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E D I T O R I A L

**WILLIAM G. (Bill) DICKERSON, DDS, LVIM**

Like many doctors, Dr. William Dickerson was unhappy with the progress of his chosen profession. Fifteen years ago he made the decision to change that. His practice success and personal metamorphosis led to his passion to help others in dentistry so that they too could enjoy the profession they have chosen. Since that time he has educated thousands of dentists all around the world inspiring them to make the necessary changes for their own practices and lives. Because of his dedication and passion to help other dentists, he is considered by many to be one of the most influential dentists in North America, affecting the practices and lives of thousands of dentists around the world. He is the Founder and CEO of the Las Vegas Institute for Advanced Dental Studies (LVI Global).

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# *The Tipping Point*

*NM Dentistry on  
Monday Night Football*



*“On Monday Night Football, November 2, 2009, PPM may have reached its tipping point and perhaps Neuromuscular Dentistry did as well.”*

Many have heard me talk about the Pure Power Mouthguard as the “SEXY” side of Neuromuscular Dentistry. PPM was created by one of our alumni, Dr. Anil Makkar, applying the Neuromuscular principles he learned at LVI. PPM was highlighted in the last issue of *LVI Visions* with Anil and Shaq on the cover (Shaq has endorsed the PPM). Those of us who are involved in NM Dentistry realize the amazing potential it gives dentists to help change the lives of their patients by eliminating a lifetime of pain. But talking about pain relief, as important and powerful as that is, does not gather the attention as does a celebrity athlete talking about how much their strength or flexibility and performance have been

enhanced. It is that kind of press that garners the public’s attention and allows the dentist who creates the PPM mouth guards to then talk to their patients about how it may also relieve them of a lifetime of pain.

Some of you may have read the book *The Tipping Point* by Malcolm Gladwell. If you have not, you should. Every successful business reaches the tipping point in their business life (or hopes to reach it) that pushes them over that point of no return, where success takes off... or they reach the top of the wave where all they have to do after that is ride the wave of success the rest of the way. On Monday Night Football, November 2, 2009, PPM may have reached its tipping point and perhaps Neuromuscular Dentistry did as well. For several

minutes the announcers went on and on about how much better the New Orleans Saints team (then 11-0, currently 12-0 and leading contender for the Super Bowl Championship) were playing because of this mouth guard they were wearing. They talked about how they were involved in the test that showed a greater flexibility and strength with the mouth guard in. The announcers talked about their own personal results doing the PPM test of flexibility and strength and how amazing it was. And along with increased flexibility and strength, a physiologic bite position helps improve “balance” significantly. PPM received millions of dollars of free advertising, simply because it did what every NM dentist out there knows, it works.

Well, my phone rang. The text mes-



sages started coming in. The national sports blogs lit up. The Saints News site highlighted that story, and for the next day PPM doctors (all LVI-trained) around the country started getting phone calls from the weekend athletes wanting a PPM mouth guard. The LA Times also ran a story about it in their sports section and it was featured on the front page sports section of USA Today.

Newspapers around the country printed articles which raved about the effect the NM position can have on people. Be it to improve their golf game or a local athlete wanting to be the best he or she can be, the calls came rolling in across

all of North America. Our own LVI Forum (a private dental support forum for LVI Alumni) was inundated with “stories” about the calls they received and the appointments that were made. Those LVI-trained dentists on the fence about joining the PPM membership jumped in head first, hoping to get some calls of their own.

As it turns out, many of these weekend athletes calling to get their own personal PPM mouth guard will have pain related to their bite and not realize it (assuming it is normal) or not know what it is caused by. They may suffer with migraines and not realize that repositioning their bite might help. But they now know that their golf game may improve by wearing a mouth guard based on the same principles that would relieve them of their pain.

And although they may not go to the PPM dentist for that reason, they will find from that dentist that perhaps they can be helped for their pain as well.

Of course the beauty of NM Dentistry is that the LVI-trained dentist will know that they can help them before they ever touch the teeth. By placing an orthotic that propriocepts them to their physiological correct

*Although learning NM principles is easy and it is our belief that every doctor out there can master these principles, there is a fountain of knowledge that must be obtained before attempting such procedures.*

bite position, they will know if the pain or discomfort they are having is caused by a misaligned bite. If they get relief and comfort then “phase 2” or NM treatment can then, and only then, begin. They may need coronoplasty (equilibration), orthodontics or comprehensive restorative treatment to restore them to this comfortable physiological bite position. But at no time should a dentist begin treatment without eliminating pain first, insuring that the bite was the problem for such pain. One of the mottos popular at LVI is, “Keep the hand piece in the holster until the patient is pain free.”

Of course proper training is essential to be able to deliver what is required to maintain and restore the bite to the position achieved in orthotic therapy. Attempting to do cases

before adequately trained is dangerous not only for your patients but your career. Although learning NM principles is easy and it is our belief that every doctor out there can master these principles, there is a fountain of knowledge that must be obtained before attempting such procedures. LVI warns alumni dentists not to do full mouth restorative cases until they

have completed the seven core programs. I do not want anyone to think that putting an athletic performing mouth guard in is all that is needed before restoring cases. Nothing could be further from the truth.

However, because of a game, and the improved performance of athletes wearing a mouth guard based on the principles of Neuromuscular Dentistry and the “sexy” side effects of being in your correct physiological position, the public may be made more aware of the “real power” of what can be done for them. Headaches, neck pain, shoulder pain, back pain and a myriad of other issues including life threatening sleep apnea, may be able to be relieved by applying the same principles that also can improve their athletic ability. Now THAT is REALLY exciting. THAT is life changing. That makes being a dentist so rewarding. Not many professions out there can claim to dramatically change people’s lives for the better. We are so lucky to be in such a profession with this type of knowledge available to us.



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- Alan Steiner, DMD



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Lorne Lavine, DMD

# Digital Radiography: An Overview

The modern dental practice has experienced a radical change over the past 15 years. Systems that were paper-based for decades have, in the past few years, been replaced by a digital dental record. Practices are moving towards a chartless or “paperless” concept, where there is no longer a need to maintain a paper chart to view important data. The area that has created the greatest amount of “buzz” in the past five years is digital radiography. In this article, we will explore the decision making process for offices that are considering this technology.



## Don't Put the Cart Before the Horse

One of the biggest mistakes that I see offices making is that they fail to understand the infrastructure that is necessary before adding digital radiography. While there are many different systems to consider, I have developed a 6-point list to evaluate these systems. They are:

- 1. Practice Management Software.** It all starts with the administrative software that is running the practice. To develop a high-tech practice, this software must be capable of some very basic functions. It is also important to understand that as much as we would all prefer that our practice management software programs can handle all of these functions, most fall short. Fortunately, there are a number of third-party programs that can provide functionality where the practice management programs cannot.
- 2. Image Management Software.** This is probably the most challenging decision for any office. Most of the practice management programs will offer an image management module: Eaglesoft has Advanced Imaging, Dentrix has Dexis, Kodak has Kodak Dental Imaging, and so on. These modules are tightly integrated with the practice management software and will tend to work best with digital systems sold by the company. For example, having an integrated im-

age module makes it very easy to attach images to e-claims with just a few mouse clicks. However, there are also many third-party image programs that will bridge very easily to the practice management software and offer more flexibility and choices, although with slightly less integration. There is no perfect system...it really boils down to paying a premium for tighter integration or paying less for more flexibility. Some of the better known third-party image programs include: Apteryx XRay-Vision, XDR, and Tigerview.

- 3. Operatory Design.** The days of a single intraoral camera and a TV in the upper corner are being replaced by more modern systems. The majority of offices are placing two monitors in the operatories, one for the patient to view images or patient education or entertainment, and one for the dentist and staff to use for charting and treatment planning and any HIPAA-sensitive information, such as the daily schedule or other information that you would prefer that the patient not see. Windows has built-in abilities to allow you to control exactly what appears on each screen. There are numerous ergonomic issues that must be addressed when placing monitors, keyboards, and mice. For example, a keyboard that is placed in a position that requires the dentist to twist his or her back around will cause problems as will a monitor that is improperly positioned.

Another important decision for the office will involve deciding whether you prefer the patient to see the monitor when they are completely reclined in the chair. If this is the case, then the options are a bit more limited for monitor placement. There are some very high-tech monitor systems that not only allow the patient to see the screen, but create a more relaxing environment for patients who are considering long procedures.

- 4. Computer hardware.** After the software has been chosen and the operatories designed, it is time to add the computers. Most offices will require a dedicated server in order to protect their data as well as having the necessary horsepower to run the network. The server is the lifeblood of any network, and it is important to design a server that is both bulletproof, has redundancy built-in for the rare times that a hard drive might crash, and can easily be restored. The workstations must be configured to handle the higher graphical needs of the office, especially if the office is considering digital radiography. The computers placed in the operatories are often different from the front desk computers in many ways: they will have dual display capabilities, better video cards to handle digital imaging, smaller cases to fit inside the cabinets, and wireless keyboards and mice. An often-overlooked consideration is that the smaller the computer, the more heat it generates. Heat is the

number one enemy of computers, and since many dentists will place their computers inside a cabinet at the 12 o'clock position, having proper ventilation is absolutely critical. With the recent release of Windows 7, computers will need more horsepower than ever.

5. **Digital systems.** We will discuss the main options in the next section.
6. **Data Protection.** With a digital practice, protecting the data is absolutely crucial to prevent data loss due to malware or user errors. Every office, at a minimum, should be using antivirus software to protect against the multitude of known viruses and worms, a firewall to protect against hackers who try to infiltrate the network, and have an easy-to-verify backup protocol in place to be able to recover from any

disaster. The different backup protocols are as varied as the number of offices, but it is crucial that the backup is taken offsite daily and can be restored in a quick manner. Many offices are now using a combination of online backup paired with an emergency server in the office. Downtime should never be more than two hours.

### The Digital X-ray Options

There are currently three major methods of incorporating digital radiographs into the practice. Each system has advantages and disadvantages, so there is no one system that is "best" for everyone. The three systems that are currently being used are direct sensors, phosphor plates, and digital scanners.

### Direct Sensors

These systems are the most popular digital radiography systems and they are the ones that most dentists will see when visiting vendor booths at dental meetings. Some of the major system vendors are Dexis, Schick, and Kodak. These systems utilize either CCD (Charge-Coupled Device) or CMOS (Complementary Metal Oxide Semiconductor) sensors that are hooked up directly to the computer in the operatory. Most use a USB connection, although a few still require an internal card. The major advantage to these systems is speed. The sensor will capture the image and send it directly to the computer; images will appear almost instantly in most cases. Most systems have their own software for image sorting and manipulation, although the dentists can also use third-party software. These image management programs also integrate quite easily with most of the major practice management software. Many of the newer systems have very good image quality, and many dentists consider the image quality to be equal or better than film. There are, however, a few drawbacks to these systems. First and foremost, for most dentists, it is cost. The basic systems with a couple of sensors can cost upwards of \$15,000. Most will only come with a one-to-two year warranty, and extended warranties can add thousands of dollars to the initial cost. While sensors are not as fragile as they once were, you still need to be very cautious when handling them. Also, the sensors are quite a bit thicker than traditional film. The







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**Sam Kherani,  
D.D.S., F.A.G.D., L.V.I.M.**

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average sensor is about 4.5 mm thick. Each sensor will have a thin cable attached to the end, which requires some practice in placing it correctly in the patient's mouth. Many patients find them to be difficult to tolerate

and, of course, they cannot be used with traditional x-ray holders such as the RINN XCP kits. Other considerations are that there must be a computer in each operatory where you plan to use the systems and there is a bit of a learning curve to negotiate.

### Phosphor Plates

These systems are different from the direct sensors in many ways. The system utilizes plates that are very similar in size and thickness to x-ray film; some are even thinner than film. The most popular systems include the Scan-X, Optime, and Denoptics. The individual films are taken like a traditional x-ray, and then the film is placed

either through slots (Scan-X) or in a drum that can hold a complete mouth series of film. The drum is placed in a scanner and the films will be seen on the computer screen between 90 seconds and 4 minutes, depending on the number of films being processed. The plates can be re-used many times by simply exposing them to a view box and each plate costs only \$25-40 to replace. This system has numerous advantages. Patients can better tolerate the thinner plates. The system can be set up like a traditional processor, but one that can be used by all the different operatories in the office. It is far cheaper to replace one of the sensors. On the downside, the cost is around \$20,000, and most offices can only afford one unit. Therefore, like a traditional processor, if multiple people need to use the unit, there may be a need to wait for the person ahead of you to finish. Another issue is that the system must be connected to a computer, so a computer must often be dedicated for this purpose. At standard settings, the phosphor plates offer a lower amount of resolution than the direct sensors, although most dentists will probably find that either choice is quite acceptable.



### Direct Scan

For the dentist on a budget, and for the dentist who wishes to digitize existing radiographs, this option offers a relatively inexpensive method of incorporating digital radiographs into the dental practice. It involves the use of a scanner with a transparency adapter. The x-rays are placed on the scanner and then scanned. The



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resulting images can then be seen on the computer monitor. In most cases, the process is made easier by using special software that can organize and manipulate the images. Direct scanning is currently the only system available for digitizing existing x-rays. The cost savings from the other systems can be quite significant. A typical scanner and transparency adapter will cost about \$750, and the software is usually quite reasonable as well. Of course, the quality of the image will be directly related to the quality of the scanner, and in some cases, will be inferior to both the direct sensors and the phosphor plates. This system is also ideal for dentists who simply

want to archive their x-rays or for the office that wants to save on costs associated with duplicating x-rays.

