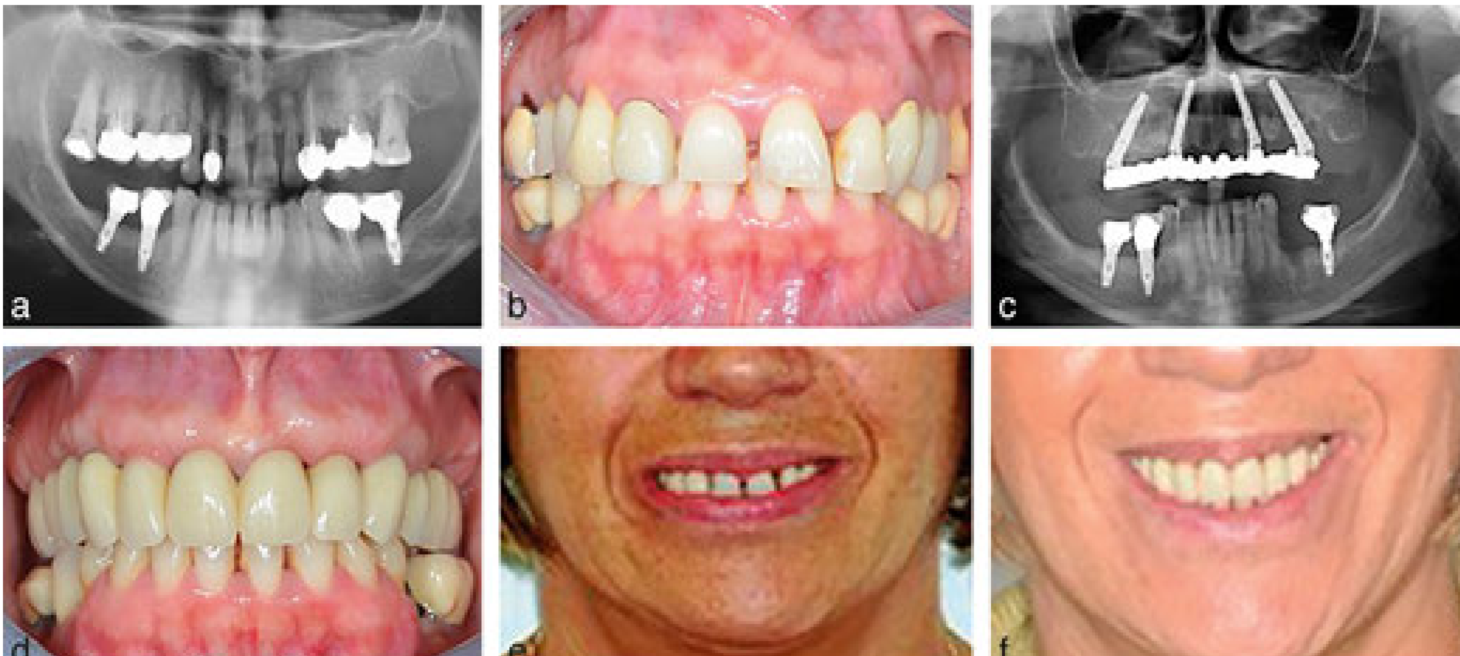
RESEARCH ARTICLE

Oral Health–Related Quality of Life and Full-Arch Immediate Loading Rehabilitation: An Evaluation of Preoperative, Intermediate, and Posttreatment Assessments of Patients Using a Modification of the OHIP Questionnaire

Immediate loading of implant-supported complete arch prostheses for the edentulous mandible and maxilla is a predictable procedure, able to provide patients with a fixed rehabilitation within a few hours. A fixed prosthesis supported by implants associated with immediate loading is claimed to represent a very satisfying treatment option for patients. In fact, patient esthetics and function are rehabilitated in a very short span of time. However, patients' satisfaction has not been specifically investigated for this kind of treatment. Current implant studies are mainly focused on the evaluation of survival rates and clinical parameters, such as bone resorption and peri-implant tissue inflammation. When the degree of patient satisfaction is anecdotally reported, it is usually based on a subjective evaluation by the treating dentist and may therefore be biased to a certain degree. Patient's opinions influence treatment and may be very important in producing satisfying results with dental implant rehabilitation. Therefore, an understanding of patients' assessments may be helpful for evaluating the effect of treatment. Growing recognition that quality of life is an important outcome of dental care has created a need for a range of instruments to measure oral health–related quality of life (OHRQoL). only. The aim of the present study was to investigate satisfaction and comfort of patients treated with implant-supported, complete immediate-loading prostheses according to the Columbus Bridge Protocol



FIGURES 1. One of the patients included in the study sample. (a) Presurgical panoramic radiograph. (b) Intraoral view before surgery. (c) Panoramic radiograph image after rehabilitation of the upper jaw following the Columbus Bridge Protocol. (d) Intraoral view of the rehabilitation. (e) Patient's smile before rehabilitation. (f) Patient's smile after rehabilitation.

