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CHANGING DENTISTRY. CHANGING LIVES

EDITORIAL

RANDY BRYSON, DMD

A New Year – Repeat Resolutions

Many of you have probably followed the long tradition of New Year's Eve by setting your annual resolutions. If you are like me, most of your resolutions may have fallen by the way side already. By the end of the month it is quite possible that all of them have been broken. With some research, I was able to compile a list of the most common New Year's resolutions.

Top 10 Resolutions

1. **Spend More Time with Friends and Family**
2. **Fit in Fitness**
3. **Tame the Bulge**
4. **Quit Smoking**
5. **Enjoy Life More**
6. **Quit Drinking**
7. **Get Out of Debt**
8. **Learn Something New**
9. **Help Others**
10. **Get Organized**

After studying this list, I realized that, as dentists, we have the most wonderful opportunity to actually follow through and stick with most of the resolutions. We are in one of the best professions, and can have total control of our lifestyle. Sadly, only a small percentage of dentists realize that they have this opportunity, and are already enjoying not only their personal lives but also their professional lives. They have found that by pursuing and continuing their advanced education that can make significant changes to their practices. All of us constantly struggle to find the perfect balance between the personal, professional, and spiritual aspects of our lives. Further analysis of the Top 10 Resolutions will reveal how they relate to us as dentists.

The #1 resolution is to **Spend More Time with Friends and Family.** Most dentists tend to be solo practitioners and are self-employed. The solo practitioner essentially should have complete control over their work schedule. This may seem

"Having this type of practice can be very rewarding, and will allow for much more enjoyment and fulfillment."

to translate into having plenty of time-off and being able to decide how much time can be spent with our families. Sadly, many studies have shown that the majority of dentists tend to work a longer than average work week. The typical dental practice can average up to 40+ hours per week in clinical time alone. This does not take into consideration the additional management time required to run a successful practice. Many dentists tend to work some evenings and weekends only to meet the demands of their patients. This means that time with family and friends can become very limited. At LVI, we often conduct an anonymous survey of the new doctors attending the first CORE program. The student population attending courses at LVI represent a wide range and diversity of dentists throughout North America and abroad with all types of dental practices. We have consistently seen that the most successful practices are the ones who often work the least amount of hours. Many dentists are still under the misconception that dental practice success is based on amount of time spent in the practice seeing patients. However, most of the successful dentists are the ones who have figured out how to work smarter, not longer. Many seeking help in this area have been able to transform their existing practices, utilizing the advanced skills they have learned from the LVI curriculum. I am not just talking about clinical skills. Bill Dickerson reminds all of us that you can be the greatest clinical dentist in the world and still not be successful. Too many dentists mistakenly believe that advanced clinical skills alone are the secret to building a successful practice. This could not be further from the truth. They are many skilled clinicians who are not able to have a successful dental practice. They possess exceptional clinical skills, but are unable or unwilling to take the necessary steps to learn how to attract, treat, and communicate with the patients who demand to have this type of dentistry. They are usually the dentists who totally ignore the importance of communication and business systems and the affect it can have on their practice success. They also tend to be the dentists who have allowed the dental insurance companies to become an uninvited partner in their practice, and determine the type of services and materials they can use for their patients. It is not only top-notch advanced clinical techniques that are important, but learning the valuable tools in the area of dental practice management that are most important. The goal for any teaching facility should be to have all of its attendees be able to go home and work on improving the level of care they provide in their practices. I know that many of our LVI alumni are only working a concentrated three-day work week, and have plenty of time for friends and family. Having this type of practice can be very rewarding, and will allow for much more enjoyment and fulfillment. On the whole, this type of practice will allow you to enjoy your life much more than studies have shown for the average dentist. This is a very discouraging response for what I believe is a truly wonderful profession.

Obtaining these tools may help a dentist regain control of his/her dental practice. It is not uncommon for a dentist to physically feel the effects of a stressful and hectic dental practice. Many dentists comment that they are nearing "burn-out" due to the heavy demands of maintaining a practice in today's environment. Therefore, it is easy to understand

that by improving your practice you will have plenty of time for yourself.

A three-day work week will leave plenty of time to become **Fit in Fitness** and will lead to **Tame the Bulge.** I feel strongly that if you are trying to promote total health in your comprehensive based practice, you must practice what you preach. I do not believe you will have much credibility with your patients if you smoke yourself. Simply put… make the effort to **Quit Smoking.**

No matter what you do for a living, work plays an important part of who you are. All of the job satisfaction surveys report that most people do not like what they do for a living. A recent Gallup poll showed that less than half of the people are satisfied with their chosen profession. This same poll also showed that 25% of the population just goes to work "to collect a paycheck". I am sure most of these surveyed cannot help but to carry this dissatisfaction to their personal lives. It would be hard for this group to **Enjoy Life More.** An independent survey completed by SDM found that nearly 98% of LVI alumni were satisfied with their career. The great majority of them attributed this to their eye-opening LVI experience to the possibilities in dentistry today.

I am certain that I do not need to spend too much time convincing anyone reading this of the importance to **Quit Drinking.** As a health professional we all should be well aware of the negative effects this can cause.

I believe that **Get Out of Debt** and **Learn Something New** most often go hand in hand. A strong commitment to education is critical for success in our profession. "A goal without knowledge is like a boat on dry land". This is one of the many reasons that more than 80% of LVI attendees come back to take multiple courses from the variable curriculum options. They are able to go back home and immediately implement the skills and techniques into their practices. This follows closely the results showing some of the most successful practices are run by those dentists who take over 200 hours of CE annually. This constant striving for education not only tends to keep dentists passionate and motivated about what they do, but typically has a dramatic effect on their practice profitability. Incorporating new technology and techniques they learn at LVI to treat their patient's problems with occlusion and TMD has had a huge impact on most dental practices. Studies have shown that a great majority of our patient population tends to have problems associated with occlusal disease and its associated problems, and this often goes untreated by the majority of dentists. However, our dental schools do not have the time to prepare dentists to treat these patients. Without the knowledge of occlusion and the affect it can have on the stability and longevity of our aesthetic dentistry, a dentist is doomed to fail. It has become way too common for dentists to criticize all-ceramic materials as the problem whenever they see failures. In most cases, it is occlusion that is at fault. Either the treating dentist has failed to properly manage their patient's occlusion, or their patient has occlusal disease.

"No matter what you do for a living, work plays an important part of who you are."

Success happens because not only doctors were trained, but equally as important so were their teams.

Over the years we have seen a lot of wonderful dentists be able to **Help Others** as a result of having a successful practice. They have donated their services and paid lab fees for those who may not be able to afford their services. A while back, immediately after Katrina, the LVI family quickly raised over $100,000 to be distributed to some dentists who were devastated by this disaster. All this happened in a few short weeks, not months to years like many other agencies had taken during the crisis.

Finally, taking control of your own practice with new found skills will enable you to **Get Organized.** We were given little if no business and management during our years at dental school. If you are like I used to be, I typically used a "trail and error" method in establishing business systems in my practice. If something worked, I would stick with it. If not I would try something else. More commonly, I found that even if I established business systems that were effective they were not adhered to by all of my team. Success happens because not only doctors were trained, but equally as important so were their teams. This greatly increases the chance of success for dentists when they return home. Getting organized in your professional life makes it that much easier to do the same in your personal life too.

I am not sure what the failure to success rate is for committing to all of your New Year's resolutions. I am sure it has to be pretty high. That is why you tend to see the same resolutions show up year after year. If you want to increase your chance of actually sticking to this year's resolutions, taking a single course could begin to lead you on the road to success. On behalf of all of us from the LVI family, I truly wish the best for all of you and your families throughout the year.

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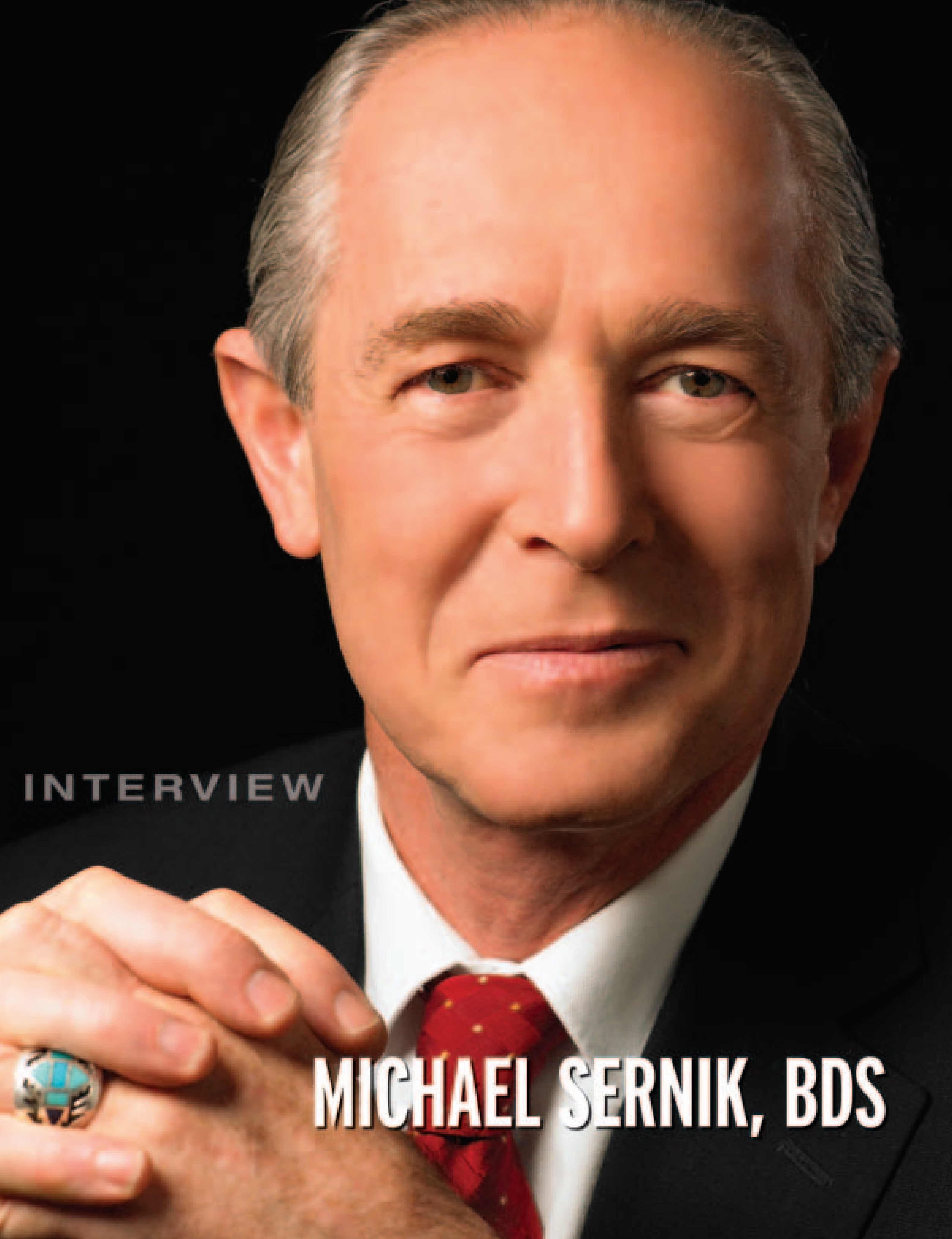
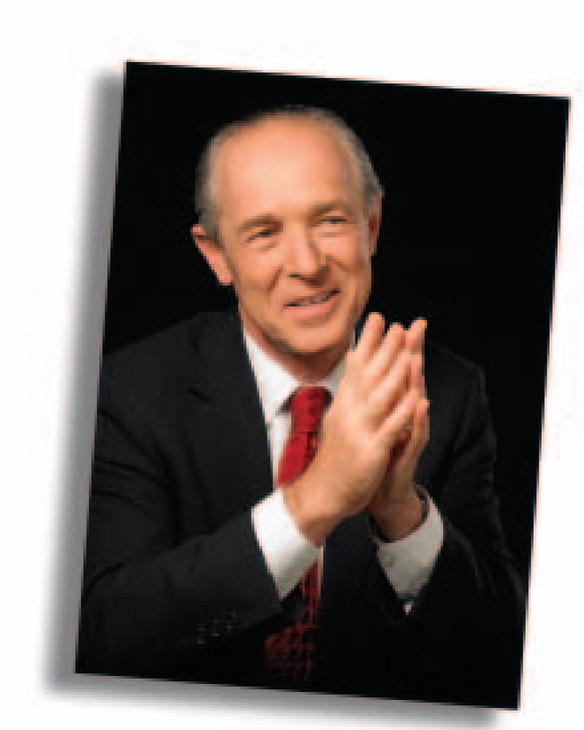

INTERVIEW
MICHAEL SERNIK, BDS

"This is a comprehensive program involving a sophisticated web-based monitoring system for each clinician, plus leadership telephone coaching for the practice owner and workshops for the dentist and team."



In 2005, several LVI dentists attended a workshop in Sydney Australia which changed the way they do dentistry. The course was PrimeSpeak, a three-day course on the new patient exam. These dentists were all experienced dentists who had attended many communication courses, but this course was quite different. It seemed to say the opposite of all the other courses and yet, following this course, when PrimeSpeak was put into practice, their patients became extremely motivated. Even patients who were previously apathetic were now demanding to have treatment that they were previously uninterested in! When word reached Dr. Bill Dickerson, he was intrigued. He asked Dr. Michael Sernik, the creator of PrimeSpeak to come and deliver his program for LVI in 2005. The results were instantaneous. As participants spread the word, PrimeSpeak has now attracted the cream of LVI practitioners and many have repeated the course several times.

In 2008, LVI is introducing the entire PrimeSpeak Leadership Coaching program to North America. This is a comprehensive program involving a sophisticated web-based monitoring system for each clinician, plus leadership telephone coaching for the practice owner and workshops for the dentist and team. More details can be found at www.lviglobal.com or www.primespeak.com. Dentists who want to learn this powerful system are advised to register with LVI. PrimeSpeak is only available through LVI in North America.

When people talk about PrimeSpeak, they always say that it is different from other communication training. What makes it different?