As dentists move into the 21st century, they are faced with an ever-increasing list of choices when adding technology to the dental practice. While there are only three basic choices available for digital x-ray systems, there are often numerous factors that must be considered when making a purchase. Cost, image quality, space limitations, speed, and a host of other factors must be considered by the dentist before making such a large investment, but it is a necessary exercise if the dentist wants to avoid making a large financial mistake.



## The Digital Dental Practice

March 19-20, 2010

June 18-19, 2010

October 1-2, 2010



Dr. Lorne Lavine, founder and president of Dental Technology Consultants, has over 26 years invested in the dental and dental technology fields. A graduate of USC, he earned his D.M.D. from Boston University and completed his residency at the Eastman Dental Center in Rochester, NY. He received his specialty training at the University of Washington and went into private practice in

Vermont until moving to California in 2002 to establish DTC, a company which focuses on the specialized technological needs of the dental community.

Dr. Lavine has vast experience with dental technology systems. He is a CompTia Certified A+ Computer Repair Technician, CompTia Network+ certified and will soon be a Microsoft Certified Systems Administrator. As a consultant and integrator, he has extensive hands-on experience with most practice management software, image management software, digital cameras, intraoral cameras, computers, networks, and digital radiography systems.



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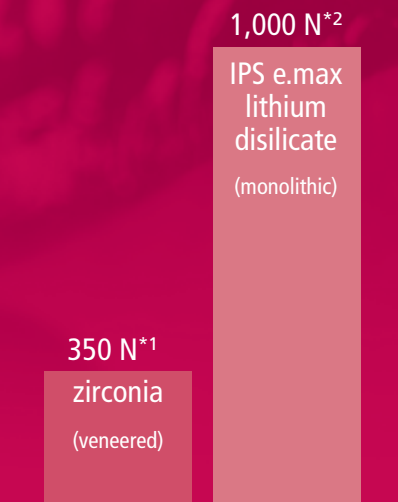
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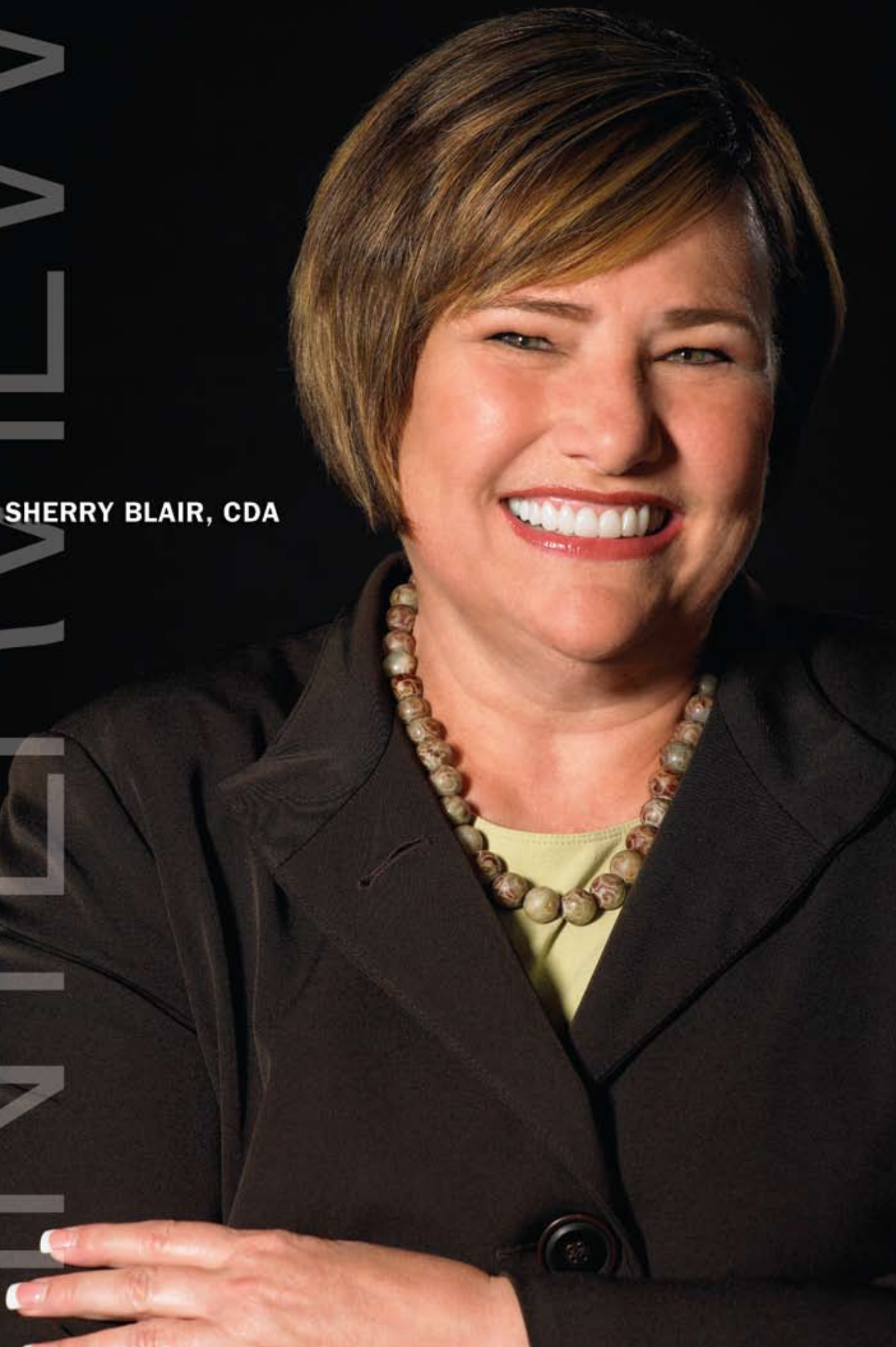
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# INTERVIEW

SHERRY BLAIR, CDA





As Director of the Dynamic Team Program at the Las Vegas Institute, Sherry shares her more than 37 years of experience managing each and every system within the dental practice. Sherry has combined her acquired knowledge and personal experience to create an inspired, effective and motivated curriculum that refines the systems surrounding the patient's total experience in a dental practice. Sherry's extensive exposure to most forms of practice management and dental systems, as well as her strong focus on patient satisfaction, make her uniquely qualified to enhance the effects of any dental practice.

Sherry Blair is featured in LVI's Dynamic Team Concepts Series - a set of courses for dental team members designed to complement the CORE curriculum for doctors.

*How did you get into Dentistry?*



If you want to go all the way back, it actually started when I was about 13-years-old. For years my parents had taken me to this grumpy, old dentist that, knowing what I now know, I believe did not enjoy doing what he was doing. His office was an old, run-down house. As it turns out, my older brother's baseball coach was a dentist and my parents decided to take us to his office. I still remember the first time I went - the new office, the friendly people. And I loved the dental assistant. I watched every move she made. She and the doctor seemed to be having fun. I can remember thinking - "Wow, this is what I want to do." I never changed my mind. I was going to go into dental hygiene and thought it would be a great idea to go to dental assisting school first to prepare for hygiene school. I worked the summer before hygiene school as an assistant and I loved it. I loved the variety of procedures as opposed to the hygiene procedures. The rest is history. I was a chairside assistant for 17 years and then it happened one day. I decided to become one of those girls at the front! Isn't that the way it is in dentistry? We have the girls/guys in the front and the girls/guys in the back. I always warn those girls/guys in the front to be careful when they say "I'll never be one of those girls/guys in the front", because one day it may happen.

*What insight did you gain while being part of a dental team?*

The patients have to come first. We have the ability to make a stressful visit, more enjoyable for that patient. Never assume that the patients do or do not have enough money or that they are too young or old to accept idea dentistry. All patients are different and they all cannot be communicated with in the same way, even though what we do for them is the same. The dental team is going to be just about as strong as its leader. In dentistry there is no such thing as an 8 to 5 job with a morning break, afternoon break, or sometimes even a lunch.

*What were the motivating factors that led you to teaching and consulting?*

I was always a continuous learner and still am. I can remember being 18-years-old and listening to Zig Ziglar and Wayne Dyer tapes. Yes, they were cassette tapes back then and for whatever reason I thought their message had everything to do with dentistry. When they came in the mail, yes snail mail back then, we would fight over who got to listen first. I almost always won, even though he paid for them. I was blessed that both doctors I worked for were CE junkies. I have been exposed to approximately ten different continuing education and practice management groups. With each group, our office would move to another level. Some of the consultants we worked with I never wanted to be anything like, but most I admired and wanted to do what they did - help offices be the best they could be. I loved working with patients but I knew the next level was working with dental teams.

*How important do you believe it is for the team to be involved in the practice?*



That depends on the doctor. If the doctor does not want a better, more productive, less stressed practice then no involvement is needed. Whether we choose to believe it or not, there are doctors that are perfectly satisfied with making no changes and that may work great for them. However, if you choose to make any kind of change in the practice the team has to be involved. If you want and need for the people within the organization to buy into what you are doing, do not decide what to change and how to change it without giving them an opportunity to provide input. What we need are “stakeholders,” not passive observers to what is going on. Start by first discovering WHY they would WANT to make the change. There are only two reasons that people will change: first, what is in it for me? Second, can I do it? Do not think the ‘what’s in it for me’ is always about money. I recently listened to a crying team member because she was a single mom of a six-year-old and a three-year-old and she would leave for work at 7a.m. and would not get home until 7p.m. All she wanted was to spend more time with her children. Other team members might desire less stress at work. After they realize how the change will benefit them, then you have to get them the training. They can do it, given the proper tools and systems. Keep in mind this will require an investment of not only money but time.

*Do you believe a doctor should share financial information with the team?*

Yes. How many fans do you believe would buy a ticket to a sporting event or how many players would remain on the field playing the game, if there was never a scoreboard? How do we know if we are winning or losing? Some offices do not even know what winning or losing means because they do not have daily goals. Why wouldn’t a team member come and ask you for a raise when they have no idea that overhead is out of control. They are not trying to make you angry but they simply do not know that you cannot give away what you do not have. I find several reasons why a doctor does not want to share this informa-





*Should the team  
be involved in  
continuing  
education?*



tion. Number one is that sometimes the doctor does not even know their overhead so therefore they do not know how to set daily goals. Another is that the doctor does not want the team knowing how much they are making. In speaking to that issue; I have to say it is okay to be successful and make a lot of money. You invested a lot of time, money and effort in going to dental school and you deserve a return on that investment. If you have team members that cannot or will not agree with that then ask yourself, are they the right team member for your practice? The third reason I hear is that the doctor does not want the team to think that they are just concerned about the numbers and not the patient. It seems that somewhere along the way dentists got rolled up with medicine and were told that healthcare should not be a business. Dentistry is optional and dentistry is a business. The interesting thing about talking with teams is that they understand that dentistry is a business; sometimes more than the doctors. They want to be informed and are usually willing to help with the business when they do know.

That question would probably be better answered by the doctors. How hard is it to explain to your team what you learned at a CE course? Think of the energy and of the environment in which you heard the information. Does that same energy exist in the environment in which they are hearing it? In addition, I believe a prophet is not a prophet in their own land. I used to send notes to my daughter's first grade teacher asking her to tell my daughter to do the same thing I had asked her to do for months. Reason: I knew she would do it if her teacher asked her instead of me. However, it is even more important to involve team at an institution like LVI. As far as I know we are the only learning institution that divides and conquers. Meaning, in addition to some lectures that the team and doctors hear together we have breakout sessions where the doctors continue to learn clinical information while the team is learning practice management information, photography, etc. So, if a doctor does not involve their team at LVI they are only getting clinical information. If that doctor is expecting to use those clinical skills without changing any of their patient care systems, they will almost certainly be disappointed. Of course we all know what happens when we bring one or two team members and ask them to take the information back to the rest of the team. I have had personal experience with this. Off we went to a course, my doctor, one of the assistants and myself. It was one of the most powerful CE courses I had been to. I laughed, I cried, and I learned. I was fired up to tell the rest of the team all about it in the team meeting. I was met with resistance. I even had one team member say to me, "I don't even know why he picked the two of you to go and not someone else." That was the last time that the entire team did not go to all CE courses together. If you want implementation they all have to hear the same message in the same environment.

*Why should a doctor want to invest money in team CE when the team member could eventually leave the office?*

And they will! Life happens. Why would you buy a brand new car when you know the value decreases when you drive it off the lot? I believe that you have to deal with the here and now. If you do invest in those team members and they take you to another level by creating a consistent solid system in the practice and they train the next person with that solid system; what have we lost? There is a difference in taking a chance by investing in the right people versus investing in team members that you know are not a fit for your practice. My question would be; if they are the wrong team members, why are they still there? I have heard every reason out there. All I can say is that when the pain is great enough, the change will occur.

*How does a doctor know if they have the right or wrong team member?*

Close your eyes and imagine this. You are sitting at your desk and this team member walks in. He/She hands you their two week notice. What is your instant reaction? Are you thinking; thank goodness, this is great news. Or are you thinking; Oh NO, I can't live without them, this is horrible. There is your answer. Also ask yourself, would the patient care improve in any way if this person was not here? If the answer is yes, do what you need to do. Your first obligation is to your patients for both their service and clinical care.