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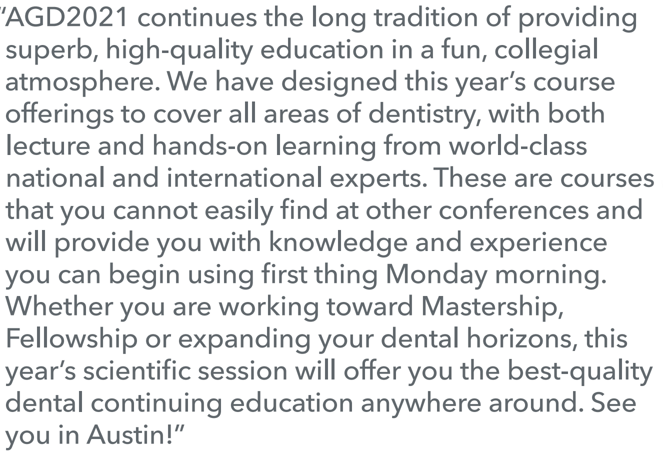
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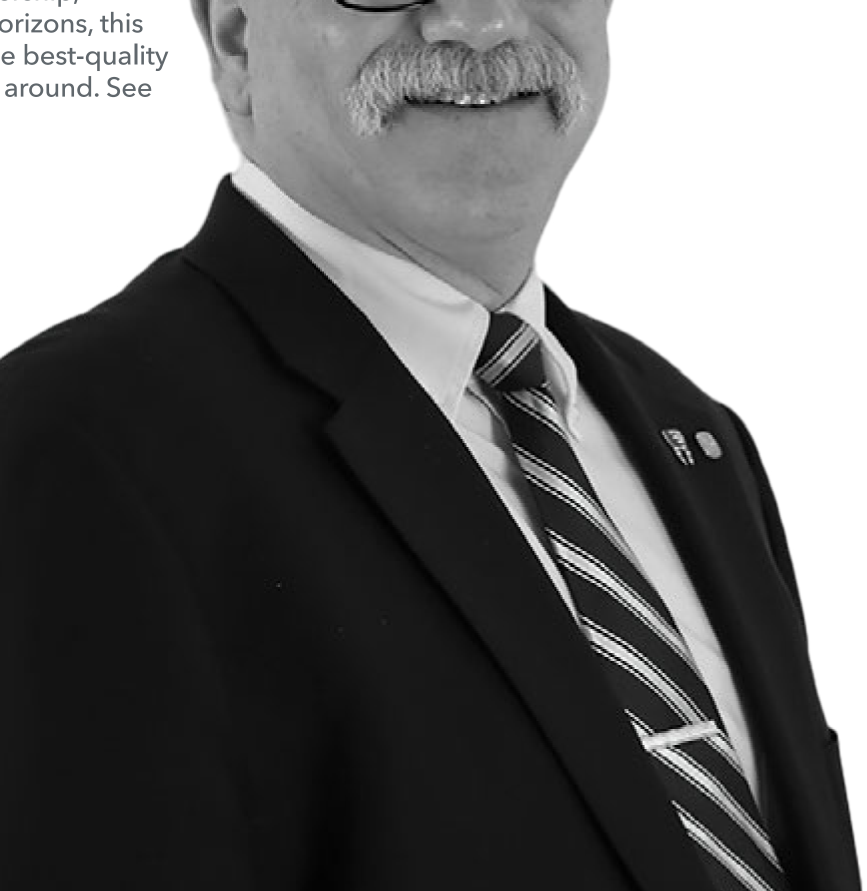

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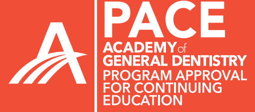