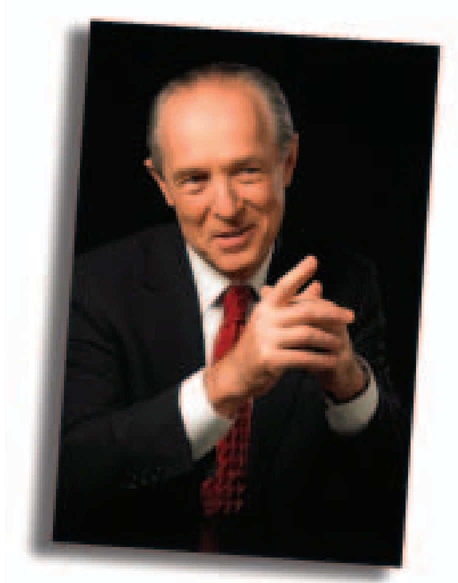
Most communication training essentially has its roots in sales training. We expect sales people to use sales techniques on us. We might not enjoy being a prospect, but we are not really shocked when a sales person tries to sell us something. It is different when your trusted doctor tries to sell you expensive treatment. That is the position we often find ourselves in. This is because most dental conditions are chronic; the patient does not know they need treatment but the dentist thinks it is necessary. We find ourselves making a recommendation that the patient was not expecting to hear. The more we explain why they need our recommendation, the more it can sound like a sales pitch. If we have been taught sales techniques and start using them, we can make matters much worse because most sales techniques are obvious to other sales people. Most business people have had sales training. The one thing sales people hate is being "the prospect". So there is a need for a communication method that is effective without ever coming across as sales.

Can't we just educate the patient?

We can, but the bigger the difference between the patient's expectations and our diagnosis, the harder this gets. If a patient interprets the dentist's recommendation as "You have a big potential problem and you should spend $50,000 to solve this problem" this can be problematic when the patient has no pain, no discomfort and no one has ever said this to them before. That is when the patient makes comments such as: "Do you need a new Porsche, doctor?"

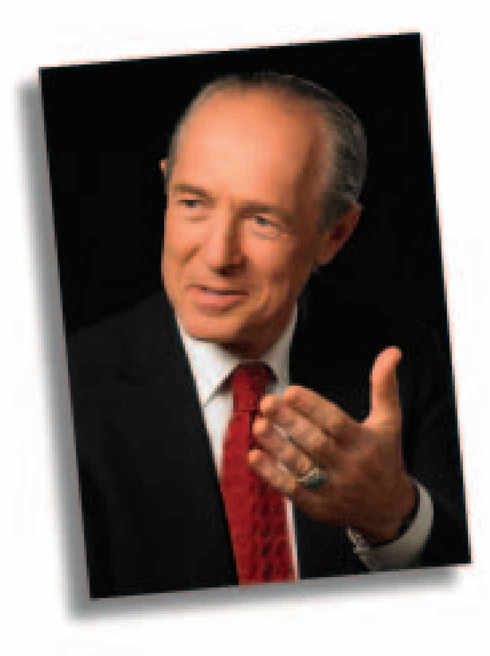
What is wrong with just doing what the patient wants?

The patient is the least qualified person to make clinical decisions about their chronic painless disease. It is our job description to influence our patients to want what we believe they need. Otherwise we end up just doing 'patch and fill' symptomatic treatment. It is natural for patients to want the quickest, cheapest option. If we give the patient the quickest and cheapest, we will be leaving a lot of chronic disease in place.



"Dentists are unwittingly creating problems and then struggling to handle the problems they created."

So, how is it possible to sell without sales techniques?



There is a whole different way of looking at the new patient exam. Instead of learning reactive scripts, we learn how to prevent objections. This requires an overall strategy involving every component of the patient's experience. We need to stage and sequence the patient's experience so that they slowly realize that they might be heading down a path that leads them to an outcome that will be undesirable. At the beginning of every exam, the dentist will have a conversation with the patient before they look in the mouth. During that time we need to get an idea of what is our likely treatment objective. If we ask the right questions we can get a pretty good idea of what we are likely to see in the mouth. Our next step is to figure out what is the patient's most likely obstacle to our treatment objective. It might be money, but that is rare. The most common objection is that the patient sees no urgency. If a chronic condition has been there for 20 years, the patient sees no compelling reason to spend a lot of money fixing the problem if he/she thinks it can stay the same for the next 20 years. This mindset must be altered if we want a motivated patient. Our overall strategy will be to deepen the patient's concerns about their condition before providing a solution. This leads the patient to look to the dentist for a solution. We want the patient to own their problem before any solutions are discussed.

Why not let dentists just carry on as they are and pick up some tips on how to deal with tricky situations?

Most training does just that. It deals with how to respond to the various problems that come up. Dentists are unwittingly creating problems and then struggling to handle the problems they created. Dentistry is stressful when we spend our time having to struggle with self-created problems again and again.

How long does it take dentists to learn this system?

We run a three-day course that exposes clinicians to the system and then most clinicians come to several two-day, skill-building sessions.

Is this type of training for just the dentist or is it for the team as well?

Our initial agenda is to help the dentist develop fabulous communication skills. If the practice has a motivated team member who works closely with the dentist then it is useful to have them there because they will learn the techniques and also be able to give the dentist feedback.

Some practices use a team member to do much of the communication to take the load off the dentist. Do you see the dentist as being the main communicator with the patient?

We see this process as having stages. First we feel the dentist needs the skills, for himself/herself and also so he/she can analyze any communication problems. Team members might leave, but the dentist remains. However, we really like the idea of the dentist having as much leverage as possible. Most dentists would be very happy to just do the dentistry and have the team do the rest. After the dentist has acquired the communication skills, we can then help the team develop these skills. The patient needs to be told what to expect (as far as time needed and who they are going to see) during their first phone call. When the patient arrives, a team member will have an initial chat with the patient and go through a structured process and pass the messages through to the dentist. This process can save the dentist a lot of time and more importantly, when done well, is even more effective than just the dentist talking. But there is a very big proviso. There needs to be excellent leadership to make this work.

How do you teach leadership?

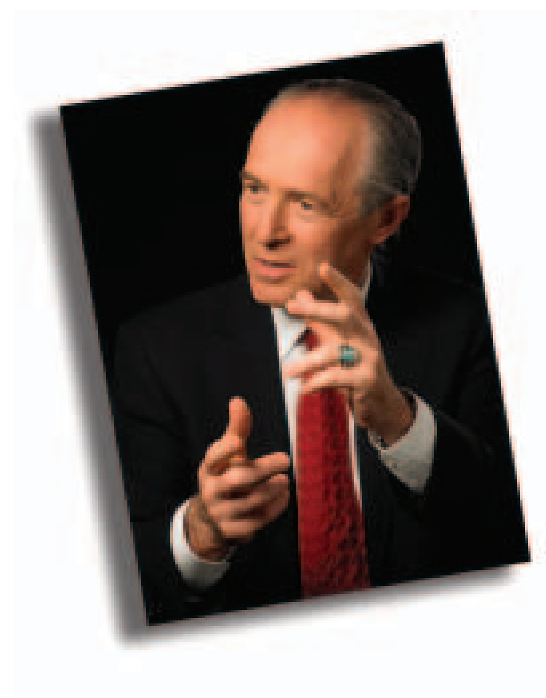
Dentists generally are unclear about what leadership is. There are thousands of books on the topic and the best companies have the best leaders. These leaders are always interested in learning how to improve their leadership. Poor companies have poor leaders who are not interested in learning this. In fact they do not even know this is a subject for consideration. Most dentists fall into this category because they have not been exposed to business at this level. We approach leadership with three tools.

• First, we need to measure what is happening. We have spent years developing a Web-Based Reporting interface for clients to enter simple production and performance metrics which our software turns into intelligent data; graphs and benchmarks. Now we know exactly what is really happening at a practice on a day-to-day basis. This gives us the ability to help avoid problems before they happen.

• Secondly, we have a structured system of coaching via telephone. Our coaches are typically psychologists who receive intensive training. They monitor the web based tracking data and consult with the leader. They focus on leadership development. Our system works on the team through the leader, not around the leader. In other words, we help empower the practice owner to improve their leadership skills.

• The third component of our leadership training is workshops on the issues critical to the skills needed for effective leadership. We run a series of two-day workshops. Some are just for the leader and some are for the team members.

"The very best athletes have continuous coaching. Coaching unlike consulting is all about helping the leader view their situation honestly and accurately, then look at all their options for improvement and most importantly implement what needs to be done on a day-to-day basis."



This three-pronged approach works very well. Our typical client will work 15% less hours after 24 months and more than double their take-home pay. This is all due to improvements in systems, communication skills and leadership. The easiest components to improve are the practice systems. There are many practices out there that have gone through practice management training to improve their operating management systems. Yet there will still be enormous differences between practices that operate with these systems.

The variables are: how effective are their communication skills and how evolved is the practice leader. The very best athletes have continuous coaching. Coaching unlike consulting is all about helping the leader view their situation honestly and accurately, then look at all their options for improvement and most importantly implement what needs to be done on a day-to-day basis. Knowledge without results is useless.

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April 25-26	Denver, Colorado
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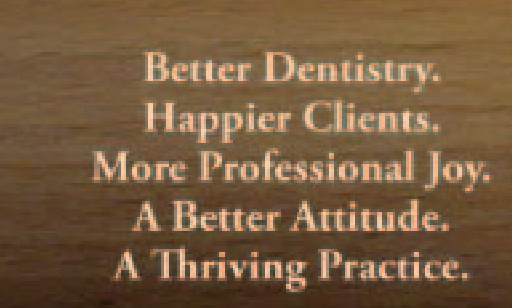

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Neuromuscular Functional Orthodontic Cephalometric Diagnostics

By Jay W. Gerber, D.D.S. & Mr. Thomas Magill

(Originally published 2006. Reprinted with permission from the Functional Orthodontist)

Since the mid 1980's it became apparent that a cephalometric analysis would be needed to support the neuromuscular functional orthodontic diagnosis. This would be of particular importance when treating the pediatric orthodontic patient. A cephalometric system should also be compatible with the unique mechanics required for a neuromuscular finish and for orthodontic/orthopedic classification purposes.

Modern orthodontic diagnostics requires an extensive knowledge of not only occlusion but of craniofacial growth. The study of Cephalometrics is an age old concept advanced by hundreds of orthodontic experts, societies and associations for the purposes of nomenclature, diagnostic and therapeutic treatment planning. The authors have advanced and improved upon the original Sassouni Cephalometrics to allow for a more neuromuscular functional occlusal evaluation of the patient presenting for orthodontic and or occlusal therapy.

Understanding Sassouni

The following information will allow the treating dentist to better interpret the diagnostic data available in the analysis.

OK, you have got the completed analysis in your hands. Now what do you do with it? If you use it well, you are well on your way to a successful case diagnosis. So how do you use this information in diagnosis, treatment sequencing and in appliance selection?

First, we will go down the bottom line, item by item, to see how you can

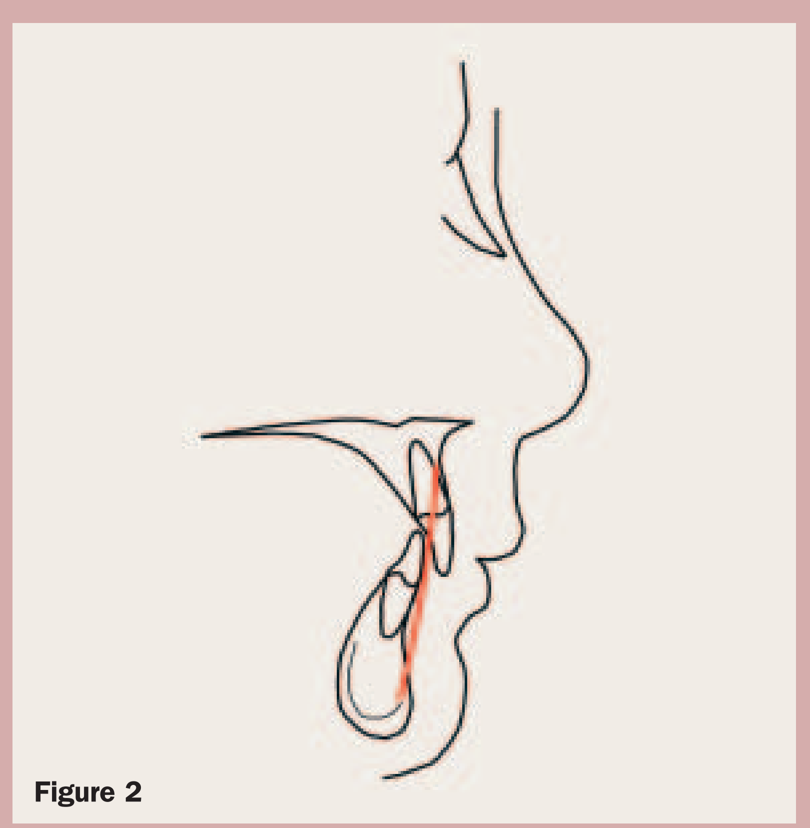

Figure 2

NFO CEPHALOMETRIC "BOTTOM LINE"

SKELETAL A – P	I II III II T III T
SKELETAL VERTICAL	N OB DB OBT DBT
DAC	_______ MM
UPPER INCISOR	N P R
LOWER INCISOR	N P R
GROWTH DIRECTION	N CW CCW CWT CCWT
ELP	_____MM
MAXILLA LENGTH	N L S - P A
MAXILLA POSITION	N P A
UPPER 6 POSITION	N P A
MANDIBLE LENGTH	N L S - P A
MANDIBLE POSITION	N P A
UPPER LIP ANGLE	N P F R
UPPER INCISOR ANGULATION	L LN N N NH H

Figure 1

ANTERIOR SKELETAL VERTICAL

Using your RED pencil, place the tip of the compass at ANS, extend to SOr and draw a small arc. By rotating the compass, transfer this dimension to the area of (ME) Menton and draw another short arc. Increase the compass 10 mm and draw a third small arc. The latter two arcs give you the range of vertical normality of the individual patient.