*What is the number one thing that holds a practice back from success?*

You may find this answer surprising. I believe that it is a lack of communication. And when I say communication I am not talking about team to patient communication or doctor to patient communication like you might think. I am talking about team to team, team to doctor, and doctor to team communication. What has to occur for this to happen? Productive team meetings. In addition to communication, I believe there is a lack of internal training. The right hand does not know what the left hand is doing or saying. Where does the training occur? Team meetings. Lastly, monitoring must occur. The entire team should be involved in the monitoring process. It is a proven fact that when you monitor progress, you improve.





*What advice can you give to help dental offices in this economy?*



I find that many offices wait until they are in trouble before seeking help - it is human nature. With heightened awareness of the economy, dental offices are increasingly aware of the chaos within their existing systems and realize that it is time to do something different. Now, more than ever, it is important to acquire consistency and continuity within the patient care systems. These days I spend more time training in this area during a consult. Additionally, I believe the number one thing that has to increase when the economy is down is internal marketing or customer service. People are still spending money, they are just thinking harder and longer about how and where they are going to spend it. Give them more of a reason as to why they should spend their money with you. Take more time to get to know patients to find out what it is they really want. The systems that are developed and the role that team members play within those systems can make all the difference in the success of the office – down economy or not. Focus on creating solid patient care systems; it could mean the difference between sinking or swimming in the current economic pool.



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# STRAIGHT

## Should I consider incorporating comprehensive orthodontic services for my patients?

**I**n this installment of Straight Tracks, I want to explore a question that comes up almost every day in emails and phone calls. As the Director of Orthodontics at LVI, I assist doctors in making decisions that have far reaching effects on patients and their practices, so in my answers to these requests I must consider the various aspects of each practice.

Let's review some of the most common concerns that general dentists have about the possible addition of orthodontics:

A. Many doctors are already providing Invisalign for their patients. They realize there are treatment gaps with this technique, and know it is impossible to treat many of these patients to a neuromuscular finish.



B. They are having a difficult time finding orthodontists to assist them in treating to a neuromuscular finish.

C. GPs often question the amount of time it will require to assimilate the

necessary skills.

D. "Where and when do I train, and how time consuming is it?"

Now that you are interested consider the following:

For doctors wishing to effectively integrate comprehensive orthodontic treatment into their general practices, one must take on a comprehensive course of study that will provide the best opportunity to succeed. This usually covers a series of courses that can extend for nine to eighteen months. The program should include a detailed study of neuromuscular diagnosis and treatment planning.

Remember that GPs have different treatment protocols than specialists so it is important to study with other GPs that have already learned or are learning to provide orthodontics within the

# TRACKS

RECOMMENDATIONS  
BASED ON A  
NEUROMUSCULAR  
PERSPECTIVE

JAY GERBER, DDS, FICCMO, ABPM

scope of a neuromuscular practice. It has been said that it takes an extended learning program in which to discover not only the treatment techniques needed, but also the definite mechanics that will allow the non-orthodontic specialist to effectively treat comprehensive occlusion. Additionally, GPs need to know what types of patients to treat, when to treat them and how to incorporate these new patients into their busy schedule.

The learning program that is now offered at LVI is designed specifically for neuromuscular dentists. It begins by training from the basic level through more advanced cases, from diagnosis to retention. It directs participants so they feel confident to provide treatment. The program includes both lectures and laboratory sessions that enable participants to develop hands-on skills.

Obviously the more complex adult and selected pediatric cases require



prosthodontic skills that can be easily combined with specific orthodontic mechanics. Many adults request or require aesthetic reconstruction. By providing orthodontic options you can now offer services that may re-

duce the number of esthetic crowns or other prosthetic services.

Pediatric treatment options are integrated within most courses. Of special note; most parents already in your practice want their children to be treated for orthodontics by you. Decisions for treatment are usually made without regard to the economy. Additionally, studies confirm that the mother will make the commitment in consultation with the GP or pediatric dentist. In over 25 years of instructing specialists and non-specialists it has become very clear to me that the primary provider (family dentist) has a huge advantage over the orthodontic specialist when the decision is to be made and where to go.

In some areas of the US more orthodontics is provided by GPs than specialists. Invisalign even reported that more cases were submitted by non-specialists. It has been shown that GPs can and often do provide



**“In summation, the decision to provide orthodontics will determine the future of his/her practice.”**

treatment above the level of the specialist. Therefore it can be concluded that GPs can be very productive in orthodontic services and treat with a high level of success.



Dr. Gerber is the Director of Neuromuscular Orthodontics at LVI Global and serves as the Clinical and Educational Director of the Center for Occlusal Studies. Dr. Jay has clinically treated

1,000's of patients since the early 1980's using the principles of Neuromuscular Dentistry. Dr. Gerber is recognized as one of early innovators of neuromuscular functional orthodontics and for the applications of the 'EMG Guided' bite registrations.

Dr. Gerber has made a commitment to stable, pain free neuromuscular correction and long-term occlusal stability. He currently maintains a private practice in Parkersburg, West Virginia.

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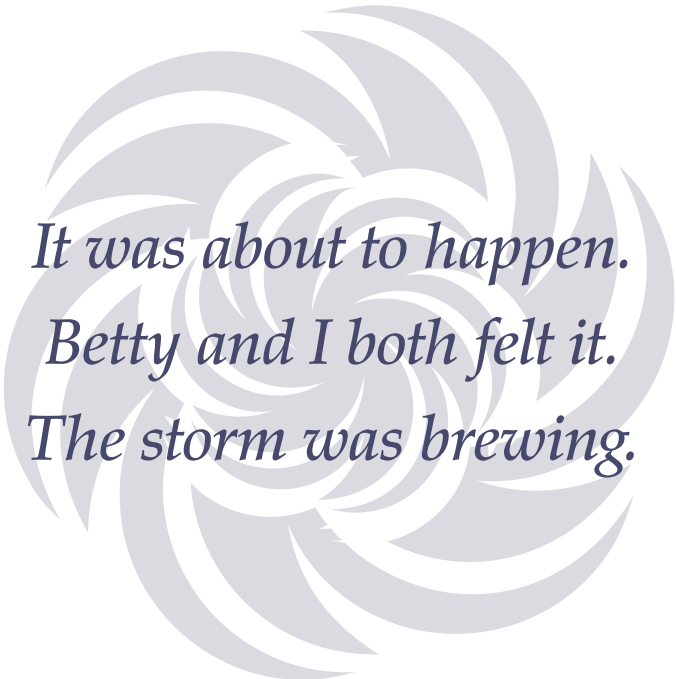
# The Patient-Centered Practice

Avoiding The Perfect Storm

Sherry Blair, CDA







*It was about to happen.  
Betty and I both felt it.  
The storm was brewing.*

It was 8:50 a.m. and all was calm as we sat working quietly. I peered out over the long counter at the patients waiting in the reception room. As they stared back, I once again realized how short the distance was between us, and how they seem to listen to every word I said even though the conversation was not meant for them to hear.

It was about to happen. Betty and I both felt it. The perfect storm was brewing. We could hear the dental hygienist wrapping up with her patient as the dental assistant was doing the same. In walks two patients, one wanting to discuss their new insurance, the other needed to give us new contact information. The tension increased as the phone rang with a new patient on the other end and then the

waves started to crash in. There were three patients headed from the back to the front. “Quick”, I said to Betty, “you take the reception room and I’ll take the back.” I now had three patients coming at me at the same time. I started to make calculated decisions; the new patient surely had a treatment plan, but how extensive was it? I have to collect the restorative patient’s money and then I see that the hygienist has laid a treatment plan on my desk for her patient. The pressure mounts, with three patients in front of me and three others listening from the reception area, as I realize that I am staring at treatment plans totaling \$5,000 and collecting \$2,000.

Think quickly; prioritize. I can collect the \$2,000 and get that patient out in approximately three minutes. I

know she has more work to schedule but I cannot deal with it now. I then ask the new patient to have a seat while I deal with the existing patient's treatment plan because after all it will take less time. Or should I have prioritized according to the size of the treatment plans? Too late now - just do it. Well, I certainly do not have time to tell this patient how much money to bring next time so I will just go ahead and schedule it and pray they pay.

Finally, the new patient is next. My heart is beating fast but I still maintain the smile on my face as we begin our conversation.

**Me:** "So it looks like you need three crowns and two fillings."

**Patient:** "Well that is what they said but could you tell me again why I need them?"

**Me:** "I'm not really sure but I can see if I can find some notes." (Now my heart is beating twice as fast! I cannot find any notes and there are no photos downloaded yet.) "Are any of these teeth hurting you?"

**Patient:** "No."

**Me:** (now panicking) "Let me see if I can go ask them."

The doctor is now on the phone and the assistant is throwing instruments in the sterilization room. She abruptly tells me that there are some cracks in the teeth and some decay.

**Me:** "You have some cracks and some decay."

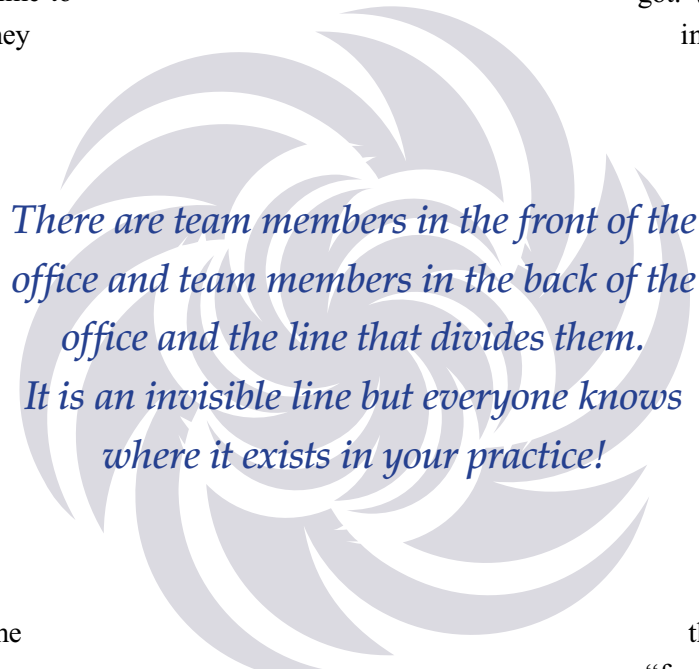
**Patient:** "Which ones have decay because that is all I want to fix?"

**Me:** "I couldn't say but I can let you

know it will be \$4,000."

**Patient:** "Never mind. I'll just call you back to schedule that."

I look around and it appears we are still afloat. Why then do I have this sinking feeling like we might drown?



*There are team members in the front of the office and team members in the back of the office and the line that divides them. It is an invisible line but everyone knows where it exists in your practice!*

## **WELCOME TO THE BERMUDA TRIANGLE OF TRADITIONAL DENTISTRY**

There are team members in the front of the office and team members in the back of the office and the line that divides them. It is an invisible line but everyone knows where it exists in your practice! Those in the front are supposed to "close" the treatment plan even though they have NO idea what is going on inside of the patient's mouth. They have never seen photos or observed what the Doctor/Hygienist/Assistant said or did. But it is their job to keep that schedule filled!

Is there a better way? In 1998, I sat in the audience at LVI as a dental team member (one of the girls at the front) listening to Dr. Bill Dickerson talk about something he called The Patient-Centered Practice or, he said, "You may know it as frontdeskless." The more I listened, the madder I got. What was he saying? I was going to lose my job? They do not need the girls at the front? A strong dislike for this man was brewing in my mind at that point. I was so angry that I almost forgot my day-to-day frustration previously mentioned in this article. I was quickly reminded when I returned home to the practice and at that point I decided it was time to do some research going all the way back to Omer Reed's

"frontdeskless" information. Today, I believe that it is the only way to practice dentistry. Why? It is better for our patients. There are fewer hand-offs, therefore fewer communication errors. Better relationships are created with patients therefore a higher level of trust develops. Higher trust equals higher treatment acceptance. This is better for the team because there is less frustration and more confidence. How? Cross-training. Proper systems. Correct scheduling.

Cross-training can occur through a commitment to productive team meetings where the team members in the back train the team members in the front and vice versa. I am amazed during team courses at the show of hands from administrators and hygienists

who have never seen their doctors perform procedures. They are not aware of the materials that are being used for procedures much less the lab quality and cost. Very few assistants could check-out a patient. I am not asking the administrative team to sit down and suck spit, I am just asking them to understand what we are doing and why. I am asking the entire team to understand that the right hand must know what the left hand is doing and saying. When cross-training occurs, a practice can become The Patient-Centered Practice.