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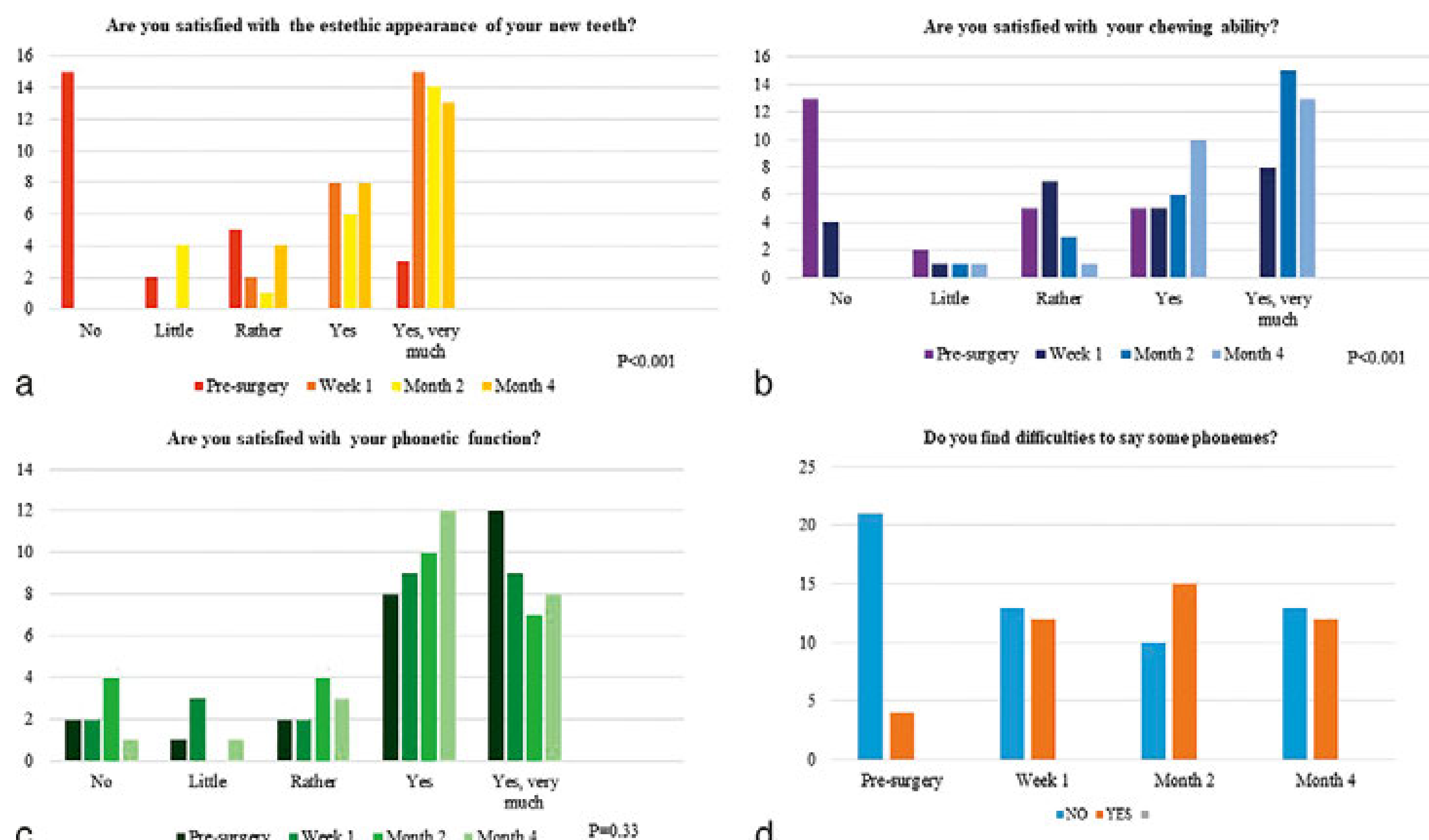
CLINICAL ARTICLE *(continued)*

(CBP). The CBP is a surgical and prosthodontic protocol for the rehabilitation of atrophic edentulous jaws using distal tilted implants. Sufficient bone volume is required to accommodate a minimum of 4 implants in the selected host bone sites, avoiding bone grafting procedures. Fixed screw-retained prostheses fabricated according to a specific prosthodontic protocol—no distal cantilevers, shock absorbing occlusal surfaces, cast passively fitting metal framework for optimal rigidity—are placed 24 hours after surgery. The null hypothesis tested in the present research was that there are no differences in patients' OHRQoL before and after treatment with the CBP. In particular, patient satisfaction related to mastication ability, esthetics, and phonetic function were investigated. Secondary aims were to evaluate the reasons leading patients to require an immediate-loading rehabilitation, pain, and swelling after treatment and patients' smoking habits, home oral hygiene procedures before and after treatment, and patient satisfaction regarding the rehabilitation and the care provided by the clinical team.