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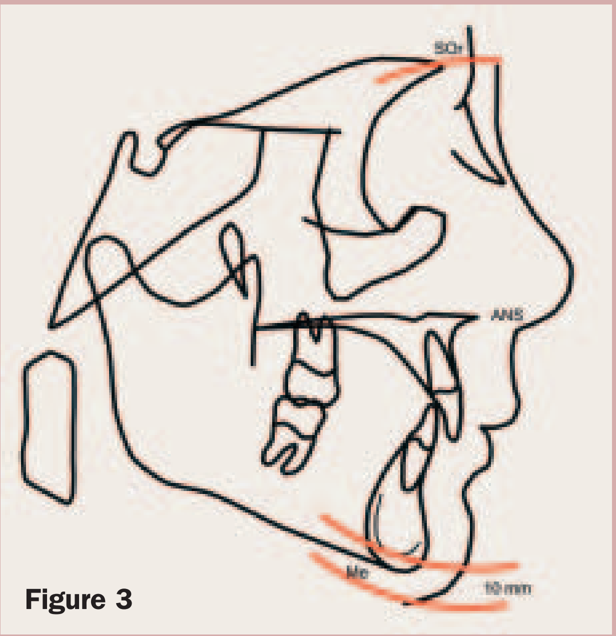


Figure 3

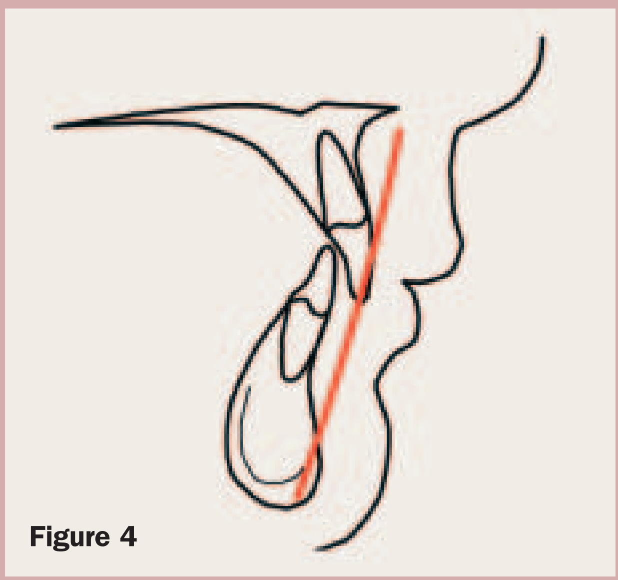


Figure 4

make the most use of the advanced Sassouni Plus. (Figure 1) The bottom-line first proposed by Dr. Richard Beistle allows one a quick look at the important points of the evaluation.

SKELETAL A-P CLASSIFICATION – By comparing the dimensionally corrected 'A' arc of Sassouni the clinician can determine the relative horizontal relationship of 'A' to 'B' (Figure 2). This illustrates the relative positions of the maxilla and mandible as they relate to one another. Class I is considered normal or the relations of the maxilla to the mandible are normal or balanced. Class II skeletal means the mandible is too retruded or behind the maxilla, while Class III means the mandible is protruded or too far in front of the maxilla, or that the maxilla is deficient and makes the mandible appear prognathic when in fact it may be in a normal relation with the cranial base. The notation 'T' found in the "Bottom Line" after the notations indicates a tendency towards a Class II or III. Generally we consider this variance from one millimeter to be mild, while a difference to three millimeters to be of strong tendency toward the skeletal classification. When the discrepancy between the maxilla and mandible (+ or -) reaches seven millimeters, the situation becomes serious, and orthopedic correction will require more time and greater cooperation from your patient. The face will often begin to show obvious distortion from normal proportion at seven millimeters of discrepancy.

When evaluating a patient for treatment it is important to remember that the maxillary-mandibular

relationship can be Class I, II, or III with either or both maxilla and mandible being poorly related to cranial base.

SKELETAL VERTICAL – is an age sensitive measurement of skeletal anterior facial height by relating upper to lower facial height (Figure 3). This measurement is critical since vertical skeletal development is essential to stability following treatment. The evaluation is derived by measuring the Supra Orbitale (SOr) to the Anterior Nasal Spine (ANS). This measurement establishes the Upper Facial Height. The arc is completed to evaluate the Lower Facial height to Menton, the lowest point on the mandibular symphysis. This point should be on the upper arc at age four, moving downward at an average of .75 millimeter per year until it rests on the lower arc at age seventeen. Movement will be more rapid during growth spurts, which will occur at about six, eight, and twelve years, and earlier in females. Development of full vertical dimension should be a primary goal in treatment.

UPPER INCISORS - This horizontal measurement is an indication of the position of the upper incisor tip relative to the arc from anterior nasal spine (Figure 4). For this to be accurately assessed, the effective length of the Premaxilla must be measured and, if short or long, adjusted using the Palatal Division compensation (Figure 5). The position of the incisor tip will be influenced by labial torque of the incisor and by its dentoalveolar compensation (eruption). In an ideal case, the anterior arc from Nasion will fall on the arc from

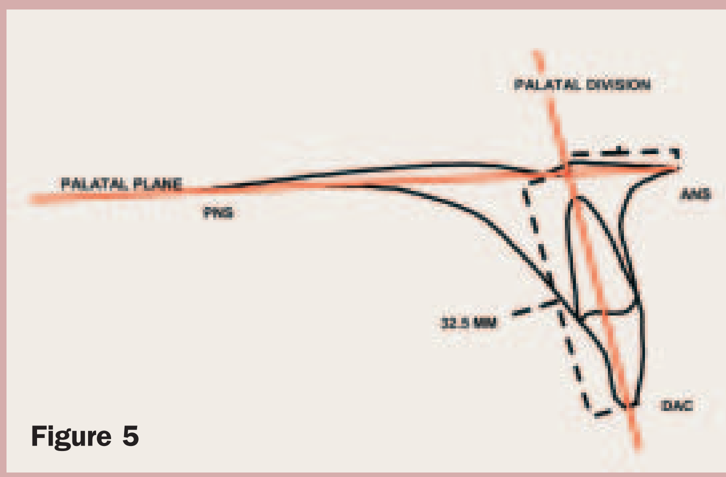


Figure 5

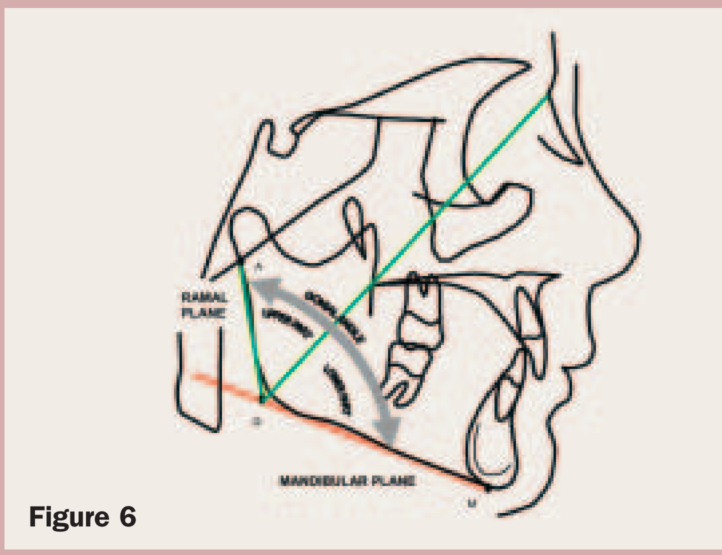


Figure 6

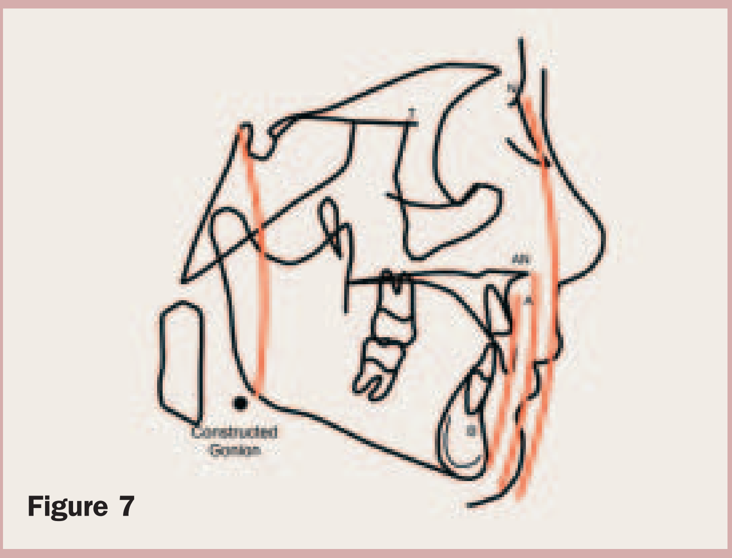
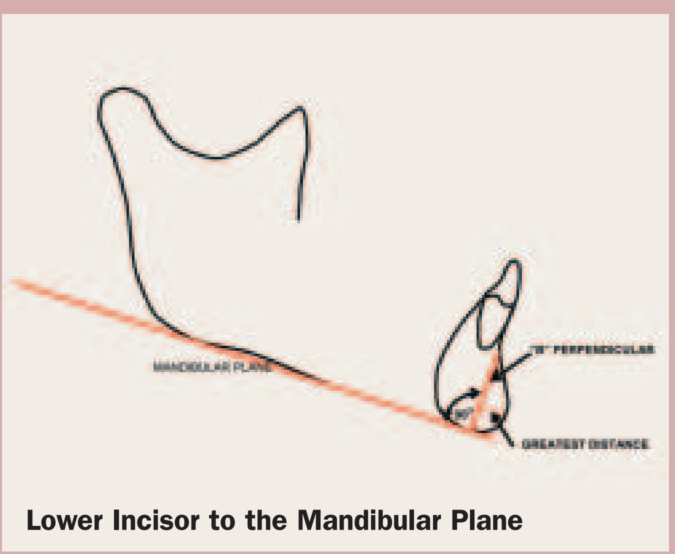


Figure 7

The mandible is divided into anterior and Posterior components by measuring the Greatest distance between “b” Perpendicular and the anterior Symphysis. “b” perpendicular is drawn From point b to the mandibular plane at a 90% angle. The distance to the anterior Symphysis is measured at a 90% angle to “b” perpendicular. This distance is Normally 6 to 9 mm.



Lower Incisor to the Mandibular Plane

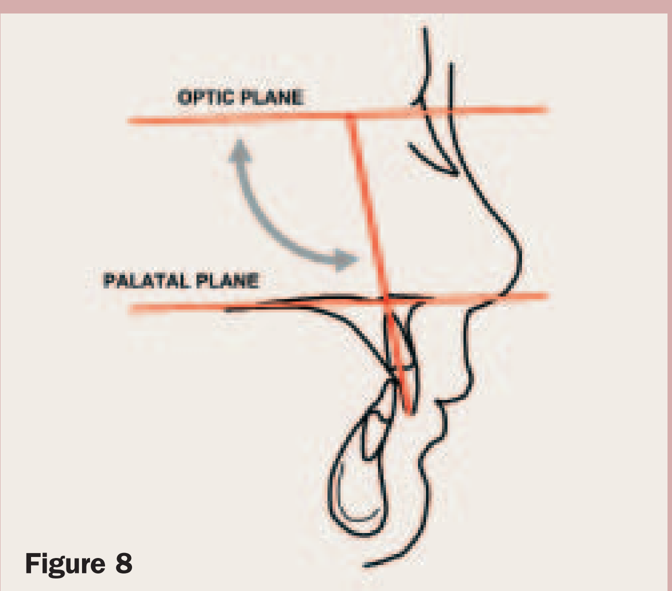


Figure 8

anterior nasal spine. The tip of the incisor should lie on the arc to three millimeters forward of the arc formed from ANS. The most desirable facial profiles have a +2 or +3 measurement anterior to the arc.

Dentoalveolar Compensation - DAC is measured from the point where the long axis of the maxillary incisor crosses palatal plane (Palatal Division), continuing along the long axis to the central incisor tip (Figure 5). In an ideal case, the average length is 32.5mm. This incisor length allows you to better understand if intrusive or extrusive mechanics are indicated, and whether retruded or protruded teeth require a change in torque. As a rule: the more extrusion the more the tooth moves labial.

Lower Incisor- This is simply the angle of the long axis of the lower incisor to mandibular plane (Figure to left). It is now felt that a more protrusive angle of 95-102° is much more stable and attractive. This permits a more desirable incisor tip to first contact the lingual surface of the maxillary incisor. This prevents labial first-contact that can initiate proprioception of mandibular retrusion.

Direction of Growth – This is one of the most useful features of the Analysis. To obtain the growth direction, the gonial angle is divided into two compartments (Figure 6). The upper compartment, with a normal angle of 52-55 degrees, is an indicator of horizontal or counterclockwise growth. The lower compartment, with a normal angle of 70-75 degrees is an indicator of vertical or clockwise growth. It is important to remember that vertical or horizontal growth does

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not occur in a straight line.

All growth is curved or arcial – this is the genius behind the Sassouni Analysis. It is arcial, and is an analysis that is capable of reflecting growth with any accuracy.

The estimation of the direction of growth is very important in the selection of functional appliances. The Constructed Gonial Angle used in the NFO Analysis improves the accuracy to which we can predict. We must go beyond accepting the Gonial Angle as a single factor of Mandibular morphology. The manner in which the Ascending Ramus and the body of the Mandible are related to each other from the gonial Angle determines how the mandible will grow. When determining this angular relationship, the Gonial Angle is divided into two parts. First, you draw the Facial Depth Line from Nasion to Constructed Gonion. This divides the gonial Angle into Upper and Lower Angles. The Upper identifies the slant of the Ramus whereas the Lower Angle identifies the slant of the body of the Mandible. The normal range of the Gonial Angle is 120° to 132°. The normal range for the Upper Angle is 52° to 55° and the normal range for the lower angle is 70° to 75°.

If the upper angle is large, the growth will be forward. If the lower is large the growth will be downward. If the upper angle is small the growth will tend to be downward and backward (CLOCKWISE). If the lower angle is small the growth will be forward (COUNTERCLOCKWISE).

The simplest and most accurate method of determining growth direction is to divide the upper angle by the lower angle. This will give you a percentage. This can then be related to the following chart to find the direction of growth.

70-78% = Neutral Growth
69.9-68.1% = Clockwise Tendency
68% or less = Clockwise Growth
Less than 60% = Extremely Clockwise Growth
78.1-79.9% = Counterclockwise Tendency
80% or more = Counterclockwise Growth
More than 88% = Extremely Counterclockwise Growth

Maxillary Position – This relates the position of the maxilla to the cranial base. Ideally, the maxilla will lie with anterior nasal spine (ANS) on the anterior arc and posterior nasal spine (PNS) on Cribiform Perpendicular. For this to be meaningful, the effective length (ELP) of the Premaxilla must be established (Figure 5). You measure from the palatal division where the long axis of the upper incisor crosses palatal plane, to the anterior nasal spine. The length should be 12 to 15 mm. A short or long Premaxilla must be adjusted for maxillary position to be accurate. The effective length must be 12 to 15 mm no matter to what degree the incisors are inclined.

In treatment planning, it must be kept in mind that maxillary position is different in male and female patients. Male patients can have the maxilla up to four millimeters behind the anterior arc with no harm to facial esthetics. In fact, anterior position of the maxilla “feminizes” the face. In a female patient, the maxilla should be at least at the anterior arc, and, for the best facial esthetics, slightly forward of the arc (Figure 7).

Upper 6 Position – This measurement theoretically gives the ideal position of the maxillary first molar. Unfortunately, this measurement is very often useless, and cannot be relied upon to plan treatment.