The aspect of having proper systems is endless but for all practical purposes at least two systems must be understood in The Patient-Centered Practice. The first is the New Patient Experience. First and foremost, the new patient should be examined in the doctor's chair initially, as opposed to the hygiene chair. The most important person involved in this visit is the Treatment Coordinator, the New Patient Coordinator, or the New Patient Concierge. Do not be concerned with the "who" before understanding the system, and then plug the right person into the system. Some examples of the "who" will be provided a little later. The most important point here is that this ONE person walks the new patient through their entire visit. That visit will consist of four components. The first component is the interview - a critical point in the visit! As a patient; I do not care how much you know until I know how much you care! Remem-

ber people do not buy what they need, they buy what they want. You have to establish the relationship first and find out what the patient wants. The right questions must be asked in the interview to get the patient to realize some areas of concern without providing any solutions to problems they do not even think they have. The same team member that became the patient's new best friend in the interview will then follow the patient through the second component which is a comprehensive exam with the doctor. That is right, no more running from the front office to ask the doctor "why?" This team member will know the ins and outs of the patient's visit due to

becomes friends during the interview also observed what the doctor said and did, and will answer all the questions about options that the doctor may have outlined. What does it all boil down to? The money! The fourth and final component is the financial presentation. If this is the most important step, why make a hand-off to a complete stranger to discuss money? Complete the seamless visit with the same team member. There are several other details to this system but remember this is an illustration of the big picture to create an understanding of The Patient-Centered Practice.

The second system to illustrate The Patient-Centered Practice is the Existing Patient Experience utilizing the Hygiene Coordinator. It is necessary to establish that a Hygiene Coordinator is different than a hygiene assistant. A hygiene assistant position is designed to set up/break down rooms, sterilize instruments, and possibly take x-rays. The Hygiene Coordinator position is designed to be a version of the New Patient Coordinator. Just like the NP Coordinator or Treatment Coordinator works with the doctor to establish a relationship and higher treatment acceptance with the new patients, the Hygiene Coordinator works with the hygienist to establish higher treatment acceptance on restorative and/or periodontal therapy for existing patients. The same concept applies. This team member has more of a relationship and creditability with



*Today, I believe that it is the only way to practice dentistry. Why? It is better for our patients.*

first-hand involvement. Now, credibility has been developed for the team member to sit with the patient during the third component of the experience which is the treatment presentation. The same person that



the patient, being part of the process BEFORE the financial presentation. Therefore the Existing Patient Experience is structured so that the hygienist is conducting the five screenings (risk assessment, head and neck/oral cancer screening, restorative screening, occlusal screening, and perio screening) at the beginning of the appointment so that the Hygiene Coordinator can be present to assist with gathering the information just as the Treatment Coordinator is present with the doctor. As the Hygiene Coordinator checks the patient out and does the financial presentation they too have credibility (and confidence) with the existing patient.

Doctors, imagine this! You become burnt out in dentistry, have a midlife crisis, quit and decide to work at an auto repair shop. Because you are not a trained mechanic your job assignment is to answer the phone and collect money. A customer's car has been tested to determine what is wrong. You are to call and get permission from the customer to fix the problem and let them know how much the estimate is.

**Burnt-out Doctor:** "You have a major oil leak and it's going to take about \$2,500 to fix it."

**Customer:** "Where is the oil leak and why will it be so much? Is it a hose leaking or some part leaking? What will happen if I leave it for a while? How long could I leave it?"

**Burnt-out Doctor:** "I DON'T KNOW - I DON'T KNOW ANYTHING ABOUT CARS - I'M A DENTIST."

How is your confidence holding up at this point?

Either the schedule is going to control

us or we are going to control the schedule. It is nearly impossible to allow the schedule to control us and provide quality dentistry. The two previous systems are designed around the idea of having better treatment acceptance on more comprehensive dentistry as opposed to "one tooth at a time dentistry". If "one tooth" diagnosing is your philosophy then The Patient-Centered Practice may not be worth the effort to change. Almost anyone can close at The Bermuda Triangle on one tooth without knowing what the problem really is.

If you choose to work smart and not hard while providing comprehensive care, then slowing down and utilizing these systems with The Patient-Centered Practice might be an answer. Therefore we ask that an hour to an hour and a half, depending on the procedures preformed, be allotted in the doctor's schedule for the New Patient Experience (the entire time will not be with the doctor but will include the interview, x-rays, and photos with the Treatment Coordinator).

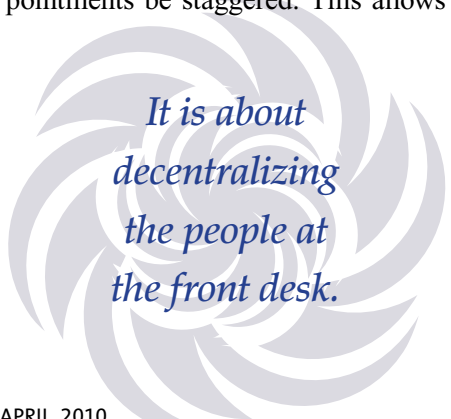
The Existing Patient Experience utilizing the Hygiene Coordinator is designed around having one Hygiene Coordinator assisting as many as two hygienists. The hygienist is scheduled for one hour with each existing, adult patient. The scheduling does require that the two hygienist's hour-long appointments be staggered. This allows

the Hygiene Coordinator to be present during the first part of the visit while the screenings are conducted and then to move to the second hygienist for screenings, and return to dismiss the first patient and so on.

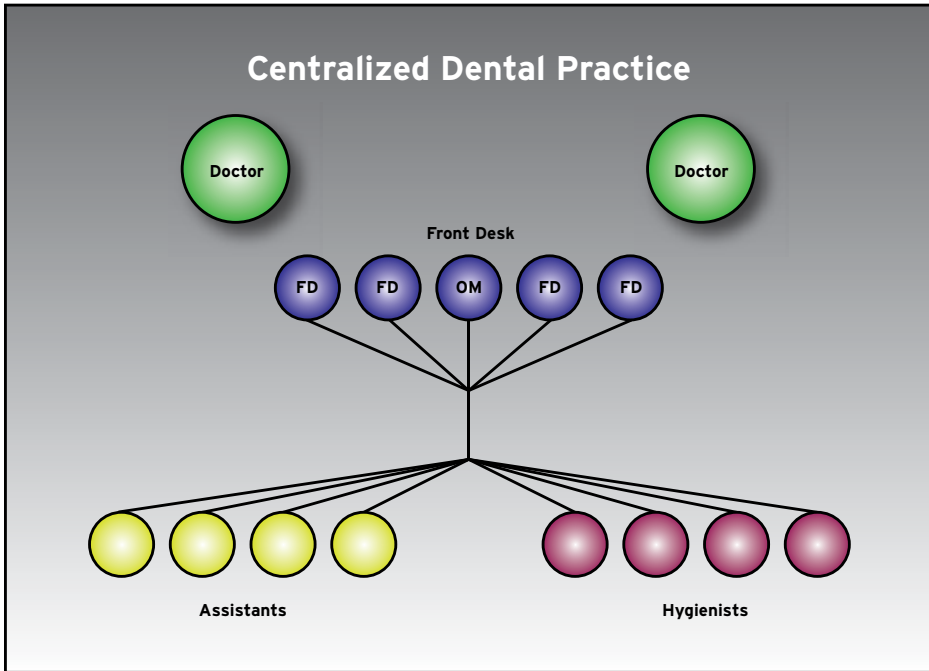
**Warning:** If you try these systems in a busy existing practice and do not change the scheduling first - THEY WILL FAIL!

Now having a minimal amount of information about these three systems, how would you ever start to think about becoming The Patient-Centered Practice? I may have lost half of you already because, of course, you have heard that a "large practice" could never be a Patient-Centered Practice. After all, how could you ever get rid of the front desk in a large practice? What do I do, fire all those people at the front desk? Tear down the front desk? NO. It is about restructuring positions. It is about decentralizing the people at the front desk. Do not worry about the inanimate object of the front desk. Put flowers on it or close it in and make a consult room. Again, see the big picture. It will help if you think in circles. Each small circle will take care of a few patients. Each circle will not hand-off the patient - they will totally take care of the patients in their circle. Take a look at the diagrams of practice models. These are real practices that I have consulted with and restructured into Patient-Centered Practices.

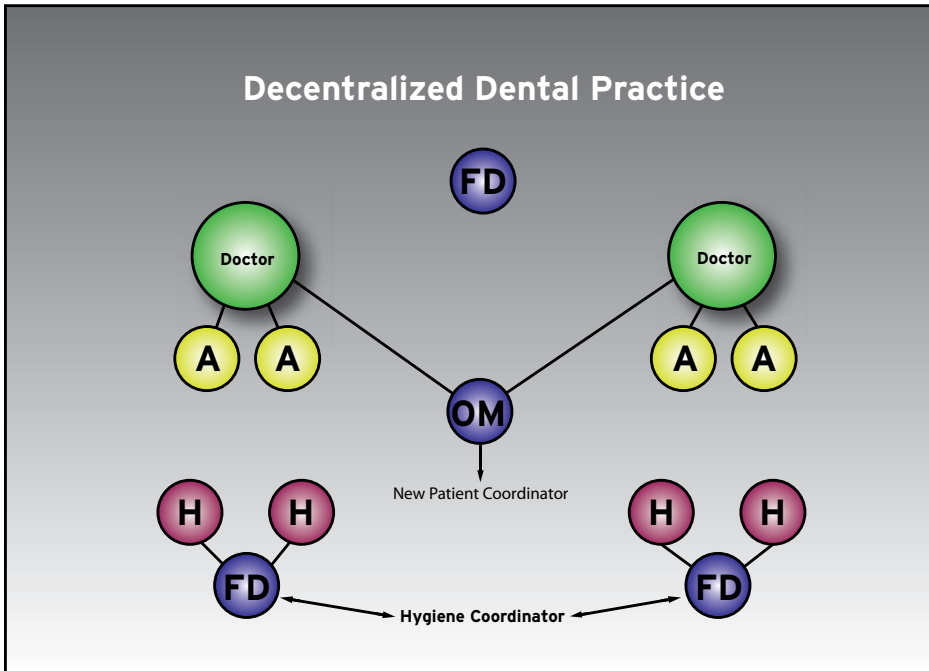
The first model is a large practice with two doctors, one office manager, four front desk, four assistants and four hygienists. You can see the centralized front desk structure in the before diagram. The four front desk team members had no designated duties. They all



*It is about  
decentralizing  
the people at  
the front desk.*



**Model 1 - Before**



**Model 1 - After**

checked patients out and all worked on the recall systems. No one person was responsible for any one duty.

New Structure: One of the team members was pregnant and was not planning on returning after birth. They were interviewing to replace her and we pulled the ad immediately. One team member was left at the front desk to act as a Concierge, answering the phone and greeting the patients. Another team

member, actually the office manager, became the New Patient Coordinator and worked with all the new patients for both doctors. The New Patient Coordinator followed the patient through the NP experience including the interview, comprehensive exam, treatment presentation, and financial presentation. The two remaining front desk team members each became Hygiene Coordinators, both being assigned to two hygien-

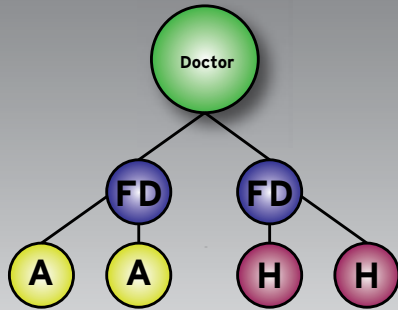
ists. Each Hygiene Coordinator was only responsible for the patients that were seen by their respective hygienists. Because we had established such a great financial system, not only was it easy for the patients to know their financial expectations at their restorative visit but it was also very easy for the assistants to know those patient's financial expectations. The assistants were cross-trained to check out their own patients.

I will admit that it took some remodeling (as many of you have experienced after I have consulted in your offices!) to get the required amount of consult rooms to complete The Patient-Centered Practice. We did remodel the front desk area to establish two small consult rooms for each Hygiene Coordinator to complete financial presentations and collect money. The practice already had an existing consult room for new patients.

So what just happened in this diagram? NO ONE IS ENTERING INTO THE BERMUDA TRIANGLE! The New Patient Coordinator is checking out his/her patients in the consult room. The Hygiene Coordinator is checking out their patients in their consult rooms and the assistants are checking out their own patients! Not to mention that we are HIPAA compliant now.

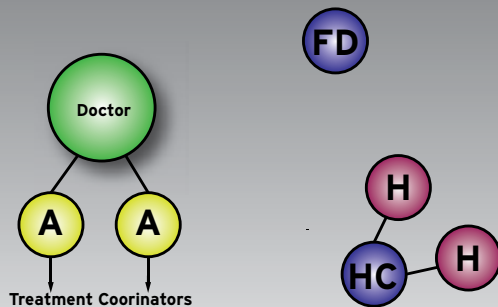
Here is another example of a smaller office that I worked with: One doctor, two front desk positions, two assis-

## Centralized Dental Practice



**Model 2 - Before**

## Decentralized Dental Practice



**Model 2 - After**

tants, and two hygienists.

It was determined that the assistants in this practice would be the best to perform the New Patient Experience as described above so we restructured their positions into Treatment Coordinators. Each would own a column of the doctor's schedule and work with the new patients in that column. They would then reschedule new patients back in their column, check them out each time and reschedule in their column again. In other words, they owned their own patients. We kept one front desk person as a Concierge, and moved another to become the Hygiene Coordinator.

Remember there is no one way to restructure and use the systems. The right way is what works best for your practice. Look at the strengths of each team member and see who would best fit into the systems and determine if they are willing to be cross-trained. Look at the team as a whole. You are not going to design a passing play if you have a running quarterback or a running play if you have a passing quarterback. But what I challenge you to do is look at the best way your patients can be served and design a structure that would create the least confusion. Confusion leads to a lack of trust with patients and a lack of confidence with teams. There can be a better way.