Elena Dellepiane, DDS, PhD, Francesco Pera, DDS, PhD, Paola Zunino, DH, Maria Grazia Mugno, DH, Paolo Pesce, DDS, PhD, Maria Menini, DDS, PhD, *Journal of Oral Implantology.* 2020 December; 46(6):541-547.



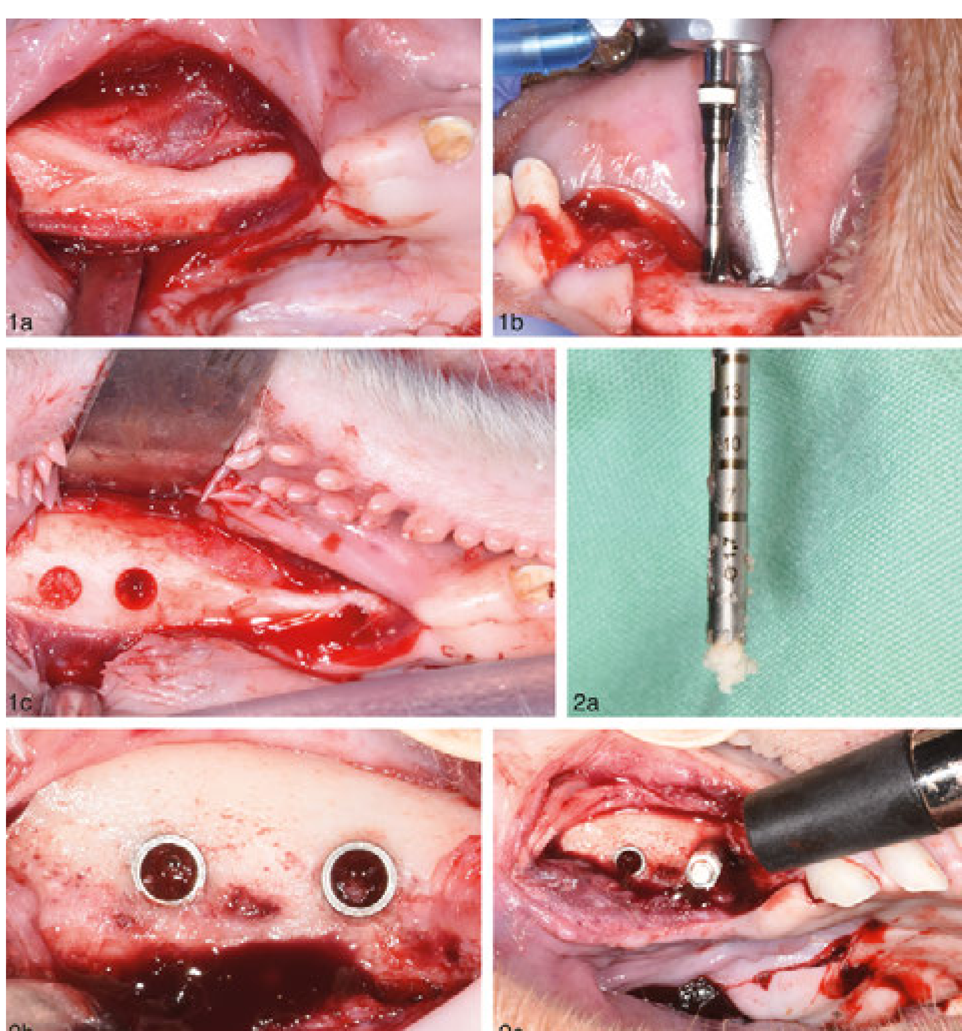
FIGURES 2. Answers to the anonymous questionnaires at the different time points. (a) Results about esthetic satisfaction. (b) Results about chewing improvement. (c and d) Results about phonetic ability.