Mandibular Position – Ideally, the mandible will lie between the anterior and posterior arcs at the age of twelve. Pogonion, the most anterior point on the curvature of the mental protuberance, should lie on the anterior arc at all ages. Constructed Gonion, the posterior reference point, should be anterior to the posterior arc before the age of twelve, passing through the arc as the patient ages. In the adult, Gonion should be up to four millimeters distal to the arc in a female, and up to six millimeters in a male. Again, the length of the mental protuberance must be accounted for in the position of the mandible. This should be from six to nine millimeters from B perpendicular (Figure 7).

Mandibular Length – The mandible should be equal in length to the distance from anterior arc to posterior arc at the age of twelve. (Figure 7) The length of the mental protuberance, from B perpendicular to Pogonion (the most anterior point on the bony chin) should be from six to nine millimeters. The mandible may be long or short anteriorly, posteriorly, or both. The mandible may be of normal overall length while being short on one end and long on the other. The mandible which is long posteriorly may predispose the patient to temporomandibular joint problems, if other factors are present. A long or short mental protuberance may have facial consequences, but there is little which can be done therapeutically to affect this, although

good lip balance certainly will improve the appearance in all cases.

Upper Lip Angle – This is included in the analysis because it has traditionally been included. We do not feel it has any diagnostic relevance. We would advise ignoring it, and judging lip balance by your patient's face.

Upper Incisor Inclination to Optic Plane – This is the simple angle between the long axis of the upper incisor and optic plane. (Figure 8) Previously this measurement was taken-off of the variable occlusal plane. We now use optic plane because it represents both a stable cranial landmark and the true horizontal reference of the analysis. Palatal plane is adaptive to maxillary and mandibular eruptive occlusal changes and to the anterior maxillary changes brought on by upper airway obstructions.

Cant of the Palatal Plane – the horizontal comparison of the Palatal Plane to Optic Plane gives us diagnostic information concerning the relative pathology underlying the skeletal and dental malocclusion. Figure #8 represents a normal balanced relationship in that the Palatal Plane parallels the Optic Plane.

In a malocclusion we might observe the planes to converge anteriorly, this indicates a lack of normal downward and forward placement the anterior maxilla or the pre-maxilla is tipped upward. The etiology is either an anterior tongue thrust or a 'finger' habit. The former may be consistent with Upper Airway Obstruction associated with open mouth breathing.

A second pathological condition would exhibit a Palatal Plane that tips-up in the back or one where the posterior Palatal Plane would converge to intersect the Optic Plane somewhere in the distance. This condition is thought to be brought on by the lack of posterior dental and skeletal growth that is often seen in patients with posterior deep bites.

It should be noted that most any anterior or posterior convergence is usually minimal and is only a few degrees. The more extreme cases are quite easy to spot.

Summary – This extensively modified version of the Sassouni Cephalometric Analysis is very beneficial to the dentist treating functional orthodontic and TMD patients. Some practitioners even derive benefits from its application when determining vertical in the edentulous patient.

The NFO analysis has been shown to be of great benefit to determine vertical proportion and growth potential of the young patient. The analysis has the ability to show incisor placement relative to opening and closing trajectory and where to place the mandible for functional advancement.

Practitioners need a diagnostic cephalogram that is visual and descriptive of the skeletal and dental malocclusion. This analysis provides many tools that will assist the clinician in making those decisions.

"All growth is curved or arcial – this is the genius behind the Sassouni Analysis. It is arcial, and is an analysis that is capable of reflecting growth with any accuracy."

Jay W. Gerber, D.D.S., FICCMO, ABPM is the clinical director of the Center for Occlusal Studies an edu cational and clinical facility where he provides treatment for Orthodontic and TMD patients in Parkersburg, WV. Dr. Gerber maintains a hospital staff appointment. He has lectured to distinguished groups, associations and at universities since 1984. Dr. Gerber is the developer of the NFO™ Neuromuscular Functional Orthodontics Gerber Technique and numerous functional orthopedic appliances. He is the Director of Neuromuscular Functional Orthodontics program at LVI.

Mr. Thomas Magill has been in the orthodontic arena for over twenty-five years as a laboratory technician and owner of Frozen Tundra Diagnostics in Minneapolis.

Mr. Magill is recognized as an authority on cephalometrics. He is responsible for many progressive updates and changes to the modified Sassouni Cephalometric Analysis including the DAC and the ELP. He has personally traced over 50,000 radiographs and is recognized as an authority on functional diagnosis.

2008 Course Schedule

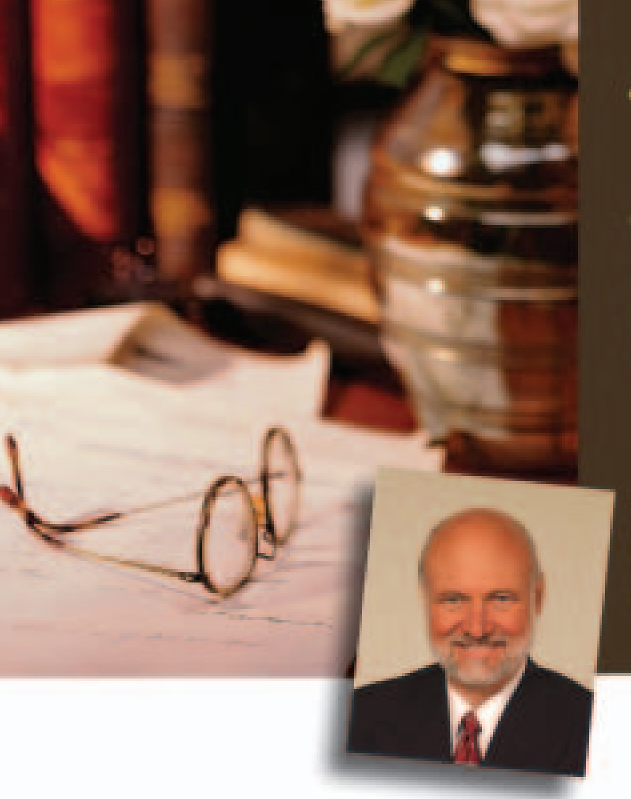
Neuromuscular Functional Orthodontics

Session I
January 10-12
June 16-18

Session II
January 14-16
April 7-9

Session III
February 25-27 (West Virginia)
June 20-22

Pediatric Orthodontics
February 11-13



THE WEATHERS' REPORT

ATTITUDE IS EVERYTHING!

USE PSYCHOLOGY TO IMPROVE ALL ASPECTS OF DENTISTRY

Arthur "Kit" Weathers, Jr. DDS

Psychology plays a large part in every phase of dentistry from case acceptance to anesthesia; and it even determines whether or not patients will show up on time, pay their bills, or refer other patients to your practice.

Not understanding the psychology of patient and team management can absolutely mean the difference between success and failure in a dental practice. This article will focus on this often overlooked aspect of dentistry.

Consider the facts

• Apprehensive patients are much more difficult to anesthetize than relaxed patients.

• Patients rarely sue doctors they like.

• The attitude of the doctor filters down through the entire team.

• Dental stress can lower a patient's resistance and delay healing.

Perception becomes reality

If one patient believes that root canals are painful, while a second patient believes that endodontic therapy is a painless procedure, usually they will both be right.

A patient's perception of a given procedure is influenced by everything from television and comments by friends to the dental team and office decor.

We can not do much about TV and frightening remarks by thoughtless people outside the office, but we can control what happens after the patient enters the front door.

The following list includes suggestions that are within the control of every dental practice:

• Paddy Lund, my long-time Australian friend, has bread baking in his office and a cappuccino machine instead of a reception desk. Every patient is greeted by his own "care nurse" as he enters the office.

• Acknowledge when you are running behind. It is common courtesy, and your patients will really appreciate your concern for their time.

• Make certain the first thing the patient sees is a modern, clean reception area that has soft music and does not smell like a dental office. (There are literally hundreds of sources of information about aroma therapy.)

• Do not leave patients alone in a cold, frightening treatment room waiting for dental anesthesia to take effect. Instead, jump-start your anes-

thesia with the X-tip intraosseous device, and you can begin work immediately without leaving the patient alone to worry about what is going to happen next.

• Hot towels are a good idea after an expensive meal, so why not provide your patients the same courtesy after an expensive root canal. Several companies market towel warmers, or you can steam wet towels in your microwave. On a hot, summer day, you might try chilling a few towels in the refrigerator.

• Handwrite your home phone number on the patient's appointment card after completing a root canal or other involved treatment. Hand the patient the card saying, "Here is my home number. Call me if you have any questions or problems." Patients rarely bother a dentist who is so considerate and available.

• If you start each day with a morning meeting, this will be a perfect time to set the tone for the day. And doctor, this part is totally up to you. If you are naturally a bubbly, morning person, then you are all set. If you are a slow starter or need three cups of coffee to get your personality tolerable, then you have got some work to do. The old adage of “fake it ‘till you make it” may help you establish a positive, up-beat in the office.

A True Story

The following story illustrates how your attitude determines your altitude, and how a poor attitude can bring down the entire team.

Mike was the kind of guy who was always in a good mood and always had something positive to say. When someone would ask him how he was doing, he would sing out, "I get up an hour early every morning just so I can spend more time with myself!"

He was unique because he was happy doing a job that most people would find dull and boring. Day after day, Mike drove a dirt mover and pushed mounds of dirt from one side of a field to the other, smiling and singing as he worked.

Mike had several drivers working under him, and his positive attitude trickled down keeping the entire group in high spirits. His employees had been with him for many years, and every day they laughed and joked as they did their job.

Another group of men working directly across the highway from Mike had a boss who was constantly unhappy, always complaining, had a high turnover rate, and had much lower production than Mike’s team.

I wondered what made the difference, so one day I went up to Mike and asked him, “I don't get it! How can you be so positive all of the time?” Mike replied, "Every morning I wake up and say to myself, “Mike, you have two choices today. You can choose to be in a good mood or you can choose to be in a bad mood.” I always choose the good mood.

Mike continued, “Whenever something bad happens, I can choose to be a victim or I can choose to learn from it. Every time someone comes to me complaining, I can choose to accept their complaining or I can point out the positive side of life. I prefer the positive side of life."

"It can’t be that easy," I protested.

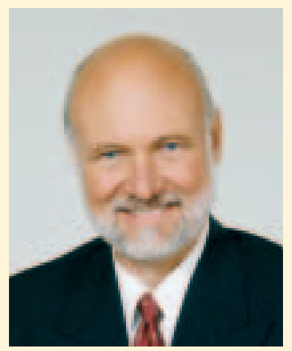
"Yes it is," Mike said. "Life is all about choices. When you scrape away all the B.S., every situation is a choice. You choose how you react to different situations. You can let people affect your mood, or you can choose to be in a good mood no matter what. You can not control what happens to you, but you can control how you react.

Unfortunately, Mike was killed in a car crash, but rather than print a photo of Mike’s mangled car, the news editor chose a picture of Mike sitting on his earth moving machine, smiling as always. The caption said, “Smiling Mike spent his entire life spreading happiness.”

I took that lesson back to my dental office, and put the photo of “Smiling Mike” on our bulletin board. Whenever anyone was unhappy about something, I would remind him or her that “Mike would never let a little thing like that get him down.” At the same time, whenever someone was in a good mood, I would say, “Mike would be very proud of you today.”

I hope I have stimulated you to think about the psychological aspects of your practice. Patients are very sensitive to the mood of the entire dental team, and if someone in the office is sending out bad vibes or does not believe dentistry can truly be painless, that negative attitude becomes a self-fulfilling prophesy.

If, on the other hand, every team member exudes positive energy, and truly believes in the office mission, successful, painless dental care becomes a reality.



Dr. Kit Weathers is featured in LVI's Endo Root Camp©

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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 two-day, hands-on training sessions at the Las Vegas Institute and his facility in Griffin, GA.

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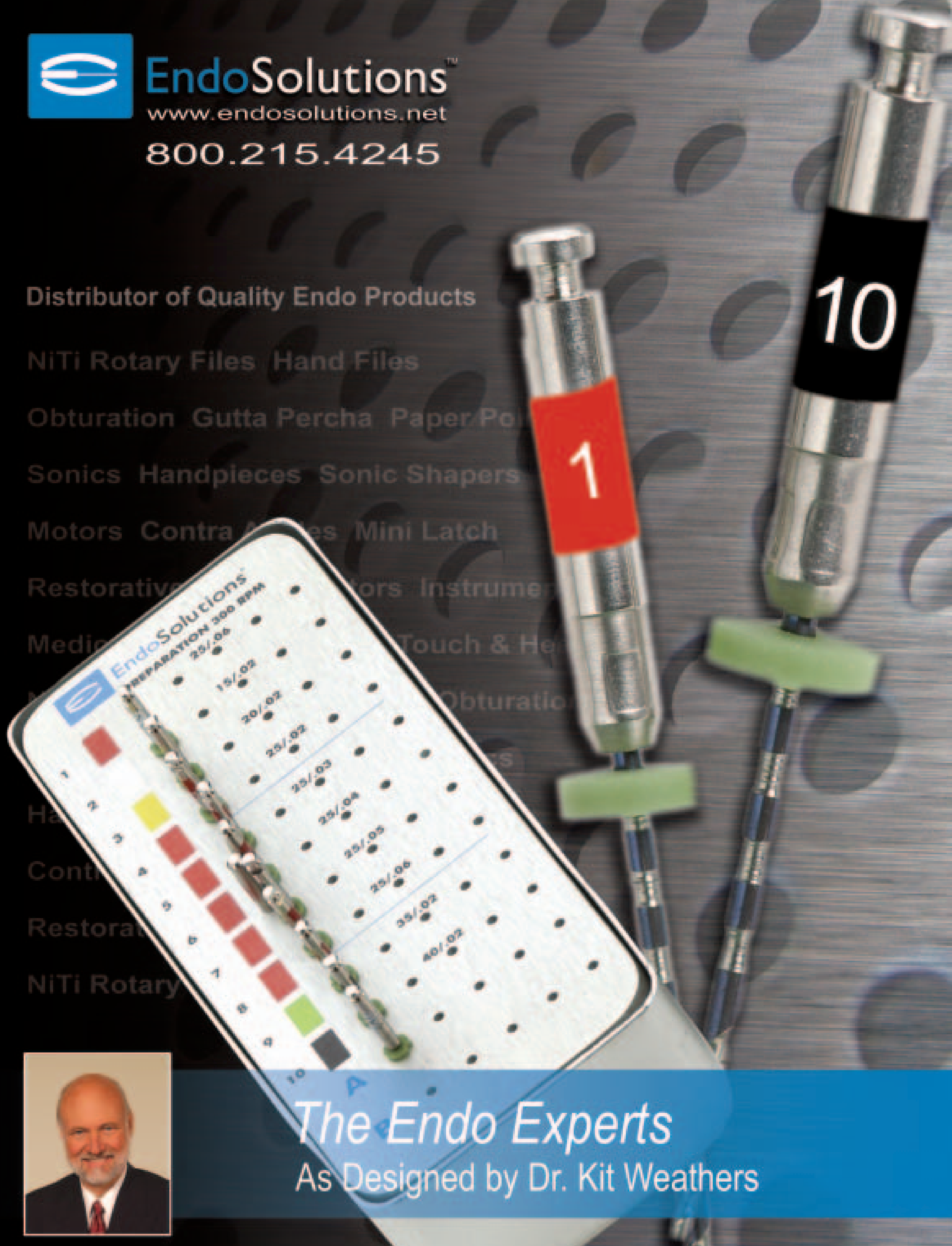
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10 SECRETS

to Achieving Case Acceptance

Dr. Michael Sernik

Recently I saw an article titled The 10 Secrets to Achieving Case Acceptance and it made me stop and think. Wouldn't it be interesting if there was a book called The 10 Secrets to Becoming a Brain Surgeon? Or The 10 Secrets to Becoming an Astronaut?