As Director of the Dynamic Team Program at the Las Vegas Institute, Sherry shares her more than 37 years of experience managing each and every system within the dental practice. Sherry has combined her acquired knowledge and personal experience to create an inspired, effective and motivated curriculum that refines the systems surrounding the patient's total experience in a dental practice. Sherry's extensive exposure to most forms of practice management and dental systems, as well as her strong focus on patient satisfaction, make her uniquely qualified to enhance the effects of any dental practice.

Sherry Blair is featured in LVI's Dynamic Team Concepts Series - a set of courses for dental team members designed to complement the CORE curriculum for doctors. Sherry is also an In-Office Consultant. You can contact her by email at [sblair@lviglobal.com](mailto:sblair@lviglobal.com).



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# Patient Management as the Core of Your Dental Practice Management Strategy



Brad Durham, DMD

*I knew I could not be everyone's dentist so  
I now use patient management as my  
primary method of practice management.*

**F**or years I struggled to create the practice of my dreams using every dental management technique available. It was time consuming, complex and unfulfilling. When I realized that it was pretty much impossible to manage a large group of patients into efficiency, (each with differing dental needs, wants and desires), I learned that all I needed to do was simply work only with patients who had similar values as myself (and are therefore inherently needing no management). This profound yet simple concept led me to search for a way to attract, identify and sift through my new and existing patient base. I knew I could not be everyone's dentist so I now use patient management as my primary method of practice management.

As I write this, we are in the middle of a recession. For many dentists, their practice has slowed down and many are seriously hurting. Yet at the same time, many dentists are doing fine and some are even thriving and experiencing growth. How could this be? When times get tough, you begin to see the weak suffer and the well prepared excel. Patient management is always a key to success. Let's explore some factors that cause this to occur.

If you are reading LVI Visions magazine, or have been to LVI, you are definitely interested in delivering more specialized services and it

should come as no surprise that cosmetic and restorative services are not desired by every dental patient. If you want to become proficient at these services, it makes sense to attract patients who will appreciate and even demand them. If you are trying to be everything to everybody, you will have to kiss a lot of frogs to find the few princes in the pond, which is a waste of time and overhead. The dental management industry wants to tell you that you can manage your existing patient base into the practice you want, but I am not buying in to that premise. What I am saying is that it is impossible to manage a large group of patients of different "dental values" in to an efficient dental practice. It takes too much energy and in the end, it makes it impossible to treat people individually according to their particular needs. Instead, everyone is treated in an average fashion to the lowest common denominator and the practice suffers greatly. Here is a short story to help explain.

Two dentists decide to go into the retail business and build a two story building. One level will house a Nordstrom and the other level a Wal-Mart. They build the building, stock the shelves, but before hiring the staff the accountant reports that they are out of money. So with their infinite wisdom they decide to hire only one set of staff to alternate between each store. Let's

play out this imaginary story and then make an analogy to the dental office.

Day one Nordstrom's opens for a whole month. The focus is on service and quality. Everything is going fine, the staff is happy and they are very profitable. On the beginning of the second month it is time to open up Wal-Mart and shut down the Nordstrom. Something odd begins to happen when the (previous Nordstrom) employees begin to work at Wal-Mart. They notice that the customers are very different and are not at all interested in service or quality, but instead only price. Eventually the staff learns how to communicate and work in the new environment and sales at Wal-Mart start to pick up and everything is working fine. The next month they shut down the Wal-Mart store and open up Nordstrom. Immediately the staff is confused again. The Nordstrom customers are again demanding way too much service and personal attention and actually seem to be not concerned with price at all.

The two owners look for a solution to the "service-price-values" mismatch and decide to alternate openings and staff changes weekly instead of monthly. Immediately the staff notices it is much more difficult to make this psychological switch. The problem is getting worse.

Next the owners incredibly decide to switch daily, and run the Nord-



## The Relationship between Needs, Values and the Marketplace

	High Needs	Low Needs
High Values	<b>A Target Market</b>	<b>A / B</b>
Low Values	<b>B / C Frustrating</b>	<b>C More Frustrating</b>

**The patient's ability to pay only tells how fast they will proceed with treatment**

strom on Monday, Wednesday and Friday and the Wal-Mart on Tuesday, Thursday and Saturday. The staff begins to get even more confused, disillusioned, frustrated and defaults to treating all of the customers in each store exactly the same. This treating customers to the lowest common denominator continues and sales go in a slow death spiral. Consequently, each store loses its "brand" and suffers. Eventually sales drop even more and the stores close.

In the dental practice when we try to be everything to everybody, there is a blend of patients of differing values and a similar situation to the retail analogy, except it is even worse as the customers (patients) are switched up hourly. What I mean by that is; in a typical day we see a variety of patients of differing dental values. We

may see an "A" patient at 8:00, a "B" at 9:00, the third, fourth and fifth patients may be a "C", then you throw in a couple of "Bs", and then finally an "A" patient shows up at 4:00pm. The team is so busy switching up trying to handle everybody of differing values that they miss the fact that the last patient is the one that wants and needs the very cosmetic/restorative procedure they love to provide. Running a blended practice (or trying to be everything to everyone) is an impossible situation for the team, so what happens is each team member begins to deliver an average level of service, the practice becomes basically average and it is difficult to attract and retain the "A" client on a routine basis. It is the definition of mediocrity!

Just as neither the Nordstrom nor Wal-Mart customers are neither good

nor bad, patients with high or low dental values are neither inherently good nor bad, except in the context of developing an efficient dental practice where there is congruency of values between the practice and patient base. Dental practices of blended values are inherently inefficient. Again, neither set of values is good or bad, they are just different. Values determine behavior, and behavior is what we see in the patient's decisions.

This takes us back to the original premise that identifying values and screening by values is probably the most important thing that you can do with the practice. It is certainly more important than banging around numbers on a piece of paper that your accountant gives you. Patient management is truly the core of practice management. Let's take a moment

and look at the relationship between the Dental Values and Dental Needs and what we typically find in the market place.

What I am looking for in my practice is a patient with high needs and high values. High values will drive them to commit to get the treatment done. High needs are a goal because it gives me something to treat. High values and low needs are okay, and it is okay to keep them in the practice, but it is not necessarily the focus because that means storing a lot of patients for continuing care and doing little to no treatment for them. Focus on maintaining the treatment that has already been completed.

Low values and high needs is a patient that is very frustrating and typically you will see this person has need, but no desire to commit. They say they

cannot afford it; the truth is they have no value. The low values, low needs patient is even more frustrating because not only do they have low values, they have low needs and are just taking up space. Again there is nothing wrong with having them in the hygiene system, and there is nothing wrong with having a big practice, it is just not as efficient. I am just limiting who my target market is to high values, high needs. I think a big mistake a lot of dentists and dental practices make is they think that money is the issue and money is what is driving the equation. In reality money does not, but values are the driving force for patients to get the treatment done. Money only tells you how fast they will get the treatment done. If the patient has high values, money will not be the issue. They will go out and find it.

To develop the dental practice that will support your desire to deliver more cosmetic and restorative services, it is simply a matter of identifying your ideal set of dental values in your existing and new patients and using this comparison to be a little selective in who joins your practice. If you choose to not enroll in this process you are committing to be everything to everybody. There is nothing wrong with that either, except you will never develop the practice to your potential, which in the estimation of many is a bit sad!

Identifying values is very easy and simply a matter of asking questions, clarifying them, and then recording them for future use. This will be the topic discussed in the second part of this article. Look for it in the next issue of LVI Visions.



Dr. Durham practices neuromuscular, cosmetic, and TMJ related dentistry in Savannah Georgia. He was the first in the world to receive the LVI mastership. He teaches Niche oriented management and technical courses at LVI and lectures frequently on the topic. For more information on this course contact LVI at [www.lviglobal.com](http://www.lviglobal.com) or 888.584.3237.

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## Advanced Clinical and Practice Applications

April 16-17, 2010

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# It's Never Too Late!



Michael Reece, DDS, LVIF



*I first met Ms. Zola Knowles in the spring of 1982. She had been in the practice of Dr. Howard Ritchey since 1954. I was the young associate and she rarely saw me. She preferred to see the more experienced dentist, Dr. Ritchey. Oh, every now and then I would do a root canal for her, or restore a broken tooth, but that was only because Dr. Ritchey was not available. However, slowly over the next 6 or 7 years she finally came to trust me and my dental skills, (it did not hurt that Dr. Ritchey had retired).*



Dear Dr. Reese and Ladies  
a hundred and one year  
old is the perfect age to  
appreciate, enjoy and grate-  
fully thank Dr. Reese and  
the Dental Clinic for  
my lovely crowned teeth!

All of you have made  
me proud and even com-  
fortable to have such  
efficient dental care for  
over fifty years.

You are truly  
appreciated and loved.

Zola Knowles

Thank you all!

One day in 1989, I went in to check her at her hygiene visit. She asked me to sit down; she said that she had a bone to pick with me. If you knew Ms. Knowles, like I had come to know her, you did as you were told. So I sat down and waited patiently, not knowing what was to come. She told me that she had her cataracts removed since she was in last and wanted to know how I had let her teeth get so yellow. This, at the ripe young age of 81! I did not know if she was really mad or not, until I saw that twinkle in her eye. She did say that she was interested in finding out what we could do to get her teeth whiter. Well, I am sure that I stumbled and stammered before I suggested that it is never too late to whiten your teeth. Connie, my hygienist, explained how she could use custom plastic trays to hold the whitening gel on her teeth, and that they would get whiter. "Perfect", she exclaimed, "when can we start?" "Right now", Connie said and Ms. Knowles, age 81, had impressions made

and was fitted with custom whitening trays.

Ms. Knowles was a very good whitening patient and was very happy with her whiter teeth. This lasted until 1992. Again, at a hygiene visit, she asked me to sit down, as she wanted to talk about the spaces that were developing around the necks of her front teeth. She knew that her gums had receded a little, but she hated the way her teeth looked with the spaces. She asked me what we could do to close the spaces. Her periodontal status was very good, with no pockets and no mobility; so I suggested that we close the spaces with some direct resin bonding. I told her that it is never too late to improve your smile. Ms. Knowles, at the age of 84, was agreeable to this and we used direct resin to close all of the black triangles on her front teeth. She was thrilled with the results for the next 16 years.

Unfortunately, the resin began to wear and stain, so we would refinish it and repolish it to remove the chips and stain. This helped for the next several years, but it seemed that every time





she came in for her hygiene visit, we were refinishing her resin bonding. Eventually, almost all of it was worn or polished away, and she again asked me to “sit down”. This was in January 2009. Ms. Knowles told me that she did not like the spaces that had “re-appeared” and wanted to know if we could redo her bonding. (This at the ripe young age of 100!) I explained that because of the wear and tear on her teeth, as well as the size of the spaces, that porcelain veneers would be a better option. “How much?” she wanted to know. When I told her the fee she said that she did not want to spend that much money. Again, she asked about the direct resin bonding that we had done in 1992. I told her that we could do it again, and that it would cost a little less than the porcelain, but it was not my first choice. However, I told her that it is never too late to rejuvenate your smile and that I would do whichever one she wanted. She said that she wanted to redo the bonding and set up an appointment to have it done. As she was leaving, she confided in Connie that she had plenty of money and that if I would give her a deal, she would do the porcelain.

The next day, Connie told me what Ms. Knowles had said, and we agreed to do the porcelain veneers on her upper front teeth, #6-#10, (#11 was part of a PFM bridge), for the same fee as the direct veneers. Connie called Ms. Knowles and she was delighted. I called my lab technician and asked him how old was the oldest person he had made veneers for. “92” was his answer. Well, I told him not any more!

Ms. Knowles was prepped in the usual manner and temporized as taught at



LVI. She was immediately thrilled with the results of the provisionals. “Now I don’t have those ugly spaces between my teeth”, she exclaimed. She was beaming as she left our office on the day of the preps and provisionals.

Ms. Knowles arrived early for her appointment on seat day, as she was excited to get her finished veneers. Everything went smoothly during the seat appointment and the lab did a great job on the case. As we sat her up for the preview, we noticed that tooth #5 should have been included in the treatment plan. Ms. Knowles was really only concerned about the spaces between her teeth, but we noticed that tooth #5 was the only tooth in her upper arch (she still had all of her upper teeth but one) that did not have porcelain on it. It had darkened over the years and the value was really low. It stood out like a sore thumb. Nanette, my assistant, and I both knew that we had to treat that last tooth. I told Ms. Knowles that I had pulled her inlay out with the impression and that we needed to change it. I quickly added that there would be no charge for this replacement. I immediately got on the phone to the lab and explained the situation to them and emphasized the fact that we needed a quick turn around on the case. For you see, Ms. Knowles was about to celebrate her 101st birthday, and I wanted to have everything finished for her birthday.

The lab said that the last veneer would be back it time for Ms. Knowles birthday party. The restoration arrived two days before her birthday and it was placed and blended beautifully. Now she was ready for her birthday party!