CLINICAL ARTICLE

Socket Preservation Using Xenograft Does Not Impair Implant Primary Stability in Sheep: Clinical, Histological, and Histomorphometric Study

The use of dental implants for the rehabilitation of missing teeth is an accepted and promising treatment option. However, implants can be problematic when the amount and volume of the alveolar bone are poor. The areas that present the most common anatomical limitations are the posterior regions of both maxilla and mandible. The dimensional changes of the alveolar ridge usually occur due to active periodontal disease, trauma, or tooth extraction. The removal of teeth is accompanied by a partial loss of the ridge dimensions on all levels and a change in the ridge topography. According to the literature, the loss in ridge dimensions can reach 3.87 mm in width and 1.67 mm the height. These results were confirmed in a meta-analysis that showed a higher horizontal loss of 3.79 mm compared to a vertical loss of 1.24 mm, 6 months post-extraction. Techniques for ridge preservation have been successfully tested in clinical trials using bone substitutes from different sources. A previous meta-analysis found that socket preservation may reduce vertical and horizontal bone loss up to 50%, compared to spontaneous healing. There are several methods to examine implant stability. The most widely used in the dental field is resonance frequency analysis (RFA), due to its high reliability in determining implant stability; bone quality is an important factor when determining RFA readings. Another measure for implant stability is insertion torque (IT). The correlation between those 2 parameters is debatable. Although some point to a positive and statistically significant correlation, others are unsure. Nonetheless, both parameters are valid and in use. Sheep are a large animal model with jaw bone structure that resembles the human jaw bone. The use of sheep allows creating bone defects with similar bone anatomy and dimensions that mimic extraction sockets in the human jaw. The model also allows taking a large biopsy to examine the results, as was done previously. This animal study aims to examine and compare bone quantity and primary implant stability 2 months after the augmentation of artificial bone defects using 2 types of xenogeneic materials.

Yaniv Mayer, DMD, Ofir Ginesin, DMD, MSc, Hadar Zigdon-Giladi, DMD, PhD, *Journal of Oral Implantology*. 2020 December; 46(6):581-587.



FIGURES 1 AND 2. FIGURE 1. First surgical intervention. (a) After incision and reflection of the flaps, alveolar ridge before defect preparation. (b) Creating the defect using a drill diameter of Ø5 mm and 8 mm in depth (c) 4 wall defects, where distal is grafted and mesial left for spontaneous healing. FIGURE 2. Second surgical intervention after 8 weeks. (a) Bone core biopsies were taken using trephine (Ø1.7 mm). (b) After implant placement. (c) Stability measurement using the Osstell system.

Member Spotlight

Q&A with Dr. Shane Samy

On March 11, 2021, the U.S. Department of Health and Human Services (HHS) authorized dentists and dental students across the country to vaccinate patients against COVID-19. Shane Shamy, DMD, FAAID, DABOI/ID, has since joined the effort to administer the COVID-19 vaccine to his patients in Eugene, Oregon. He shared his thoughts on his experience so far with the AAID.

Dr. Shane Samy

Q: What made you decide to sign up to be a dental practitioner who delivers the vaccine?

A: Dental practitioners are front-line health care workers. Studies have demonstrated that dentists have a higher proficiency in giving injections compared to their physician counterparts. For me it's a "no brainer" when we can contribute to helping our communities by administering the COVID-19 vaccine.

Q: How did you sign up to volunteer for this initiative? Explain the process for other dentists who might be interested in joining this effort.

A: The process will largely differ from state to state, but here is a brief synopsis. In the state of Oregon, our governor signed an executive order permitting dentists to administer the vaccine. Subsequently, the Oregon Board of Dentistry required training at Oregon Health Sciences University (OHSU). However, to qualify for this training, I had to complete all the Centers for Disease Control and Prevention online training and obtain several continuing education certificates. Once I successfully completed those trainings, OHSU issued me a certificate that I then had to present to the State of Oregon ALERT ii system. I then received an ALERT provider ID, which meant that I could officially administer vaccines in my state.

In addition, in order to volunteer at mass vaccination clinics in Oregon, you must present your ALERT provider ID to SERV-OR, which coordinates with the local Public Health Department to schedule you as a vaccinator.

While recent federal legislation signed by the President grants every dental practitioner the privilege to administer the vaccine, state rules and regulations still likely determine the path to obtaining the required authorization, so check with your state's board of dentistry for specifics.

Q: What response have you received from your patients?

A: The responses from the people I have had the privilege of vaccinating have been overwhelmingly positive. Every other person I met was literally crying tears of joy and happiness. Most of these emotions were based on the ability to see their loved ones, children, and grandchildren in person again, to be able to hug and kiss them, and to resume some sense of "normalcy." I am honored to be a part of that.