There are dentists earning $200,000 per year and there are dentists who earn $5,000,000 per year. Both might have equally excellent clinical skills. Perhaps the difference between the two is that one of them has read The 10 Secrets to Achieving Case Acceptance. Imagine how popular this article would be!

Experienced, high-grossing clinicians all know that the new patient exam is a complex psychological minefield. It is not a coincidence that the top clinicians are the most interested in high level communications training; are the most engaged at these trainings and are the ones who cannot get enough of this type of training. It is certainly a case of the more we understand, the more we realize there is to learn!

At the basic level however, people just want scripts and shortcuts. Just tell me what to say when the patient gives me an objection such as "Boy, that's expensive!" This is entirely understandable. After all, as dentists we are all so very busy. A practice owner has to keep up with all the new clinical developments; has to deal with the financial challenges of practice ownership and then there is a whole world of leadership skills to master. We were only trained to be clinicians. It would be so convenient to just learn a few tips in order to get on with doing all the clinical dentistry the patient needs.

When it comes to the world of dentist-patient communications, dental school taught me to examine the patient and tell them my diagnosis. If they did not understand, just give them dental education. If they could not afford it, well…talk about a finance plan. It all seemed so simple.

Many dentists will enroll in short programs to improve their case acceptance, hoping to pick up some tips. That is understandable. I have studied many of them -- but typically what I learnt were sales techniques that were geared to teach scripted responses to our patient's objections. If you have done these types of courses and are still under-utilizing your clinical abilities, it might be useful to consider the agendas in advanced communication training.

"There are ethical ways of creating desire for dental treatment, even though the patient is in no discomfort."

Problem-Solution or Solution-Problem?

Imagine a sales person trying to sell you something that you knew you did not want. The sales skill would have to be extraordinary for you to buy. In any sales situation there are two variables to weigh up. There is the sales skill of the sales person versus the desire of the prospect for the product. In the sales process we could put our efforts into improving our sales skills or put our efforts into developing a desire in the prospect. If there is desire, the sales skills would hardly matter.

Trying to sell something before there is a desire is almost impossible.

Now consider a dental scenario. How often do we tell the patient our diagnosis before the patient has developed a very strong need for the treatment?

Whenever we do that, we are creating objections. Now I ask you for a leap of faith. I want you to know that there are ethical ways of creating desire for dental treatment, even though the patient is in no discomfort. If this were possible, then I assert that all the clinician would have to do is help the patient understand their options. As a further leap of faith I want you to know this can all be achieved with zero pressure coming from the dentist.

There needs to be a perceived

problem before a solution is discussed. In the dental practice, it is common for dentists to offer solutions to problems that the patient is unconcerned about. By understanding this relationship, our communications can create objections or prevent objections.

Another perspective on the sequence of our information is that typically, the clinician will first make a diagnosis and then deliver dental education in order to persuade the patient of the merits of his or her proposal. An unintended consequence is that the patient can view this dental education as part of a sales process.

We teach a method of giving the patient relevant dental education before the diagnosis. In fact, the conversation is structured such that the patient actually asks us for this information.

Sales Techniques Can Harm the Practice

Most people in business today have had some sales training. In fact they often have had a lot more training than their dentist; so they are able to recognize a sales pitch when they hear one. If there is one thing that a sales-attuned person hates, it is being the prospect. Many times the dentist uses a sales technique without even realizing it is basic sales. Sales people are taught to use the word 'investment' rather than 'cost' or 'fee'. Dentists are sometimes told to tell patients that they are 'investing' not 'spending' money. While these sales techniques may work some of the time, they can potentially damage the doctor-patient relationship. If we are buying from a sales-person, we expect to be 'sold' and we expect the sales person to act as a sales person. No one is very comfortable with the notion that their health care professional has a financial agenda.

Some of the more common, sales techniques dentists use are: "How do you feel about your smile?", "How do you see your teeth in 20 years?", "If I could show you away to…", etc. Some of these questions are asked for valid reasons, but because they are obvious sales techniques, they have the potential to annoy a percentage of our patients.

Even when we achieve an 80% acceptance rate, this means we also must have a 20% rejection rate. Potentially we might be creating some disenchanted patients by using transparent sales techniques. If a practice has 1,000 patients per clinician, the doctor can ill afford to create dissatisfaction within this small precious group of patients. Good news may travel fast; bad news travels like lightning! It gets even worse when dentists or their teams try to use closing techniques on patients. Closing techniques always put pressure on people and have the potential to annoy them even more.

It might be wise to avoid all techniques that have the potential of damaging the relationship. Just because other people say these things, does not mean you should too. If it feels unnatural, do not do it.

Scripted Responses or an Integrated System

There are advanced communication techniques that can shape the

"We teach a method of giving the patient relevant dental education before the diagnosis. In fact the conversation is structured such that the patient actually asks us for this information."

patient's concerns before any treatment solutions are discussed. The process of creating a motivated patient is a psychological puzzle game. To be successful, the clinician needs to understand all the pieces and then apply them in one integrated system.

Preventive communication is much more complex than reactive communication.

"Advanced communication training bridges the gap between having clinical skills and using them."

We spent years on clinical training, only to find our patients do not always view their chronic dental conditions with appropriate concern. Without advanced communication skills, dentists can find themselves frustrated by having clinical skills that cannot be used to help their patients. The consequence of never finding a preventive solution to these objections is that it condemns dentists to a career with a continuous loop of reacting to the same types of self-created problems and the patients receive sub-optimal treatment.

All Dentists are Created Equal. All Dentists Do Not Perform Equally.

When we graduated from dental school, the variation in clinical skills was not great. However, if one hypothetical patient were to visit 1,000 dentists we would undoubtedly see a wide variation in outcomes. Some dentists propose treatment and are rejected. Others achieve impressive results without hearing any objections.

The dentist's ability to bond and communicate is the variable. Advanced communications training bridges the gap between having clinical skills and using them.

I am still trying to come up with a killer article called The 10 Secrets to Case Presentation. I know when I do it will be a great success!

Dr. Michael Sernik is the creator of PrimeSpeak - a five-day advanced communications training devoted specifically to the new patient exam. His courses are held at the Las Vegas Institute for Advanced Dental Studies and in Australia. See www.lviglobal.com or www.primespeak.com for more information.

Dr Michael Sernik is a dentist who, after 23 years of clinical dentistry in Australia, moved into the world of corporate training and spent 10 years working throughout USA, Canada, UK, and Japan, lecturing and training corporations in leadership, management, communications and sales. He is a partner in Prime Practice (www.primepractice.com.au), Australasia's leading dental practice management company and Dentist Job Search (www.djs.com.au), Australasia's leader in dental recruitment and practice sales. PrimeSpeak has evolved over many years and was made possible through Michael's vast experience in both dentistry and sales psychology.

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Yugo Hatai

Reproducing Nature: Smile Design

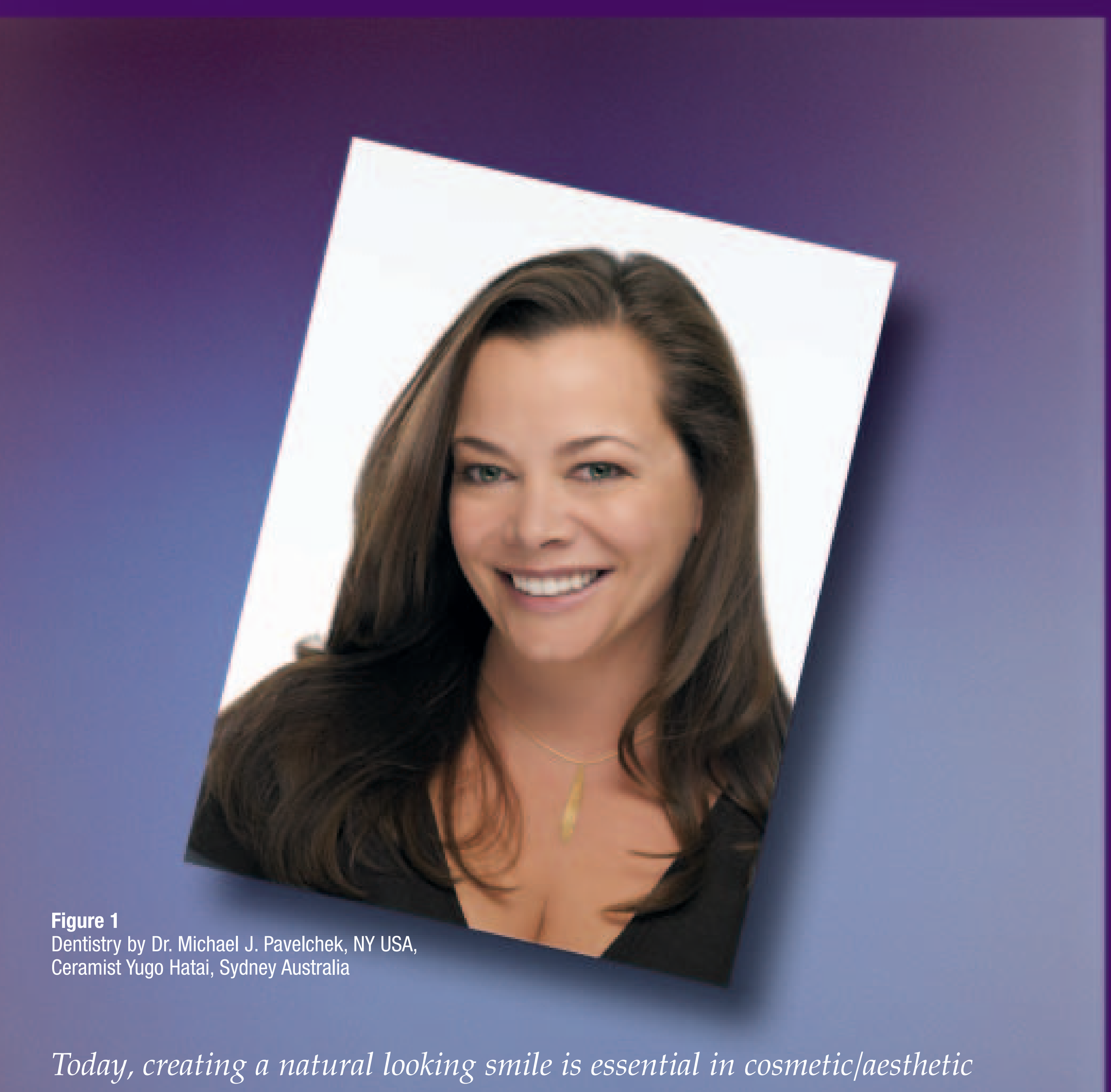

Figure 1
Dentistry by Dr. Michael J. Pavelchek, NY USA,
Ceramist Yugo Hatai, Sydney Australia

Today, creating a natural looking smile is essential in cosmetic/aesthetic dentistry. Many people think that white "Hollywood smiles" look fake but is this really true? Have you thought about bleached natural dentition? I think this looks healthy and attractive but obviously does not look artificial at all. This is the type of benchmark I set for myself when the patient is after a perfect smile.

Another important thing is that, every case should look different to fit the individual patient and if someone can pick who the ceramist is, to me, I have failed.

W hat is the definition of perfect anyway? Does it mean that it is perfectly in proportion, perfectly adapted to the patient's desire or could it be perfect looking and ridiculously artificial? To me, Nature = Perfect, so it is important to include the principles from nature constantly to avoid making the restorations look artificial.

Figure 1 shows a completed case - 10-units (15 to 25), for an American dentist and an American patient from New York wanting a bleach shade 030/040 (Chromascop shade guide, Ivoclar Vivadent) as a base. We all have stereotypes in mind that Americans want fake-looking, super-bright white teeth, but obviously most people do not mind looking "perfectly" natural. A natural-looking attractive smile is desired regardless of where you live! Of course there are some exceptions but it may come down to educating the patient. I find a lot of patients who want cosmetic work do not really want people to find out that they had their teeth done. Therefore, we should aim for something which blends into the patient's character and the facial features as well as their profile. Their desires and concerns should also all be included in the planning.

Another important thing is that, every case should look different to fit the individual patient and if someone can pick who the ceramist is, I have failed. A ceramist who has a certain style in shape and color and constantly ignores the individual cases does not really follow nature. Although there is a basic rule to follow, nature does not have a constant style in shape or color. As long as it looks like teeth in the mouth (i.e. not a crown) and meets the patient's expectations, then for me, it is a success. Creating a beautiful smile is not an easy thing to do. With larger cases - from six anterior units to a full arch, through full mouth reconstruction - there is so much room for creativity that it is easy to fall into a trap which would make the restorations look unhealthy and artificial instead of natural and artistic. There are a couple of principles I follow to achieve an attractive, natural looking smile. Here are the steps I follow for Smile Design.