I had to go out of town to teach so three members of my team were able to go to her birthday party being held at the assisted living facility where Zola resides. Anyone having a March birthday celebrated in the dining room. The party was hosted by the St. Joseph Sunshine Auxiliary members. The room was decorated for the party and there was a decorated cake and large crystal serving bowl with punch, finger sandwiches, etc. One of the auxiliary ladies was playing the piano and the guests were clapping along. Since my team members seemed out of place while waiting, several people asked who they were and why they were there. When they

explained that they were her dental team and had fixed Zola’s smile they were impressed on two accounts: one, for Zola’s beautiful new smile and two, we took the time to come to her celebration. Much to my team’s surprise there was another birthday celebration for a lady turning 105 a few days prior.

Zola loves her new smile and loves all the attention that it has generated. It has been the talk of her residence ever since. She told me that she plans on being around for a while and now she is not self-conscious about all the “spaces” around her teeth. It is never too late to do anything about your smile –does she really look 101?







Dr. Reece received his pre-dental education from Texas Tech University. He received his DDS degree from the University of Texas Dental Branch in Houston in 1978. Following Dental School, he served in the US Air Force at Maxwell AFB in Montgomery, Alabama until 1981. He then started his private general dental

practice in Bryan, Texas. He now focuses on cosmetic and comprehensive restorative neuromuscular dentistry.

He is a fellow of the world-renowned Las Vegas Institute for Advanced Dental Studies (LVI) and was given the honor of being a clinical instructor for the institute in 2003. He teaches dentists from all over

the world in the latest treatments for cosmetic dentistry, full mouth reconstruction and neuromuscular occlusion. He is a member of many dental organizations and a Fellow in the Academy of General Dentist, Federation of Dentaire International, American College of Dentists and International College of Oral Implantologists. He received accredited status in the American Academy of Cosmetic Dentistry in 2001. He has been named as a Texas Super Dentist in the cosmetic field by Texas Monthly Magazine for the last four years.



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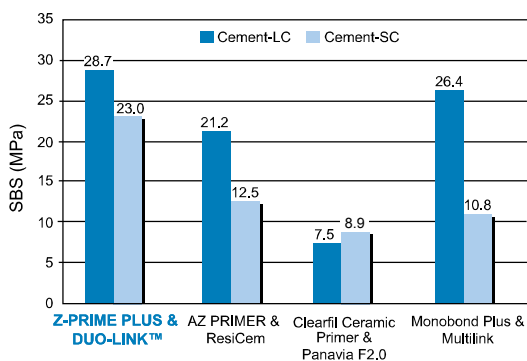
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# PRODUCT

## REVIEWS

Mark Duncan, DDS, LVIF

Once in a while, a technology comes along that dramatically changes the quality of dentistry.

The move from amalgam to adhesively placed dentistry is an example of a technology that made a great impact. The change from fixed bridges to implant supported crowns is another. As dentists are aware, the better the visibility, the better the dentistry can be, and this has led most to utilize loops for magnification. There are a number of great designs and I have thoroughly enjoyed the benefits from companies such as Designs for Vision and Orascoptic. There is no question that these products have improved the caliber of my dentistry. However, dentists are still using somewhere between 2-5x magnification to prep cases and then send them to the lab where they are trimmed at 10-20x magnification or more. It always seemed odd to prepare cases at a tenth of the magnification than the laboratory works with. If that

kind of detail is critical for the end result, why not use the benefit of higher magnification in the patient's mouth?

Well, the answer is obvious. If you have ever worn a 5x loupe, the thought of a 25 power magnification and the damage that the optics would do to posture and the cervical collar of muscles spells out clearly the reasons not to wear that kind of magnification. It is not a case where there is no benefit, but rather a case of practicality. Ergonomically, it simply is not possible to work with that kind of magnification. However that is exactly why dentists should. With the demands placed on the eyes and natural decreasing acuity over time without the occupational strain, in many ways dentistry is a self-limiting profession. Heavier strain on the eyes causes them to wear out at a

faster rate. As visual acuity decreases postural compensation increases. Less than ideal posture makes it more difficult to perform the tasks of daily surgery that is dentistry.

A number of alternatives have been tried; however none have been a workable solution until now! MagnaVu has recently released a product that not only enables better viewing, but also features proper ergonomics, and communication/documentation tools! Finally there is a turn-key solution that accomplishes what dentists have been trying to do for years with a combination of loupes, microscopes and cameras. The MagnaVu is a system that allows you to sit in a neutral and correct posture while viewing dental procedures at very high resolution on a flat LCD video screen. It will eliminate the occupational compromises like back, shoulder and neck pain because it places the operator in the ideal position. Operation of the MagnaVu is simple to learn and incorporate with





a previously unavailable 6" depth of field. Once positioned, everything stays clear and in focus!

At LVI, I have had the opportunity to witness first-time users sit in front of the MagnaVu and within a matter of minutes become skilled and competent at working with the MagnaVu to view indirectly all areas of the patient's mouth. It offers perfect and complete illumination of the operating field for an incredible way to SEE the mouth. The MagnaVu enhances your vision with magnification at 24x! Imagine watching not the mouth, but the flat screen display in real-time. During the demonstration at LVI, the operator was observing from a flat panel LCD however, the audience watched a 42" high-definition monitor. The level of precision that can be achieved when the prepared tooth is seen at dozens of times life size is incredible! Additionally, there is hands-

free, motorized zoom, freeze frame capability, and image capture to disk or computer. This technology can also be used to create incredible before, during, and after photos with high-quality resolution and perfect lighting. What a powerful way to skyrocket the quality of your dental services!

The MagnaVu was developed to provide the operator with a better, more comfortable position and stay at rest through the procedure. What they

have created is a system that actually improves the quality of dentistry! You can see with incredible precision exactly where you are and what you are doing. There is no need to question the 'if' anymore. You know when the tissue is retracted. You know when that cavosurface margin is level and smooth. When placing a Dickerson Ditch like taught in the Core II pro-

### Various MagnaVu Setups



gram at LVI, you will know exactly where you are. You can see the adaptation of the matrix in direct restorative visits, and you know what the impression has captured.

Simply put, MagnaVu allows you to be a better dentist and perform at a higher level while saving your neck and back. LVI will be utilizing the MagnaVu during live-patient treatment courses, so make sure you check them out. Once you see the simplicity and benefits of the MagnaVu, it will only be a question of when you bring this technology into your practice. My recommendation is to get it in place before postural issues and neck and back pain begin!



### Preparation and Impression evaluation



## LVI Stratos System

In a departure from the traditional Product Review, which often explores newer materials and technologies, this review focuses on a grossly underutilized and forgotten dental tool. There is little question that it would be easier to help patients make great health care decisions if they better understood what is possible in dentistry. With a heightened awareness of the consequences of neglect and delaying treatment, patients would press dentists to move their treatment along sooner. Helping patients to understand how involved the mouth is with the rest of the body is best done by utilizing a diagnosis and patient education tool often left behind in dental school. Without having explored every dental school, it is a pretty safe assumption

that in dental school all students used articulators in the treatment planning of cases. At some time later, a process of treating the patient one tooth at a time is put into practice and the number of steps in the planning begins to decline. One of the first steps dentists walk away from is the diagnostic review of the mounted models. Since the vast majority of cases are restored to the existing centric occlusion, mounting it would not make any difference. Further simplification of the planning process occurs as restorations are not built on a full arch model. Since most fixed prosthetics consist of just one or two units, dentists never look back.

Going back to the basics, the articulator is one of the most effective tools at our disposal. Not only is

it possible - but quite likely - that a patient would accept, even demand comprehensive evaluation and treatment when the dentist utilizes the articulator. It has to be simple, predictable and easily understood by the patient. This combination allows for doctor and patient to walk a path of logic and common sense to arrive at the optimal treatment.

That is exactly the beauty of the LVI Stratos System. It is built on the quality and exceptional usability of the Ivoclar Stratos articulators. They are easy for a technician to work with and designed to work for both fixed and removable cases. More importantly, the LVI Stratos System is easily calibrated and eliminates the need to ship the entire articulator back and forth



with each case. An articulator in the office and one at the lab will mount exactly the same way allowing the dentist and ceramist to produce more predictable, higher-quality, comprehensive cases without having to keep it mounted on a dedicated articulator through the entire process.

The LVI Stratos System has a specially designed mounting platform for mounting to skeletal landmarks with accuracy based on cone beam CT studies of 95% or higher. This skeletal landmark was discussed as far back as 1955; however students are still forced to utilize subjective and soft tissue-based face bow transfer systems to mount cases in dental school. Again, with limited application in traditional restorative dentistry, dentists quickly leave this concept behind. There is no reason to mount the maxillary arch precisely with no plans to complete any significant restorative work in the first place. This is exactly the catch 22 that hinders observation of the patient with open eyes. The face bow was generally an imprecise way to approximate the maxillary arch that is in line with the hinge axis which is no longer believed to exist anywhere



**Occlusal Plane Analyzer**

near the mounting location. If it is now taught that the hinge axis is not anywhere near the TM joints; the real question is, why mount based on it? It may have been the best available but did not really provide much valuable information and the use of face bows was discontinued. The LVI Stratos System is used to accurately mount the maxillary arch with 95% predictability in a way that represents the patient and is simple to use with no special chair-side contraptions or equipment. The biggest hurdle is having patients see what is really happening with them in a way that is meaningful and



**Mounted study models with occlusal damage highlighted**





impactful. Without an exploration period it is unreasonable to expect patients to comprehend what is happening with their oral health and decide to take corrective action. A dentist who only looks at the tooth-to-tooth interface on incomplete models, will also miss what is happening with the patient. This is the real power of the LVI Stratos System. Used comprehensively, it is the best visual aid in the dental office. Dentists and patients can make good decisions about oral health, and as an extension, the rest of the body.

There is a dramatic canting to the arch that is not always noticeable in the patient's face since the head is often postured to attempt to level the plane of occlusion, resulting in a compromised head posture and creating muscle strain as well as hypertonicity in the muscles of mastication including the Anterior Temporalis and Masseter.

When meeting with a patient to explore the details of their models, they are amazed! While observing the upper arch mounted on the HIP (Hamular Notch – Incisive Papilla Plane), patients notice how their upper jaw fits within their head. The LVI Stratos accurately orients the cranial base so that the head is in the proper posture, eliminating a number of issues. Details are discussed during the Core courses at LVI, but the point is that the LVI Stratos is utilized to make a diagnosis as to how the upper jaw fits in space with an accuracy of 95%. The beautiful thing about the LVI Stratos System is, for both dentist and patient, it makes sense!



There is a dramatic canting to the arch that is not always noticeable in the patient's face since the head is often postured to attempt to level the plane of occlusion, resulting in a compromised head posture and creating muscle strain as well as hypertonicity in the muscles of mastication including the Anterior Temporalis and Masseter.

Exploration by the patient leads to understanding that the arch should be level and a realization of the benefit of improving this relationship. Providing patients with an opportunity to see their mounted upper arch lets them explore their mouth in a novel way. Most dentists themselves have not participated in the discovery process, much less embarked on this process with the patient. What a great way for patients to also discover that the dentist's comprehensive care is different than the 'complete exam' they are accustomed to. It is not just an exam that includes a quick cleaning, four bitewings and a pan.

It is widely known and accepted that the maxillary occlusal plane should be parallel to the plane of the maxillary arch and that should allow the cranial base to be properly oriented and posture the head correctly. The dynamics of proper head posture is incredible; a slight increase in forward head posture will create a 300% jump in the force required to hold the head in that pathologic position. Proper placement of the cranium is directly related to the position of the maxillary arch which is directly related to the position of the maxillary occlusal plane. Without examination of the maxillary arch and occlusion an appropriate decision cannot be made about the health of the patient. When confined to treating diseases of the hard tissue and just patching decay, it does not make much difference where the head is because what is not observed or understood cannot be diagnosed and treated. Dentists can elect to live up to the charge and embrace their professional obligation by evaluating the soft tissue and supporting musculature as well. The big picture must be in focus.

HIP analysis allows patients to examine the pitch and position of their arch, giving them a better perspective and the opportunity to make a more informed decision.

It is well established that the ideal jaw architecture would include a Curve of Spee and a Curve of Wilson. When these are properly developed, the arch essentially sits on the inside of a sphere so that the upper teeth are higher on the buccal cusps and higher in the posterior. This is

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HIP analysis allows patients to examine the pitch and position of their arch, giving them a better perspective and the opportunity to make a more informed decision.

a normal arrangement and is easily visualized or created if you have the proper frame of reference. This is the second area where the LVI Stratos becomes an indispensable tool. The development of the arches is easy to evaluate and correct with this perspective and then the proper alignment of the arch as a whole can be determined for the patient.

As seen in the illustrations, there is no question as to the distortion of the maxillary arch, and a patient who is considering any amount of dental work deserves to know what they are

doing in their mouth and what they are correcting. The foundation of the Core courses at LVI begins with an exercise of mounting and evaluation of the doctor's arches. The participants are amazed at how much more they can see in their own mouths when they look at the occlusal plane on the LVI Stratos System. Imagine how much better the patient's decisions will be when they have the same experience!

Comprehensive diagnostics and comprehensive treatment need to be considered every time options are pre-

sented by which a patient may benefit. When patients are offered a comprehensive exam, it should be exactly that; comprehensive. The comprehensive exam must also be meaningful to the patient and enable them to make good decisions based on the results of the exam and viable treatment options. With the effective and efficient LVI Stratos, it is time for dentists to utilize the articulator again. As physicians of the head and neck, we owe it to ourselves to explore what is happening with our patients. It is the first step in eliminating chronic pain and protecting airway and above that, it is our professional obligation! Get the LVI Stratos in your practice and make a difference for your patients!