If you have something you would like us to spotlight in the next issue of AAID News*, send a message to editor@aaid.com.*

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Maximum Learning
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By William Liang, DMD, FAAID, DABOI/ID

PERSPECTIVE

Of all the benefits of being an American Academy of Implant Dentistry (AAID) member, one of the most unique might be access to the organization's robust Maxi-Course® programs. These offerings that consist of comprehensive training curricula in implant dentistry are held throughout the United States and internationally. They provide 300 or more hours of lecture, laboratory sessions, live surgical demonstrations, and home/office assignments. The instructors are among the country's top authorities in implant dentistry who usually present their topics in 10 parts, once a month, over a 10-month period. As the director of the AAID Vancouver MaxiCourse, I have found that they are comprehensive educational endeavors. They teach both the fundamentals as well as explore more advanced treatment planning and bone grafting techniques, in a fashion not covered during formal dental education.

MaxiCourse History and Content

The AAID MaxiCourse program started 33 years ago with Dr. Terry Reynolds. He wanted to provide maximum education for dentists who wanted to dedicate their career to the field of oral implantology. Dr. Reynolds wanted this program to become the gold standard of implant education. And he succeeded: MaxiCourse programs provide numerous advantages. When dentists are looking for an education in implant dentistry, they are not seeking a destination for patient referrals, nor are they typically looking for a quick fix for their offices to be equipped to handle such patients. They want a comprehensive education that equips them properly to handle implant cases and independently make intelligent decisions regarding their patients' treatment. As chair for the MaxiCourse programs, I have seen that most participants recognize "they don't know what they don't know," and there is always something new to learn. Unlike smaller, less comprehensive courses, MaxiCourse programs make it clear to participants that this field is a lifelong learning journey and there is no shortcut to success.

Topics covered too quickly in short courses are carefully examined within a MaxCourse, expanded upon, and applied to numerous case studies. Hands-on training is carefully constructed to maximize the application of didactic learning. Vital to the success of the MaxiCourse program is the useof clinical labs, simulations, a live surgical observation, and hands-on surgical experience under the one-on-one guidance of qualified surgical mentors. Much of the learning comes through observation of the healing process as participants monitor the post-surgical recovery of their own patients.

In my experience, MaxiCourse participants appreciate that attempting to take shortcuts in this field can lead to implant complications and failures. These results are avoidable with a careful approach to treatment planning and a full understanding of the fundamentals (anatomy, physiology, pathology, and others). There is only one universal goal of MaxiCourses and it is to develop successful, critical thinking, lifelong learners in the field of oral implantology."

Who Teaches These Programs?

One of the greatest strengths of the Maxi-Course model is the emphasis on both multi-disciplinary and multi-perspective approaches. There is no corporate agenda or singular approach to instruction. Speakers teach from their own backgrounds and perspectives. Although presenters are not limited to AAID members, our organization has a treasure trove of talented and dedicated AAID and ABOI/ID credentialed implantologists. If you count the years of experience from the faculty at any given MaxiCourse, you will appreciate a millennium of wisdom and clinical experience. Dentists are thus exposed to different approaches and learn that thinking critically is vital to their future success.

MaxiCourses Are Always Evolving

Indeed, as the field of oral implantology has evolved over the past three decades, MaxiCourse directors have not rested on their laurels. To maintain the gold standard of implant education, the organization continually has evaluated its effectiveness and honed its skills at developing competency and proficiency in participants. To further strengthen the programs, the AAID is currently studying measures to standardize parts of the MaxiCourse program, recognizing that there are certain foundational components that will benefit from having a degree of uniformity across all programs. What sets MaxiCourse programs apart from others is a strong history, the close ties with the AAID, and the credentialing process available to MaxiCourse graduates. Dentists completing the MaxiCourse can distinguish themselves from other implant dentists in their communities by challenging AAID exams and earning credentials in this field.

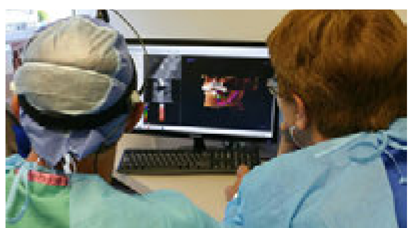
Vital to the success of the MaxiCourse program is the use of clinical labs, simulations, a live surgical observation, and hands-on surgical experience under the one-on-one guidance of qualified surgical mentors. Much of the learning comes through observation of the healing process as participants monitor the post-surgical recovery of their own patients.