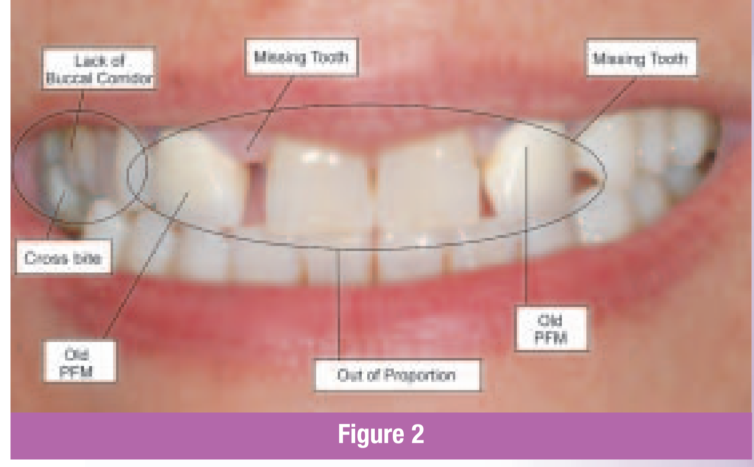

Figure 2

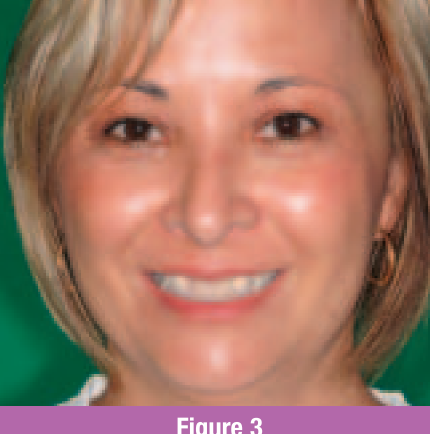
Figure 3

Case Planning and Diagnostic Wax Up

"The case from hell" would be the best way to describe Figure 2, which shows the problem aesthetically. Ideally, orthodontic treatment would be used initially to move the teeth into their optimal positions over time, however, often patients are unwilling to wait or accept this treatment plan.

This patient was not a suitable case for implants, so we decided to go ahead with another option of tooth replacement - a bridge. As you can see, the lateralised canines are almost in the middle in between the centrals and the first premolars. This means that I had to change the proportion and the position of the teeth significantly. I had hoped that the position of the bridge separations would not be on the abutment of the lateralised canines. Unfortunately, I found out later that this would be the case. As a result, the difficulty of the case increased. There is a limitation with what the clinician can do and what the technician can do on this type of case and it could be called "a compromised case" for this reason. This does not of course preclude trying your best.

In this case, the patient is a 44-year-old female hairdresser from the UK with concerns for the aesthetics of her upper teeth. In her words, she "desperately wants an attractive smile", however, had found selecting an "enthusiastic" dentist that could deliver the desired result difficult.

When approaching highly aesthetic cases such as this, I typically use diagnostic wax-ups to avoid most of the guess work. Once you start guessing, problems that could be corrected easily early on, start to compound. The minimum information the clinician should provide for creating the diagnostic wax-up is:

1. Indication of the number of units and position of the teeth
2. Patient's profile
3. At least two photos (See Figures 3 and 4) - a full face photo with a natural smile and a close up of the lips. Smile design is based on the essential soft tissue detail. The full face photo is utilized to determine:

a. Ideal Mid-Line

Figure 4

Figure 5

Figure 6

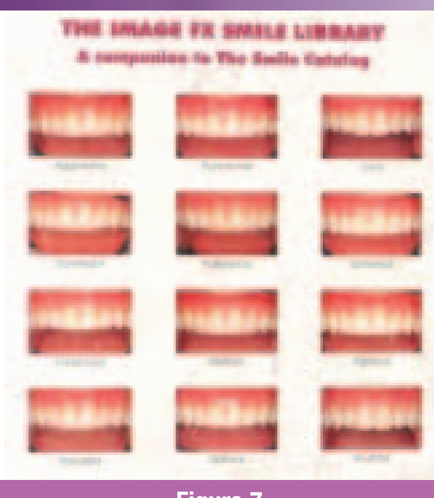

Figure 7

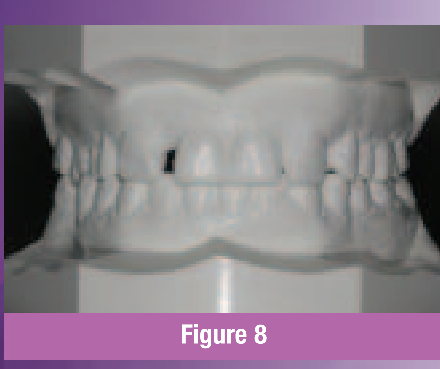
Figure 8

Figure 9

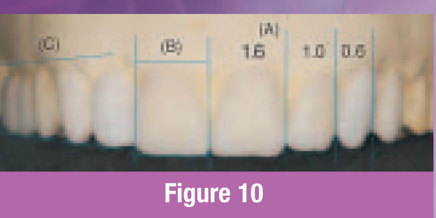

Figure 10

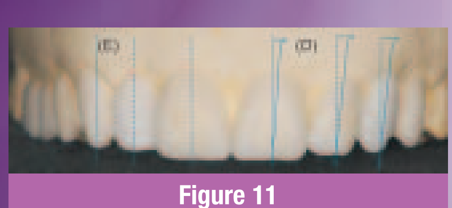

Figure 11

b. Ideal length of centrals
c. Ideal Proportion
d. Pitch
e. Roll
f. Yaw
g. Fullness of the arch - Buccal Corridor
h. Suitable style (shape) using the facial features
Figure 4 is utilized to determine:
a. Smile Line (i.e. high smile line is usually known as a gummy smile)
b. Lower lip relation to the Incisal Curve (i.e. ideally, incisal curve should follow the curve of lower lip)
c. Ideal length of centrals
d. Ideal proportion
e. Fullness of the arch - Buccal Corridor
Note: It is not possible to determine the mid-line from Figure 4!
Figures 5 and 6 are both optional but I find it important. These photos are utilized to determine:
a. Ideal incisal edge position
b. Over bite, over jet relationship
c. Ideal length of centrals

4. Style (shape) patient prefers - they can bring a photo or clip from a magazine which they desire for the final result or we can show them a style book (Figure 7 shows The Smile Catalogue by Dr Bill Dickerson). Amazingly, a lot of patients can be very particular about this and it is important for everyone to know what we are trying to achieve in the end.

5. Patient's main concern - ultimately, we are trying to make patients happy so we always have to take their concern and desire into account. The last thing we want is to be going backwards and forwards.

As mentioned, this is just the minimum amount of information you should receive from the clinician and of course, more is better. Constant communication is key and do not be afraid to ask for more information when you have a doubt. The more information we have, the better the results will be.

Figure 8 shows the pre-op model and Figure 9 shows the wax-up using the information provided. We decided to use Empress (Ivoclar Vivadent) veneers on the 16-14 to bring the buccal corridor out, a Zirconia bridge milled on a Lava system (3M ESPE) on the 13-11 and the 22-24 and a single Lava crown on the 21. This totals 10 units in all. For me, it is important to make the wax-up as close to what we are trying to ultimatly achieve. Here are a few principles I include from nature to help achieve this:

1. Proportions of the six anterior units - aim for the golden proportion. The number indicates the ratio (Figure 10)
2. Tooth proportion - ideally, around 75%-80% (length to width, square is 100%) (Figure10)
3. Graduation of posterior teeth (Figure 10)
4. Axial incline - long axis from cervical should cant to distal (Figure 11)

5. Zenith - for the central and canine, the position of the zenith should be towards distal and for the lateral, it should be in the middle (Figure 11)
6. Gingival level - the lateral should be shorter by around 1.2-1.5mm (Figure 12)
7. Incisal embrasure - should increase towards distal up to the mesial of the first premolar in relation to the contact points (Figure 12)
8. Contact points - should get closer to interdental papilla towards distal, up to the mesial of first premolar (Figure 12)
9. Morphology - always try to get some idea from the pre-op model if there is any natural dentition left. If not take a look as some other example or model of natural dentition to get some inspiration. Figure 13 shows some models of natural dentition from CALLAplus, TeamZiereis (more information on this later in the article).

You might notice that I have inclined the 12 inward however I do not recommend doing this just to make them look natural. This is high risk, difficult to attempt and a lot of patients would not want this. For this particular case, I have done this for a couple of reasons with the clinician's and the patient's permission. Even so, I have kept it in proportion so it will not appear noticeable in the mouth, especially in the patient's view. If you want to try something different, then I always recommend doing it on the laterals. Quite often, in natural dentition, there is no symmetry in laterals and it would look natural as a whole. It is just a matter of getting the balance correct - irregular but in proportion.

The beauty of having the diagnostic wax-up prior to the porcelain build-up is that the patient can visualize the ideal final result with the temps made from the wax-up and we can make any changes necessary without too much trouble. Essentially, we use the wax-up to eliminate the amount of adjustment which could possibly occur with final restorations in the mouth.

It is also important for clinicians to take an impression of the temps with alginate after any adjustment or touching-up so that technicians can visualize the current condition of the temps in situ. Even if the clinician does not make any adjustment, I still require this information. There is no guarantee that the wax-up and the temps in situ would be the same. Technicians can only guess that clinicians fitted the soft wash putty key in just the right position but, how do you know?

After the wax-up, technicians can provide a soft wash putty key off the wax-up so that clinicians can easily make temps with self cure material in the mouth (Figure 14). Also providing a prep guide would make the clinician's life easier when prepping. Figures 15 and 16 show the prep guide we normally provide and Figure 17 shows the ideal prep design I produce. I know exactly how I want the clinician to prep to achieve the ideal result we are after so, I prep the model and provide it as a prep guide so the clinician can visualize the ideal preparation in three-dimensions. Figure 18 shows the result with my prep guide and the final impression from the clinician. See how close they are!

Figure 19 shows the temps in situ. In this case, because of the patient's flight

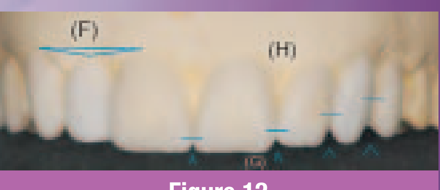

Figure 12

Figure 13

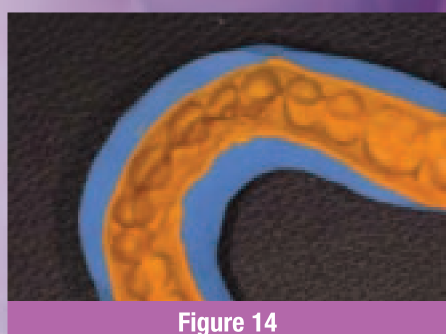
Figure 14

Figure 15

Figure 16

Figure 17

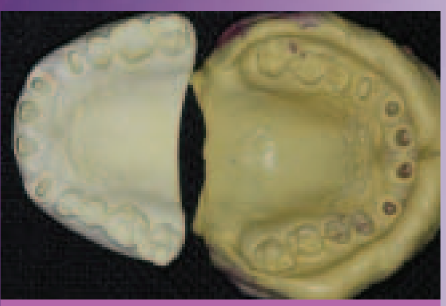

Figure 18

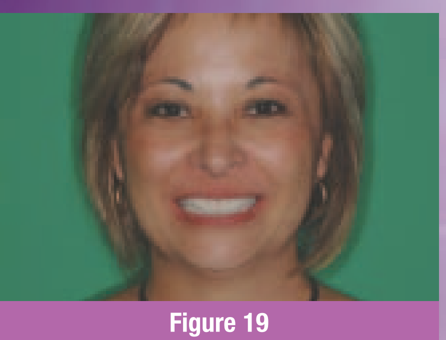

Figure 19

Figure 20

schedule, the photo was taken on the same day but normally the temp photos should be taken at least 24 hours after the treatment as the anaesthesia can affect the soft tissue information in a negative way and make it inaccurate. The patient was "over the moon" with the result, so little change was required. Even so, I can see some areas that could be improved which I will address in the build-up.

The Coping Design

I believe it is a big challenge for ceramists to achieve individual looking bridges. Personally, to be able to achieve a good result, the first element that crosses my mind is the position of the connector. If you get this wrong, regardless of what you do subsequently, it will look like a bridge rather than single teeth. It is fairly easy to place the connector in a correct position. I want you to go back to Figure 12. You can see the contact points and with a bridge, normally contact points = the position of the connector. So all we have to do is just follow the principles. Another tip is that I tend to place the connector slightly towards palatal for a couple of reasons:

1. I get more room to play with during the build-up labially and this will help the separation and make it slightly easier to make them appear individual.
2. The palatal region is not in the aesthetic zone so it is better to put greater strength in this area. 99% of the time, the patients just want smooth anatomy at the back of the teeth so I simply create a nice and smooth area with Zirconia and polish it after glazing without putting much porcelain on it. It's important to use both the aesthetics and function wisely.

It is essential, however, to check the bite before you place the connector or add support, as the last thing you want is to have the connector in occlusion or a heavy bite.

Figures 20 and 22 show the bridge design on the 22-24. You can see that I place the connector fairly low, just above the interdental papilla as that is where the contact point should be. There is plenty of support on the marginal ridges and the functional cusp on the premolar (Figure 20; palatal cusp on the upper – it may be difficult to see).

Figures 21 and 23 are for the 11-13. You can see that the connector in between 11 and 12 is higher than the position of the connector in between 12 and 13. To me, this is a must. I always make sure the contact points against the canine are just above the interdental papilla as that is how it is in nature most of the time. If you put the position of the connector high against the canines, the restorations would immediately appear artificial.

If you look closely, you can actually see where the prep is and that it is necessary to put enough support for the strength and longevity of the restorations. Another thing I would like to focus on at this stage is the incisal embrasure. This should also follow the principle detailed at the diagnostic wax-up stage (Figure 12).

It is very important that the ceramist is always involved in the design of the copings. Do not leave it to whoever does the waxing or scanning. Basically, the build up starts from here so if something goes wrong, do not blame it on them. It is the ceramist's fault if they do not do the design themselves!

Introducing CALLAPLUS CERAMIC - TREATMENT

I have been a ceramist for quite a while, long enough and experienced enough to be able to tell the difference between natural dentition and very well-matched restorations. Going through dental magazines or books, I see many great restorations but often it is fairly obvious which one is a restoration. Regardless of how much I train myself to reproduce nature, there is one thing I just can not control. This is the "micro bubbles" within the porcelain which tend to appear on the surface of the finished restorations (Figure 26). Worst of all, this becomes more obvious when polishing after the glaze firing and just before we finish the job and send it out (the courier is usually pacing the reception area by now and giving me dirty looks!). Once I see these tiny bubbles on the surface, I get very upset. My eyes just lock in on them and the restoration does not look like a tooth to me anymore! It may sound like I am being very fussy, but it is a serious issue for me.

Natural dentition has very smooth dense layers regardless of the surface anatomy (Figure 27). It is very annoying to try and get rid of a tiny bubble on a finished restoration that you have spent so much time creating. I have tried to fix this problem by condensing the porcelain prior to firing, mixing the porcelain to get rid of any visible bubbles under the microscope or making sure the porcelain is constantly wet to avoid wet-dry-wet build-up. I even tried many different firing cycles. However, nothing seemed to work; I still had those tiny little bubbles which drove me insane!