A 1995 graduate of the University of Oklahoma, Dr. Duncan vigorously pursued continuing education to grow beyond what was taught in dental school; twice being

recognized as the leader in Oklahoma for Continuing Education. He completed the surgical and prosthetic sections with the Misch Implant Institute earning a Fellowship with the Institute as well as holding Diplomate status with the International Congress of Oral Implantologists. He has also earned the Fellowship with the Academy of General Dentistry in the shortest time period allowed by the Academy. He considers his real advance in education to have started with his journey through the Las Vegas Institute where he earned a Fellowship and currently works full-time as Clinical Director. Dr. Duncan is a member of the International Association of Comprehensive Aesthetics (IACA) and holds a position on the Board of Directors.



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# Meta



## What They Don't Teach You in Dental School

**T**here is, perhaps, nothing quite as enlightening as being reminded that you don't know what you don't know. I can honestly attest that reaffirming my lack of knowledge is the best thing I can do for my patients. Sounds weird, I know, particularly when we're all part of a profession that requires a public display of confidence and knowledge but (and it's a big BUT) it's easy to be confident when you don't realize that you're under educated.

### **Maybe I should backtrack a bit...**

In 2001, I graduated from Tufts and joined the ranks of some 160,000 dentists currently practicing in the

U.S. Sure, Tufts is a great school and I worked my backside to the bone to earn that diploma but I, like every other new dental graduate, was about \$300K in debt and scared out of my wits. You can study books until you go blind and you can theorize until you lose consciousness but the fact is, without real world knowledge and application of skills all you really know is what somebody else told you. Of course, I didn't know this when I left school. Like anyone else, I was chomping at the bit to get out there, slide on some nitrile gloves and start rooting around in someone's mouth.

After school, I joined a practice and began my career as a dentist. It was great; everything was new, exciting and challenging. Then the lights began to dim and my level of interest and appreciation started to fade. After practicing for about 3 years, I found myself bored, confused and



**Shahin Safarian, DMD, MBA**

questioning whether or not I had chosen the correct direction for my life. For me, the luster of the profession had vanished and the daily labor had become entirely monotonous. At just 3 years in, I came to realize that



# morphosis

**meta•mor•pho•sis n. change of shape, substance, character, or transformation**

I wasn't controlling my environment, my environment was controlling me.

Think about what you learn in school. The basics, right? You learn what you need to know to technically pass as a dentist and then it's somewhat assumed that the rest of the job will sort of be stumbled upon once you start getting your feet wet. I found myself feeling much like a drone; not really free to do my own thing but rather going through the motions and moving one patient out to get the next one in. In my eyes, it was the same song and dance every time.

Now, let me save you a few years of sleepless nights and cut to the chase. I had zero prospects for moving forward in my career and (more importantly) zero prospects for moving forward with my understanding of my own profession. You have a basic set of skills when you graduate but it's only the tip of the dental iceberg.

What you don't learn in dental school and end up absorbing once you get out, is that dentistry is a service industry. Yes, they're patients but they are also paying customers - that is to say that they pay for your expertise. Therefore, wouldn't it behoove both you and your patients for you (as the dentist and the expert in the room) to have the widest breadth of understanding as possible?

More to the point, fresh out of school you do not know much about orthodontics, implants, cosmetics, rehabilitations, TMJ and the list goes on and on. I can fully guarantee that you will come across people who both need and desire these services on a daily basis. Based on what I've seen, you'll have to refer every one of these patients to someone else and just like me, you'll lose out on that added income and you'll get the displeasure of seeing your patient scared, confused

or even upset that you (their trusted dentist) can't handle their problem and likely can't even comprehend it.

So, three years into my dental journey, I recognized the need to expand my knowledge and increase my skill level. I chose to attend LVI so that I could catch up on all the things you don't learn in school but are reminded of the need for daily.

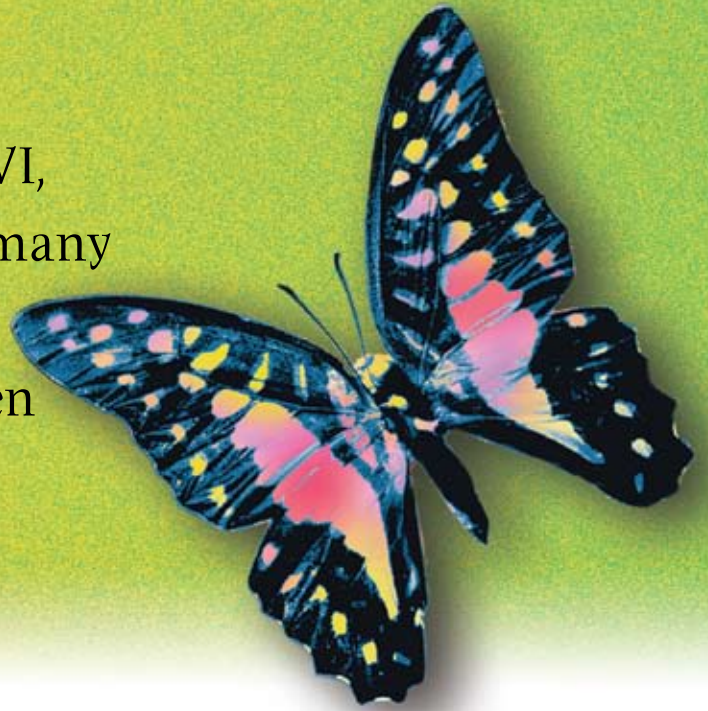
I won't lie, it was a tough decision and one that I was scared to make. Already being \$300K in debt, the prospect of tacking more money on to that debt seemed like potential financial suicide. Nonetheless, I opted to continue my education and find out what LVI had to offer.

**Now, let's fast forward  
to the present...**

Over eight years into my career now, I can truthfully tell anyone that



“Every time I attend a course at LVI, I am reminded that there are so many aspects of the profession that not only do I not understand, but often didn’t even know existed.”



attending LVI was the single wisest decision I have made. No, I am not getting paid to say this and I enjoy no tangible benefit from saying this. Logically speaking, continuing your education is not only a smart business move but also something that every dentist owes him or herself.

After devoting countless hours, years and dollars to your education why would you want to emerge from school as a run of the mill dentist? You can fill a cavity but so can the dentist in the office down the street from you. My take on it is that your patients probably ended up choosing you because: A) your name was on their list of dentists approved by their insurance and B) your office has the shortest driving distance from them. I don’t know about you but I want people to choose me because they love the work I do, they feel comfortable in my office, they know that I can help with virtually any dental problem or question and because they feel confident in me because I have

confidence in my work. I don’t want to be in debt for nothing, I want to be the best I can possibly be at what I do. My patients deserve the best and I deserve the best.

It’s all about outcomes. We have all invested in our futures by paying for our educations and through our work. We all want to see a return on that investment. You’ll make that return doing the basics but I guarantee you, you’ll make that return considerably faster by continuing your education with LVI and that’s not promotion, that’s reason. The more services you can offer means that you’ll be taking in that much more income. Without offering any supplemental services you might see 20 patients a day. Now, imagine if you could bring in more money and only see 5 patients. Which makes more sense: a busier day, less time with patients and all this for less money or a higher income with the freedom to properly communicate with your patients? The way I see it, the choice is obvious but you will nev-

er improve your skills, career or way of life by doing nothing.

Every time I attend a course at LVI, I am reminded that there are so many aspects of the profession that not only do I not understand, but often didn’t even know existed. This profession evolves so quickly that understanding and providing the best care for your patients depends on your ability to adapt. These days, I have my own practice and I’m constantly busy but I still find the time to learn new skills and refresh my understanding of current skills whenever new methods or technologies are made available. No matter how busy you are, time can be made to improve your career.

You can do this, I assure you. It’s all a matter of taking that initial step. Instead of referring patients to specialists, why don’t you become the specialist yourself? Instead of working at someone else’s practice for your entire career, why not take some business courses and start your own? Everyday you will face shortcomings and prob-

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A handwritten signature in black ink, which appears to read "Brad Durham". The signature is written in a cursive style and is positioned over the lower part of the portrait of Dr. Durham.

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Remember, this is a service industry.  
If your 'services' improve then  
your business improves.



lems in this business but overcoming them will come down to your ability to own the problem rather than dodge it. In short, if there's something you don't know how to do - learn how.

Your patients want someone who provides a comfortable environment. They want someone who exudes confidence. They want someone who understands their fears and problems and has an answer for them. In my experience, that is what keeps people coming back, stops them from switching dentists and motivates them to suggest you.

I believe that 85% of dentistry is trust and relationships. You will never have either of those components if you don't want to. Earning them requires you to strive to be the best informed and to always want to improve what you already know. Remember, this is a service industry. If your 'services' improve then your business improves.

Patients trust a dentist who knows how to help them, is capable of explaining their options, maintains an

open dialogue, understands their fears, caters to their comfort and displays a thorough knowledge of all these things.

The walls of my practice are covered with LVI certifications that convey my expertise in various aspects of dentistry learned throughout my continued education. When a patient walks by, they can stop and take in all the skills and disciplines that I've accumulated through LVI and they can derive comfort in knowing that I continually seek to be a better dentist and provide better care...but they don't need to. The skills I learned at LVI speak for themselves and even if my walls were bare, my patients keep coming back to me because I can offer them the most diverse and inclusive dental care they can find.

My debt is still there but I can comfortably say that it's dwindling a lot faster than most because of the return on my investment in continued education. Whether it's monetary, self-confidence building or patient-relationship building, I enjoy perks

from all directions. To this day, I still take courses at LVI; both new and refresher courses. I can do it on my own time and have to spend a minimal amount of time away from my practice while doing so. In fact, most courses take a total of no more than 6 days to complete (3 days if it's a non-clinical course). When I return I have a new skill, a better understanding of what I do, a new service to offer my patients and a new way to keep patients coming to me rather than referring them out. Forget what you've been told. Knowledge is not power. Implementing knowledge is power and learning how to do so provides the largest return on your investment in LVI.

Today, I have achieved the rank of LVI Fellow and my patients reap the benefit of a dentist who has taken over 15 courses at LVI, ranging from clinical skills to business management. However, even with an ever-growing list of studies, I still find myself needing support. The network of professionals linked to LVI



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serves as the single most useful perk. I have unlimited access to a wealth of real world knowledge through my mentors and fellow LVI alumni. Every time I take a new course and I realize how much I didn't know, I reaffirm why taking it was such a good decision in the first place and my mentors are there for me before, during and after.

Obviously, LVI is not free but like most things in life, nothing worth having is free or easy. I also recognize that accruing more debt isn't a highly savored thought to anyone new to dentistry. However, let me ask you this: if not now, when? You know as well as I do that the longer you put it off, the less likely it is to ever happen.

The ability to increase your happiness, profit, efficiency and self-confidence rests on your shoulders. You can literally change your life by gaining the leverage to understand and practice diagnostic, cosmetic and elective dentistry. Without that leverage, you're just another name on the directory.

If you are interested in embarking on your LVI journey and would like a bit of guidance, please don't hesitate to contact me.

**Shahin Safarian, DMD, MBA**


**LVI Fellow**

**safariandmd@aim.com**

**www.safariandmd.com**

Dr. Shahin Safarian attended U.S. International University on a soccer scholarship in 1986, where he attained his MBA. From 1992 to 1995 Dr. Safarian played professional soccer for the San Diego Sockers and Puebla F.C., but by 1997, Dr. Safarian recognized the need to pursue a more stable future and he opted to attend dental school.

Dr. Safarian graduated from Tufts School of Dental Medicine in 2001. Three years into his profession, he felt the need to better himself as dentist and began attending LVI for continued education. To date, he has completed over 15 courses at LVI and has achieved the rank of LVI fellow. In the near future, Dr. Safarian aspires to instruct at LVI and host seminars. One day, he would love to volunteer his time to motivate student athletes to embrace their education and sport simultaneously; teaching them that "education is your foundation for life."



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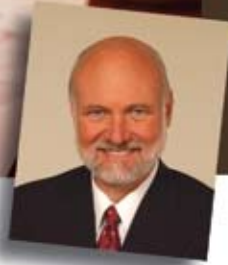
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# THE WEATHERERS' REPORT



Arthur "Kit" Weathers, Jr., DDS

## Profound, Predictable and Painless Anesthesia in 60 Seconds or Less

*What you don't know about dental anesthesia can hurt your practice.*

**Y**our patients may not know if you do great root canals, but they definitely know if your anesthetic technique is ineffective. One of the best ways to build your practice is to be recognized as a painless, caring dentist. With a few simple changes in technique, you can achieve profound, painless anesthesia on 98% of your patients (2% of your patients will not get numb no matter what you do, but treating that group is the subject of another article). Best of all, one of the techniques discussed in this article provides profound, predictable and painless results in less than 60 seconds.

If you have a one hundred percent success rate with mandibular blocks, you can skip this article all together, but if you are like most dentists, this article may be just what you need to



Most dentists would agree that inability to obtain profound anesthesia is the most stressful aspect of the dental practice.

eliminate problems caused by the "Inferior" alveolar nerve block. That is right, "Inferior" is in quotes for a reason. So why not try one or more

of the following tips to increase your level of success as you lower your level of stress.