Currently there are 14 MaxiCourses offered worldwide. Visit *aaid.com* for more information and to sign up for classes.

Editor's note: This is the first in a series of editorials focused on educational programming, which will provide AAID members and those who are interested in learning more about oral implantology a deeper understanding of what the AAID offers to further education among its members. Our hope is to share more personalized information with those who want to pursue the AAID credential or become a Diplomate in implant dentistry with the American Board of Oral Implantology/Implant Dentistry.

START YOUR IMPLANT CAREER ON THE RIGHT FOUNDATION

The Las Vegas and New York AAID Maxicourse provides online and immersive hands-on training to ensure an in-depth 300 CE hour education program in implant dentistry. These Maxicourses qualify and prepare participants to take the written portion of the AAID Associate Fellow Membership Examination.



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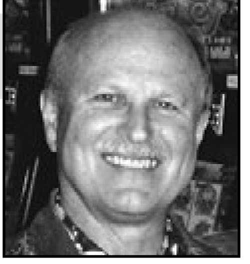

John Carbery, DMD, passed away at the age of 71. He graduated from Oregon Health Sciences University in 1974. During the Vietnam era, John joined the US Navy and served and earned his pilot 's license in the Dental Corps in Cupertino, CA. His practice was in Yakima, WA. Dr. Carbery joined the American Academy of Implant Dentistry on September 28, 2001. He completed the 2003 New York Maxicourse and became an Associate Fellow in 2007. Outside of the Academy, he served on the State Board of Judicial Affairs, Ethics and Peer Review for over 15 years. In 2017, John was elected to serve on the American Association of Dental Boards, which oversees the licenses of over 500,000 oral health practitioners. He served on the State Board of Dental Examiners and as an examiner on the Western Regional Examining Board since 2011.

Nicholas John Shubin, DDS

Nicholas John Shubin, DDS, died at the age of 60. He graduated USC's Undergraduate Studies: Psychobiology Honors Program and dental school in University of California, Los Angeles (UCLA), in 1984.

Within the American Academy of Implant Dentistry, Dr. Shubin became an Associate Fellow in 2006, Fellow in 2007, and ABOI Diplomate in 2008. He served on the public relations committee from 2010-2013. He practiced general dentistry in San Juan Capistrano, CA, providing general dental care, cosmetic dentistry, dental implant therapy, full mouth reconstruction, and sedation dentistry.

Dr. Shubin was part of the UCLA School of Dentistry, Department of Restorative Dentistry in July 2002, Co-Founder and Educator in the California Academy of Implant Dentistry, and Mentor in the Terry Tanaka TMD and Restorative/Prosthodontic Study Group.

Jeff M. Eaton, DDS

Jeff M. Eaton, DDS, passed away at the age of 61. He was an Associate Clinical Professor at UCSF School of Dentistry and lectured on a variety of subjects including dental implants. He practiced dentistry for more than 25 years.

Dr. Eaton graduated from UCSF School of Dentistry in 1983 and completed year-long training programs in Oral Surgery for General Dentists from UOP School of Dentistry as well as the Maxi Dental Implant program at Loma Linda University School of Dentistry.

He was the co-founder and co-director of the ET Advanced Dental Institute, a program that helps foreign-trained dentists prepare to return to school for advanced training. Dr. Eaton was a member of the American College of Dentists.

Thank you to the 2020 AAID Foundation Silent Auction Participants

The AAID Foundation continued its tradition of raising money for AAIDF grants and programs during the 69th Virtual Annual Conference in November 2020. The Foundation thanks the following individuals and organizations who donated items for the auction.

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Congratulations to the AAID Foundation Silent Auction Raffle Winners

The AAID Foundation congratulates Dr. Wai Kee Fung for winning the AAID Raffle for 2021 AAID General Membership. The Foundation also congratulates Dr. Mitchell Tossberg-Wilson for winning the 2021 Academy of General Dentistry General Membership raffle.

new members

The AAID is pleased to welcome the following new members who joined between January 28, 2021, and April 5, 2021. The list is organized by state, with the new member's city included. International members are listed by country, province (if applicable), and city. If you joined the AAID recently and your name does not appear below, it will be listed in the next issue of AAID News*.*

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AAID Announces Opening of Award Applications

As the foremost organization in implant dentistry, the American Academy of Implant Dentistry (AAID) is the home of the most prominent leaders in the discipline. Every year, the AAID and the AAID Foundation recognize the accomplishments of clinicians, researchers, students, and volunteers in the field of implant dentistry through various awards.