Finally I found a solution - the CALLAplus Ceramic treatment (the first in Australia) from German company TeamZiereis GmbH (Figure 24).
Instead of hand mixing the porcelain powder on a plate, you simply put the porcelain powder and the liquid together in to the glass container of the CALLAplus and turn it on. It then sucks the air out of the container and once you get a full vacuum, you turn the built-in vibrator on. In 30-60 seconds (the time can be varied), you get bubble free porcelain paste! Figure 25 shows the amount of air that comes out of the porcelain paste. Scary!

Figure 28 shows the surface of a crown built with the bubble-free porcelain. This is a dream come true. The advantages of the CALLAplus ceramic treatment include:

1. You can use any type of porcelain powder and re-use the dried out porcelain as if it is brand new again (The glass container comes with a lid, so make sure you put the lid on when you are not using the porcelain to avoid having dust in it)

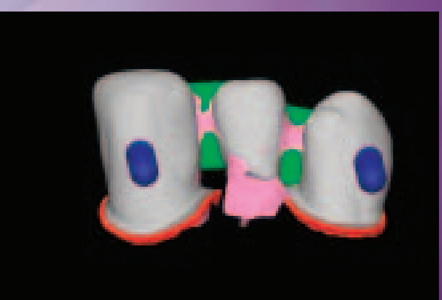

Figure 21

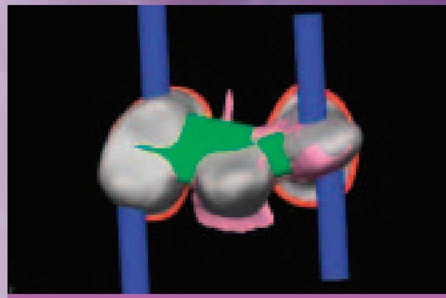

Figure 22

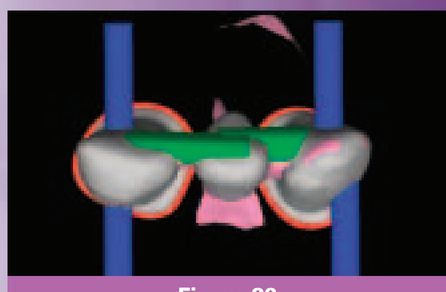

Figure 23

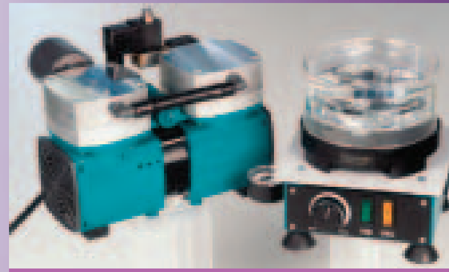

Figure 24

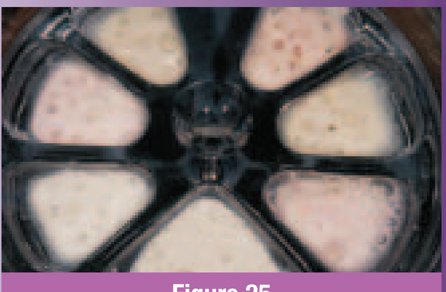

Figure 25

Figure 26

Figure 27

Figure 28

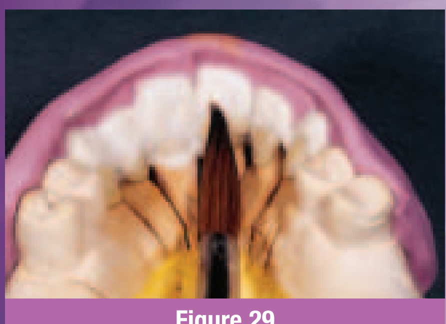
Figure 29

Figure 30

2. Maintaining the color and translucency you desire - the color definitely comes out better. I think the micro-bubbles create some slight shadow into the restoration and that makes the color inaccurate

3. Great hygiene - far less plaque on the finished restorations

4. The porcelain tends to be more stable during the build-up - the first time I used it, it almost felt like it was a completely different porcelain! Because it is very condensed already, it is easier to control after the treatment. It almost feels heavy! Also, the porcelain paste seems to keep the moisture longer. It does not dry out as quickly as untreated porcelain.

5. The restorations with treated porcelain are stronger than untreated ones due to the density.

6. When using silicone core, the porcelain does not stick to it (Figures 29 and 30). Note: these photos are not from this case. They have been provided by TeamZiereis.

7. Achieving great surface finish without worrying about the tiny bubbles!

8. For me, no bubbles, less stress!

The Build-up

With larger cases, some people tend to think they can get away with doing whatever they want in relation to the color. However, a large case does not mean you do not have to put forth any effort. In fact, I generally put in the same amount of effort into big cases as when I am working on a single crown. If you make uniformly colored monochromatic restorations, these would look artificial and obvious in the mouth. So what can we use as a guide or to draw on for inspiration?

Again, natural teeth provide the answer. I always include some characterization to the way color appears from the pre-op photos if there is any natural dentition left (for this case, two centrals and the posterior teeth) and also from lower teeth (mainly anterior). In this way, it is not that difficult to make the restorations blend in.

Figure 31 shows a photo of natural dentition in relation to the models from Figure 13 (CALLAplus TeamZiereis). This gives me a great idea of how the color relates to the shape. The color of internal structure always relates to the shape of the tooth as a whole and also to the surface anatomy. This is one of the reasons I think it is important to visualize the final result (shape-wise) prior to the build up so I can accurately fill in the space with the color I am after.

Another reference source I constantly use is the book called Analysis by one of the master ceramists I admire, Mr Gerald Ubassy from France (Figure 32). This book is a photograph collection of natural dentition. I find that constantly looking at natural dentition while building restorations helps prevent me from making restorations that look artificial. Even when I work on a single posterior crown, I still look at photos, models of natural dentition or surroundings to avoid putting my own style in it. Once you start learning from nature, the depth

is just endless and you never stop learning. And again, every case should look different as every patient is different.

Moving onto surface anatomy, most of the time I use the natural dentition from the pre-op model as a guide. For this case, the patient has a naturally smooth surface anatomy so it is absolutely unnecessary to create a lot of detail on the surface. In regard to lustre, you can see in the pre-op photos (Figures 4-6) that it appears to be highly glossy so this is what to match. Again, this is not about what you think would look good - it is a matter of following nature and meeting the patient's expectations.

Figure 31

Finished Restorations

As I mentioned earlier, while this is a compromised case, the result shows that we can still manage to get a great result. The color matching among Empress Veneers, Lava restorations and the natural dentition came out well (Figures 37 and 38). The color of the lower anterior is A1/A2 base and patient wanted 040/B1 base for the final result, hence the upper teeth appear to be slightly whiter to meet the patient's expectations.

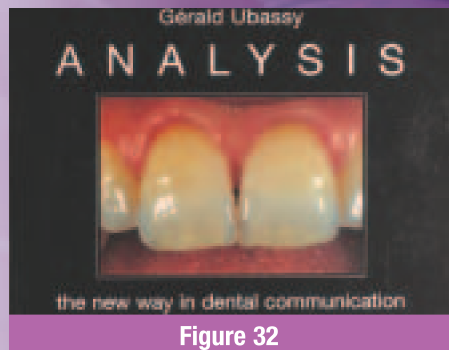

Figure 32

There was some difficulty with the shape but it is possible for the ceramist to control the gum condition by placing a suitable emergence profile and necessary contour to help the gum regain from the recession. A very firm fit on the pontic was also required. Without having any gum re-contouring, the result is very satisfying. I received the full face photo from the patient two weeks after bonding and you can see that interdental papilla is settled in a suitable position (Figure 39).

I would like to thank Dr. Kaye McArthur for achieving this result with me. Without her outstanding knowledge and skills in cosmetic dentistry, this article would not have been possible. Many thanks also to everyone who was involved in this article.

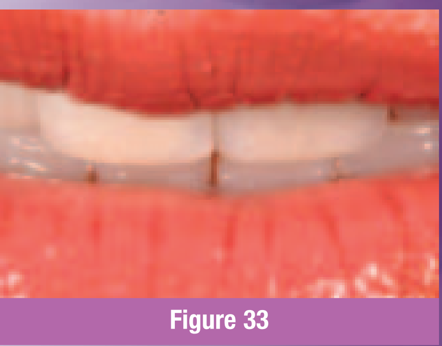
Figure 33

Feedback From Dr. Kaye McArthur, Gold Coast, QLD, Australia

Bev's case presented both Yugo and I with a number of aesthetic challenges, most arising because of the drifted root positions of the canines that were now sitting midway between centrals and premolars and positioned differently in each quadrant.

Figure 34

This mid-space presentation required us to camouflage abutments that were midway between the two teeth we wanted to replace. The gaps available made it difficult to correct the smile by creating a more aesthetic Golden proportion type tooth size relationship.

We were lucky that Bev has a relatively low lip line as the ovate pontic bridge style and laser gum re contouring we would normally prefer to do in anterior

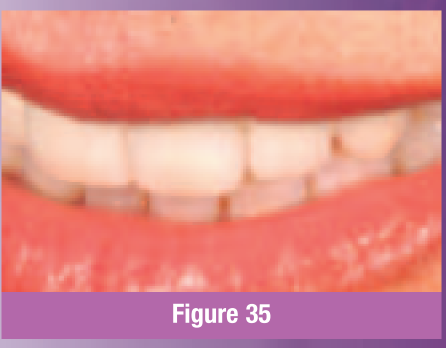
Figure 35

Figure 36

Figure 37

Figure 38

Figure 39

cases was unavailable to us because of compromised root position.

Envisaging the final result and precision prepping of the teeth were crucial in providing the space that Yugo needed to create the final ceramics, crowns and bridges for this challenging case.

Bev's case is typical of many Yugo and I have treated where the patient has been told by many practitioners that their case is untreatable or cannot be done without orthodontics. Could Bev have had achieved a better result with orthodontic root repositioning first? Yes, Maybe. But was she happy with the final result we produced treating this case in ceramics only? Absolutely! The tears and gratitude of a patient who had been afraid to smile for 30 years say it all. That is why we do what we do.

Feedback From the Patient

Dear Yugo & Kaye,

I would like to take this opportunity to truly thank you for the immense effort and expertise you have shown, to give me a wonderful new smile.

For many years I have longed to be able to smile without hesitation and you have made that possible. From being a small child and being teased about the fangs that were once in the front of my mouth, I have never thought it would be possible. For as long as I have been able, I have tried without success, until now, to fix my teeth.

At the age of 14 in the UK I finally received crowns to cover the "fangs". It made things better but I always knew they were not perfect. I was told that that was the best that they could do for me.

Over the years, I never relented my quest for better teeth and have sought other opinions from many other dentists. All of them would come to the conclusion that my case was a "hard job" and that "the results would not be worth the money I would have to spend". I had almost given up hope and thought that maybe I should "give up the ghost", until I found you.

The results are amazing I could not have wished for better, they are beyond my wildest dreams.

So, I would like to thank you both for having the tenacity, knowledge and sheer "we can conquer anything" attitude to give me back the confidence to be able to truly smile at the world without hesitation for the first time in my life.

Just one question though… I have tried to floss my teeth but it does not go over the teeth in some area. What am I doing wrong?

Yours Sincerely,
Beverley Jones

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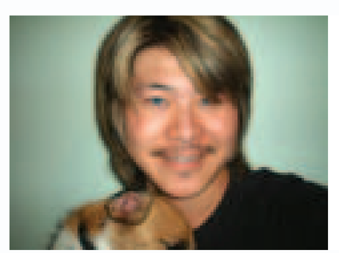

Yugo Hatai, a native of Japan, became a registered dental technician in 1998. He is a highly respected cosmetic dental technician who has enjoyed numerous accolades from many leading dentists and prosthodontists for his attention to detail and ability to re-create a natural tooth. After being recognized for some of the most amazing achievements ever made by trainees at Osaka University, he immigrated to Australia in December 2000. At that time, he was specializing in maxillary prosthetics dentures, chrome, telescope crowns, light cure composite resin, ceramics and implants. In 2004, Yugo became interested in the understanding of neuromuscular dentistry. There is no doubt that the Las Vegas Institute (LVI) has become one of the leading academic institutions in neuromuscular dentistry. Yugo has become a master technician of LVI. He plans to continue to study further in neuromuscular dentistry. Currently, Yugo runs the boutique department at Race Dental Laboratory and takes care of high end clients who have demanding expectations. Yugo is a member of the American Academy of Cosmetic Dentistry. He has published four articles which have received great accolades locally and internationally, including leading legends in dentistry, Master Ceramist Ernst Hegenbarth, Gerald Ubassy and renowned Prosthodontist, Professor Dr Gerard Chiche.