***Increase your success rate by 15% on your next "Inferior" alveolar nerve block***

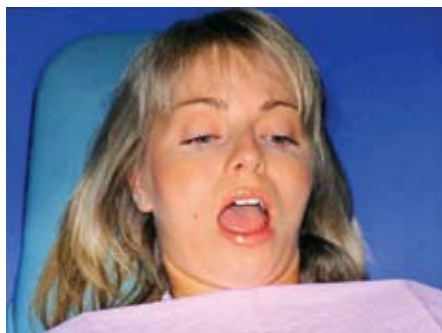
Let's start with a simple technique change that can instantly increase your success rate with the inferior alveolar nerve block by approximately fifteen percent. Studies have shown that the inferior alveolar nerve enters the mandible higher than normal approximately 15% of the time. Therefore, if you simply inject one and a half centimeters above the occlusal plane instead of the recommended one centimeter above, you should see an immediate improvement in your success rate.

***Make certain the patient's chin is tilted back***

The position of the patient's head is much more important than most people realize. When your patient sits down, her chin is usually almost on her chest (figure 1), so when you say, "Please open wide," the access is compromised (figure 2). If you will gently tilt the patient's head back prior to asking her to open (figure 3), you will have much better visibility (figure 4).



**Figure 1-** Patient's chin is on her chest



**Figure 2-** The visibility in the patient's mouth is compromised



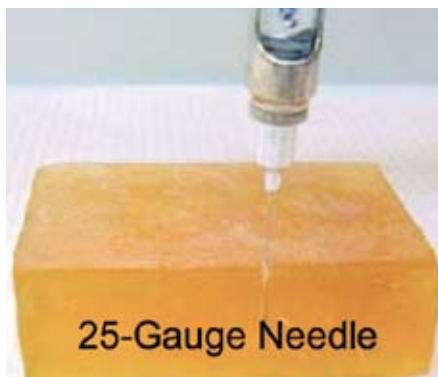
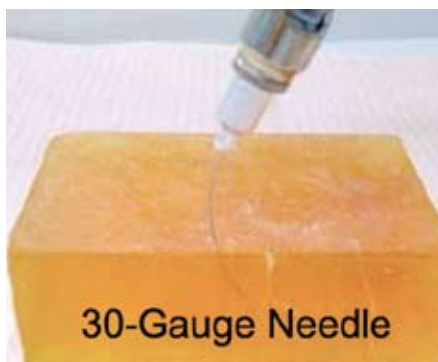
**Figure 3-** Tilt the patient's head back



**Figure 4-** Visibility is much better

**Use 25-gauge needles**

Patients cannot tell the difference between a 25-gauge and a 30-gauge needle, so consider using 25-gauge needles to prevent deflection or possible separation of the needle into the tissue. If the doctor mistakenly believes a 25-gauge is more painful than a 30-gauge needle, he or she may inadvertently project that feeling to the patient, which is the subject of our next anesthetic tip.



**Figure 5-** The 30-gauge needle is deflected in a bar of soap, while the 25-gauge remains straight.

***Be aware of the Psychology of Pain***

Even though your patients cannot tell the difference between a 25, 27 or a 30-gauge needle, the attitude and actions of the doctor can influence what the patient feels. A good example of the psychology of pain can be seen in the way I dismiss my patients.

At the completion of every root canal, I say, "You will probably have a two-aspirin toothache, so take what you normally take for a headache." I then handwrite my unlisted number on the back of an appointment card (or my business card), and say, "If you need anything stronger than what you usually take for a headache, call me on my unlisted phone number." There are several subliminal messages hidden in this brief exchange.

By mentioning the "two-aspirin" toothache, I give the patient permission to hurt a little, while at the same time suggesting the tooth will only be slightly painful. Incidentally, when I give a patient my unlisted phone number, they virtually never use it, but if they do call, I know they really need me.

By the way, when I first meet a new patient, I say something like, "If I promise not to hurt you, what else would you like to know?" Notice, I did not say there would be no pain, but that is the implication, and it tends to help relax the patient. Most patients are only concerned about two things; will it hurt and how much will it cost? In one sentence most patients have the answer to 50% of their concerns.

I also make certain that my patients are never left alone in the operatory.

Sitting in a strange environment staring at ominous looking instruments causes patients to worry about a lot of things that ‘might’ happen. If I can get patients profoundly numb in 60 seconds or less, there is no good reason to leave them in the operatory alone.

### ***Be careful when inserting the anesthetic needle***

It is important to be very careful when encountering bone, or the tip of the anesthetic needle may become bent and cause damage on the way out of the tissue. If you think the tip of the needle might have been compromised, drag it across a sterile 2x2 gauze sponge. If the needle tip hooks even one of the cotton fibers, do not use that needle to re-inject the patient and immediately dispose of the needle.

If the injection needle is positioned too far posteriorly, anesthetic may be injected into the parotid gland causing dangerous systemic effects, such as temporary paralysis of Cranial Nerve VII (7), causing Bells Palsy-like symptoms. If the needle is placed too far medially, the medial pterygoid muscle can be injected, resulting in trismus. If the needle is too far to the anterior, you may hit the ascending ramus of the mandible. The sphenomandibular ligament can also be damaged when administering the inferior alveolar nerve block. Careful attention to all of the landmarks will greatly minimize the chance of these problems occurring.

### ***Are two cartridges better than one?***

I frequently use two different cartridges of anesthetic for mandibular blocks. Early on, I would inject the first cartridge, occasionally hurt the patient, and then have to give a second injection. Then I decided to skip the part where I hurt the patient. The first cartridge would be minus epinephrine, so it would rapidly begin to spread and numb the area. As soon as the patient reported numbness in the lip, I would administer the second cartridge, which contained epinephrine to prolong the duration.

The sheer volume of two cartridges might also increase the odds for success, although I have no scientific proof of that. Incidentally, anesthetic without epinephrine does not cause the burning sensation that is common with anesthetics containing epinephrine. I have been told it is the epinephrine preservative that causes the sting, but I cannot prove that either.

### ***Intraosseous anesthesia takes effect in 60 seconds or less***

The last tip in this series concerns the use of intraosseous anesthesia. Placing the anesthetic directly into the bone allows it to rapidly diffuse to the roots numbing the tooth or teeth in less than 60 seconds. Placing the anesthetic close to the root virtually guarantees anesthesia of all accessory nerves in the area. It works when all else fails, but I usually do not wait for all else to fail. Even if I give a block, I follow it immediately with an intraosseous injection so I do not have to wait to start the procedure. The success rate for intraosseous an-

esthesia approaches 100% when used in combination with a block.

Incidentally, I no longer recommend periodontal ligament injections because intraosseous infiltration has a higher success rate and longer duration when used as supplemental injection. In combination with a block, Intraosseous is at least 98% effective and when used in combination provides 60 minutes of profound pulpal anesthesia.

Compare that to intraligament infiltration with a success rate of 60 to 70% and duration of only 15 minutes. Periodontal ligament injections (PDL) have also been known to cause transient inflammation and/or root resorption as well as causing bacteremia approximately 95% of the time. The bacteremia occurs when the needle is inserted into a bacteria infested sulcus and then forced down into the bone. PDL injections cause pain about 50% of the time, compared to intraosseous injections, which are painful less than 1% of the time.

An article in the Journal of Oral Surgery, Oral Medicine, Oral Pathology, Oral Radiology and Endodontology concluded that supplemental intraosseous injection of 3% mepivacaine increases the success rate in cases of irreversible pulpitis from 25 to 98%.

The “Inferior” Alveolar Nerve Block is ineffective 5 to 25% with a normal pulp, but with an inflamed pulp, it is ineffective 30 – 80% of the time. Combine that with problems caused by past painful experiences and apprehensive patients and it is easy to see why so many people are





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afraid to go to the dentist.

In a future article, we will discuss the role of other alternative injection techniques such as the Gow-Gates or Akinosi injections. We will also discuss the status of 4% solutions such as Prilocaine (Citanest) or Articaine (Septacaine) and their possible connection to par-esthesia. Meanwhile, the tips in this article should go a long way toward helping you eliminate stress caused by ineffective anesthesia.



For more than thirty years, Dr. Arthur "Kit" Weathers has lectured worldwide on technologies, products and processes designed to simplify the practice of endodontics by the general dentist. The developer of a range of dental products, Dr. Weathers pioneered the EndoMagic! Nickel-titanium file system for general dentists seeking to improve both the quality of care and the economics of the endodontic services they offer. As the clinical technique developer of the X-tip Intraosseous Anesthesia System, he has assisted practitioners in need of patient-friendly anesthetic application methods.

Dr. Weathers is the author of numerous articles on innovations in endodontic treatment products and processes as well as intraosseous anesthesia delivery systems. His most recent four part series of articles entitled, "Endodontics, From Access to Success," appeared in Dentistry Today. Dr. Weathers has also introduced the well-reviewed C.E.Magic "edutainment" interactive learning system, entitled "Antibiotics in Dentistry" to the field of dental continuing education.

Dr. Weathers serves as the Director of Endodontics at the Las Vegas Institute for Advanced Dental Studies (LVI). Lecturing extensively to dental organizations, Dr. Weathers integrates an academically grounded approach to his subject with humor, magic, and mnemonics to enable his audience to recall his well-accepted techniques. As the founder of the Practical Endodontics "Root Camp," Dr. Weathers offers numerous twoday, hands-on training sessions at the Las Vegas Institute and his facility in Griffin, GA.

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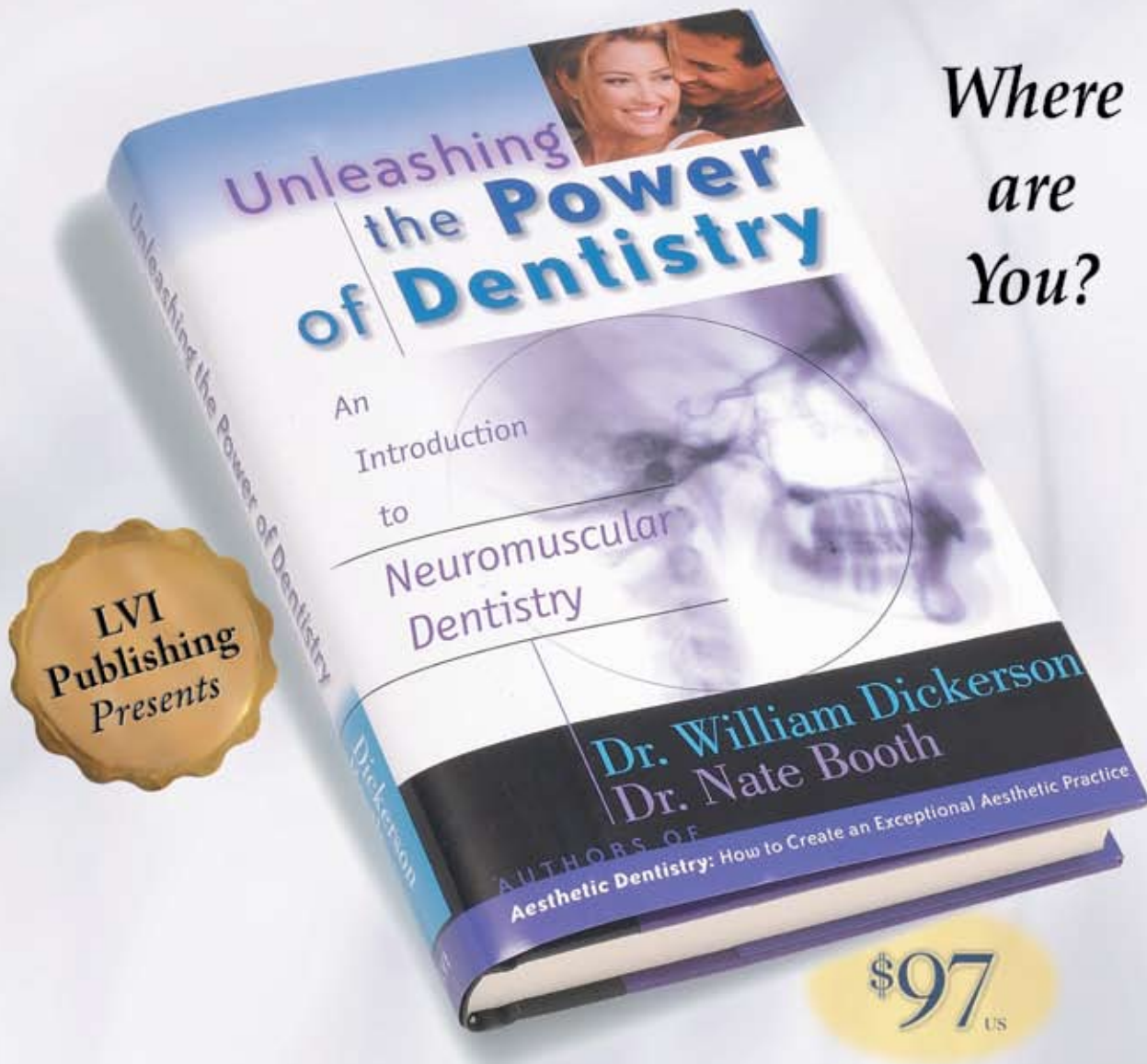
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