Please consider nominating an AAID Member for these accomplishments. The AAID website *www.aaid.com/awards* has the most current information for the nomination process including how to submit a candidate.

Terry Reynolds Trailblazer Award

The Terry Reynolds Trailblazer Award was created to recognize Dr. Reynolds' vast contributions to the profession of implant dentistry.

Dr. Reynolds conceptualized, developed, and founded the implant MaxiCourse®, which has become the gold standard for implant education and is trademarked by the AAID. He was the first MaxiCourse® director and, in 1998, became the first African American to serve as AAID president.

The award recognizes an AAID member who epitomizes the spirit of Dr. Reynolds' work through:

- Demonstrating leadership in implant dentistry
- Achieving accomplishments and accolades as an innovative educator in the art and science of implant dentistry
- Embodying the spirit of inclusion, outreach, and selfless service through humanitarian efforts within the dental community, fostering training, know-ledge, and compassion for better patient care worldwide

The deadline for submissions is June 10, 2021.

Honored Fellows

The Honored Fellows Committee is seeking nominations of AAID members to be distinguished as AAID Honored Fellows in 2021. Members may self-nominate, nominate another member, or be nominated by their peers.

To be eligible, members must have been voting members (Associate Fellow, Academic Associate Fellow, or Fellow) in good standing for at least eight years.

In determining the 2021 Honored Fellows, the Committee will review nominees' AAID leadership and volunteer experience alongside their body of work in the dental community, as well as other leadership or volunteer roles.

Honored Fellows are selected based on the following criteria:

- Distinguished professional, clinical, research or academic endeavors. Examples include: speaker at AAID conferences and/or other meetings; teacher of AAID or other course; published author for *JOI* or other academic journals; as well as academic qualifications, research endeavors, leadership in other dental societies, and community efforts
- Noteworthy accomplishments within the field of implant dentistry, such as special awards or recognitions
- Demonstrated support of the AAID, including but not limited to District involvement, committee service, or AAID Foundation volunteerism

The submission deadline is June 30, 2021. To submit a nomination, please go to *www.aaid.com/honored* to see a list of those eligible members and submission information.

New Members

continued from page 36

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Sinan Aithraa, Alexandria
Shabmam Ravadgar, Ashburn

Wisconsin
Robert Moss, Baraboo

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Andrea Cain, Morgantown

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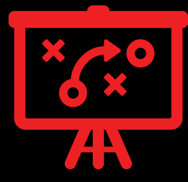

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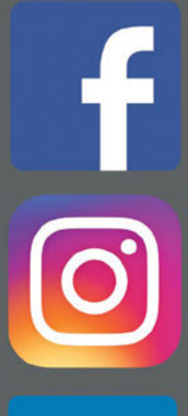

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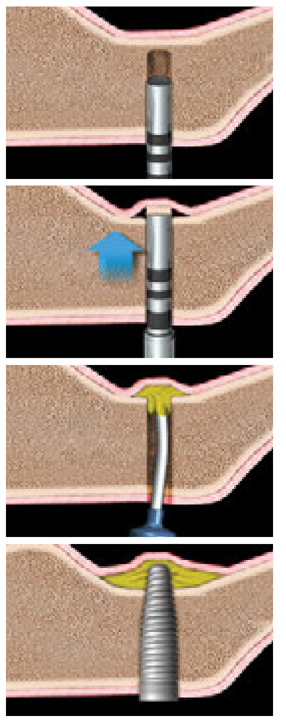

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1. Kotsakis GA, Mazor Z. A Simplified Approach to the Minimally Invasive Antral Membrane Elevation Technique Utilizing a Viscoelastic Medium for Hydraulic Sinus Floor Elevation. Oral Maxillofac Surg. 2015 Mar;19(1):97-101. 2. Mazor Z, Ioannou A, Venkataraman N, Kotsakis G, Kher U. Minimally Invasive Crestal Approach Technique for Sinus Elevation Utilizing a Cartridge Delivery System. Implant Practice. 2013;6(4):20-24. 3. Mazor Z, Ioannou A, Venkataraman N, Kotsakis G. A Minimally Invasive Sinus Augmentation Technique using a Novel Bone Graft Delivery System. Int J Oral Implantol Clin Res 2013;4(2):78-82.

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