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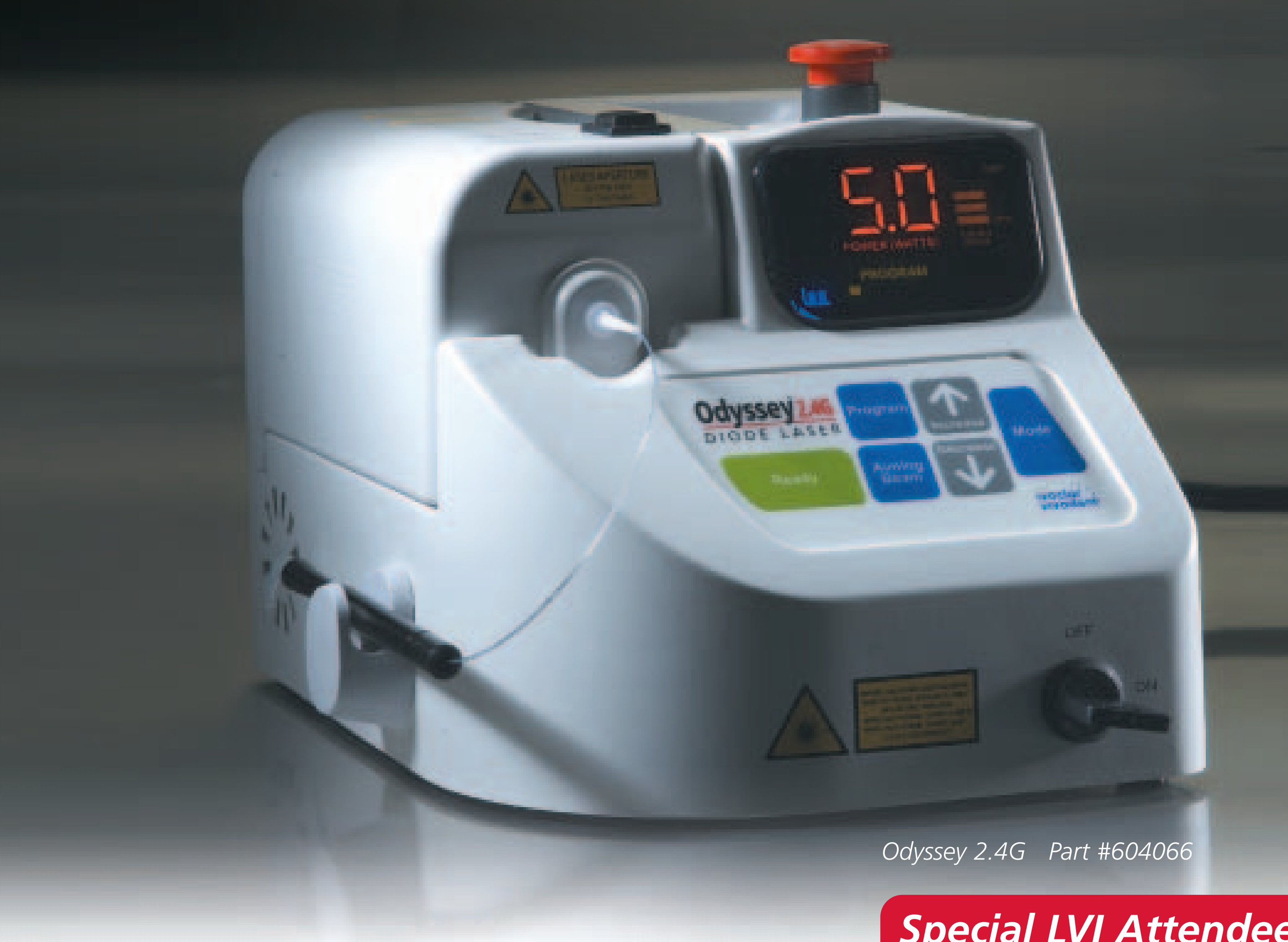

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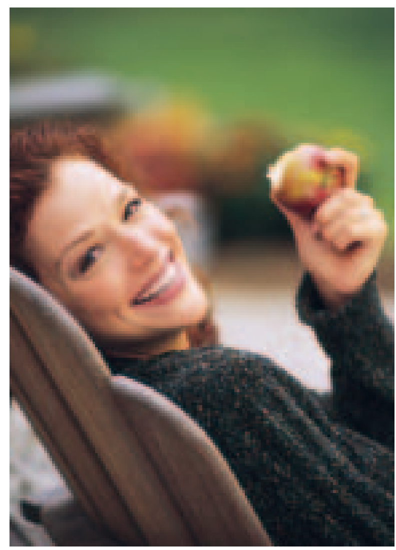

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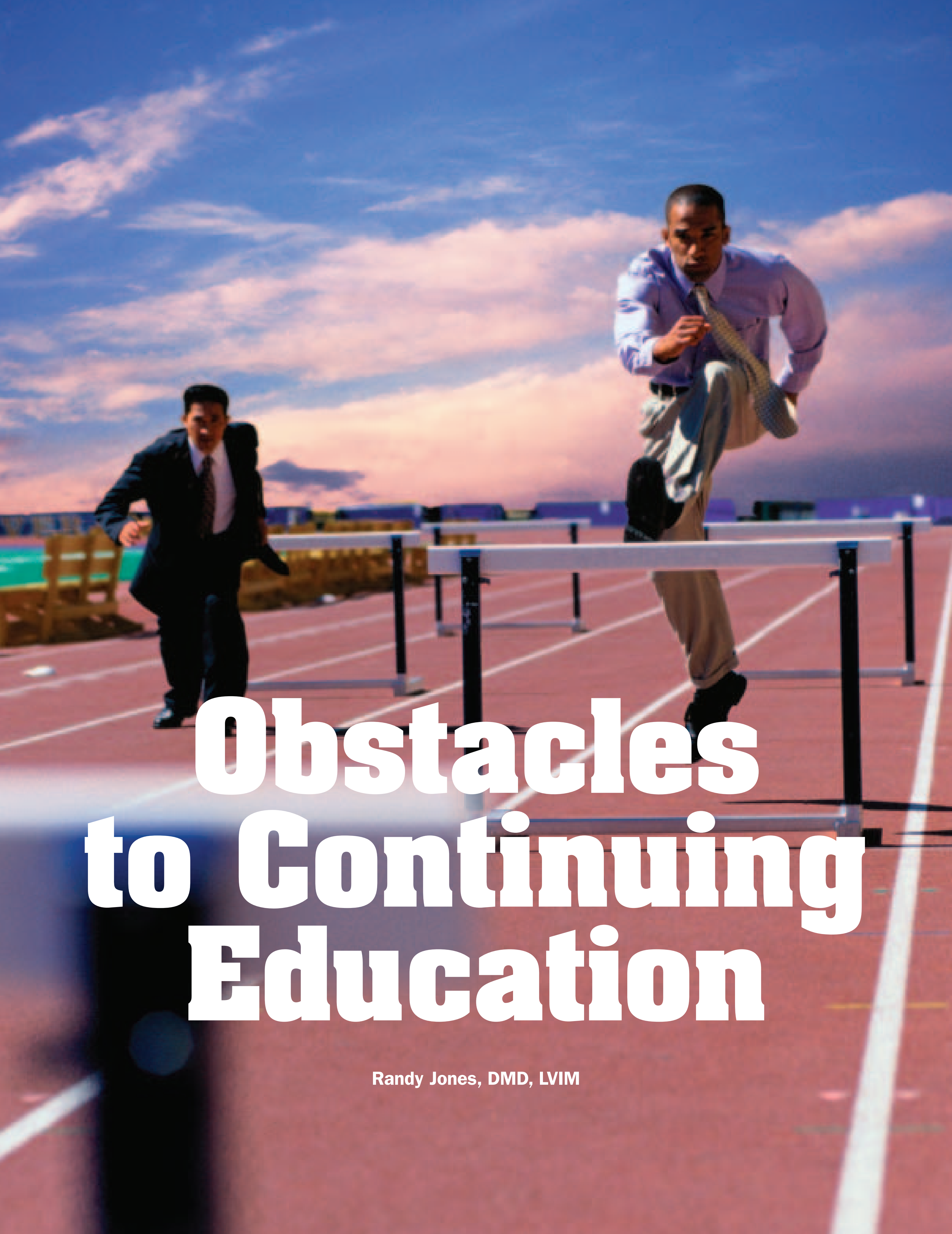

Obstacles to Continuing Education

Randy Jones, DMD, LVIM

An obstacle is defined as one that opposes, stands in the way of, or holds up progress.

Primary incentives to pursue continuing education:

- Personal gratification
- Financial gain
- Peer recognition
- Patient recognition

Primary obstacles in attending continuing education:

Distance

Some places are just too far away or too hard to get to. Some people just cannot fly every time - especially not from coast to coast. Often times, traveling adds an extra day away. It would be so much easier if it were a short drive away.

Time Requirements

You do not have the time. If you were to take a week out of your practice you would think it was not cost effective. It does not seem to make sense to close the office and pay the team while you are gone. That is just too much time away.

Cost

In addition to lost production time while away from the office, there are fees associated with the course as well as travel expenses. You have to consider the cost of airfare, hotel, meals, and of course entertainment. You can not afford that - especially not for a continuum of courses. Is there a perception that there is no more to learn – at least not enough to value the expense? Do you feel like you know it all without even seeing what the course really has to offer?

Convenience

You can not inconvenience your patients, let alone your family. Your patients have been scheduled for six months to see you at their hygiene visit. Time away would not be fair. Who will take the kids to soccer while you are gone? What will your spouse think - left there all alone while you are away whooping it up? No, you can not do that to your patients and family. Or can you?

Overcoming obstacles to continue education:

Distance

The obstacle of distance is easily overcome. You need to get out of the office, and out of your normal environment to concentrate effectively and get the most out of what is being offered. You can not do it at home with all the distractions.

A new environment renews the mind. Where else can you go and talk to others in a situation similar to yours? Where else can you get your questions answered immediately? Not only is support offered while you are there, but oftentimes it is available later through personal contact or electronic forum discussion.

Time Requirements

How can you take almost a week off to go to a course? You can if it is to attend the most advanced, up-to-date, exciting education in the world. Technologies advance quite rapidly and it is important to go where you can keep up with them easily and accurately?

The education experience itself continues to get better through modern PowerPoint presentations, humor, personal experiences, informative content and interesting dialogue. A first-class faculty that works extremely hard to keep you mainstreamed with the most current and useful dental information is paramount. Great food and an impeccable facility add to the experience. The instructional quality should be very high and the

You have so much more to offer your patients because of your training and education.

teaching styles should reach the students and motivate them. It is one thing to disseminate the knowledge; it is another to make the knowledge usable and easy to incorporate upon returning to the office. It is even a more impressive task that you will want to immediately put into use what you have learned.

How long will it take you to go through a series of courses? One year? Five years? 10 years? Most find that they have to know the answers to their questions to move on, so they move rapidly to the next course to gain further insight and answers. Everyone travels the journey at their own pace - whatever is comfortable for them. Personally, I went through a continuum of courses as fast as I could. I could not get enough, fast enough, to do better dentistry. It is all up to you.

Convenience

Your patients want you to be the best dentist in the world. That is why they chose you in the first place. They think you are the best - otherwise they would have gone to someone else. Do you think they would mind if you took time out of your practice to improve yourself so that THEY would receive better care and treatment? Perhaps they want you to stay so you can check their teeth after the hygienist cleans them, just like you have always done - without knowing the cause of buttressing bone, forward head posture, a flattened curve of Spee, why they have tinnitus, what about their click and pop in the joint. They have been waiting six months to see you. Another week will really make them mad so we will not put them off to better ourselves for THEIR benefit. Right? Of course not!

You have so much more to offer your patients because of your training and education. That is why you became a dentist in the first place - to serve them as a health care provider? How can you offer them health if you can not diagnose the disease? What if your MD said your earache was from an inner ear infection because he did not know about Acoustic Neuromas and all of a sudden life got much worse, because he was not educated on the alternative. Well, how can you diagnose a proper smile if you do not know the golden proportions and all that it relates to?

It is not that you become so brilliant from continuing education, it is that you know enough to start the conversation about the problem in the first place. Otherwise, you do not diagnose what you do not know and you can not talk about something you do not even know exists. Continuing education should teach you to think like a mouth doctor and not a tooth mechanic as we were taught in dental school.

Cost

How in the world can you afford continuing education when considering all the expenses involved? Better question; how in the world can you

You should learn to be a better business person with more profit and less loss.

NOT afford to continue? Not only myself, but hundreds of other doctors can tell you that if you go to a quality course it should MORE THAN pay for itself. You just have to get over worrying about the initial outlay of dollars and know it will be a financial asset. Better yet, contact an office where the TEAM has gone along with the doctor. Call my office. They will tell you high-quality continuing education is the best money the office has ever spent - on anything. You will learn to be a better business person with more profit and less loss.

When you first get back from a course and implement what you learned, just relax and watch what happens. The patients become better educated because of you, and they actually ask for better dentistry. You will understand that you OWE your patients the very best and you will not stop giving it to them. What a wonderful cycle when transitioning from education, to treatment, to healthier patients, to financial success, and the final outcome is not only financial independence, but personal gratification for doing it well and doing it right.

A wise man once told me; "If you treat people truthfully, with respect, and do on them what you would do on yourself, you'll never, ever have to worry about buying groceries." I think that says it all about money.

Benefits of continuing your education:

You will communicate so much better with colleagues:

- The orthodontist about facial proportions, curve of Spee and Wilson, overbite, overjet, serial extractions, arch width, bicuspid drop off, etc.
- The oral surgeon about tmj
- The periodontist about occlusal disease and osseous breakdown
- The endodontist about nerve death, cracked teeth and trauma from occlusion

You get the picture. You do not have to nod your head in a discussion with them like you understand what they are saying yet, you do not have a clue. You will be leading the conversation.

You can read and interpret journal articles so much easier and faster - with confidence. You will understand that most articles are saying the same thing in a different manner because very few programs take on the role of advancing the profession. Every article you read on veneers says the same thing - here is my before, here are the materials I used (all the same), and here are my after pictures. They do not tell you why one dark tooth needed a blockout, what porcelain ingot to use, why you must sterilize the tooth before etching, what degree of surface anatomy and incisal translucency were chosen and why. Don't you care to know? You should because you want to offer your patients the very best - exactly what you would want for yourself.

Of course, there are many other

Everything you learn in your education makes you a better professional.

benefits as well, just not enough time to talk about them.

Everything you learn in your education makes you a better professional. When you are successful and happy at work you are better at home as well.

These results we see over and over again:

You will be able to do in three days what you used to do in four, leaving you with more time to spend at home with your family. Your technique is improved and you are more prepared and equipped. Your systems are in place. Your confidence is huge.

You have a more financially profitable practice, but more importantly, one you enjoy. Ask others – they will share with you how they used to run from room to room and not have enough time to return a phone call. At the end of the day all the stress and chaos does not reflect in the amount of money collected. Although discouraging, do not stress yourself out at work all day long and go home worn out and in a bad mood. This is not fair to yourself and your family. There is absolutely no reason to have something come into your office that you feel you can not handle. A great continuing education program can teach you to do it faster, more efficiently and more productively. That is what being educated is all about.

You will be a better parent and spouse. How does this relate to my dental education? When you care enough about your patients to give them the best, this will carry over to your family. They are the reason you go to work. Do not become better educated for yourself, do it for your family. They will love you for it. They will not love you for being away while you are learning, but in the long run, you will be their blessing. Ask me how I know.

I have seven children, two dogs, two offices, twenty-one team members, college tuitions (that is plural), private school tuitions, car payments, house payments, football practices, tennis practice, gymnastics, and a great wife at home who is on board with it all. So if we can make it all possible working three to three and one half days a week, I know you can too. Stop making excuses an obstacle to making yourself happy and fulfilled. Get on board. Get educated.

Open your mind!

Randy Jones, DMD, LVIM

Randy Jones attended Clemson University majoring in biochemistry with a minor in psychology. After graduating Cum Laude in 1980, he attended the Medical University of South Carolina where he obtained his dental degree (DMD) with honors.

Upon graduation from dental school in 1984, he established two dental practices, one in Summerville and the other in Johns Island, SC. Both practices focus on Aesthetic and Neuromuscular Dentistry with an emphasis on old-fashioned care and compassion, along with the latest advanced technology utilizing the highest quality materials available.

He is a member of the ADA, The SCDA, The ImageCD, The IACA, as well as many other smaller localized dental societies.

He is a graduate of and clinical instructor at LVI and on the board of directors for The IACA.

He consults for various dental labs and is on the think tank for New Dental Products for 3m.

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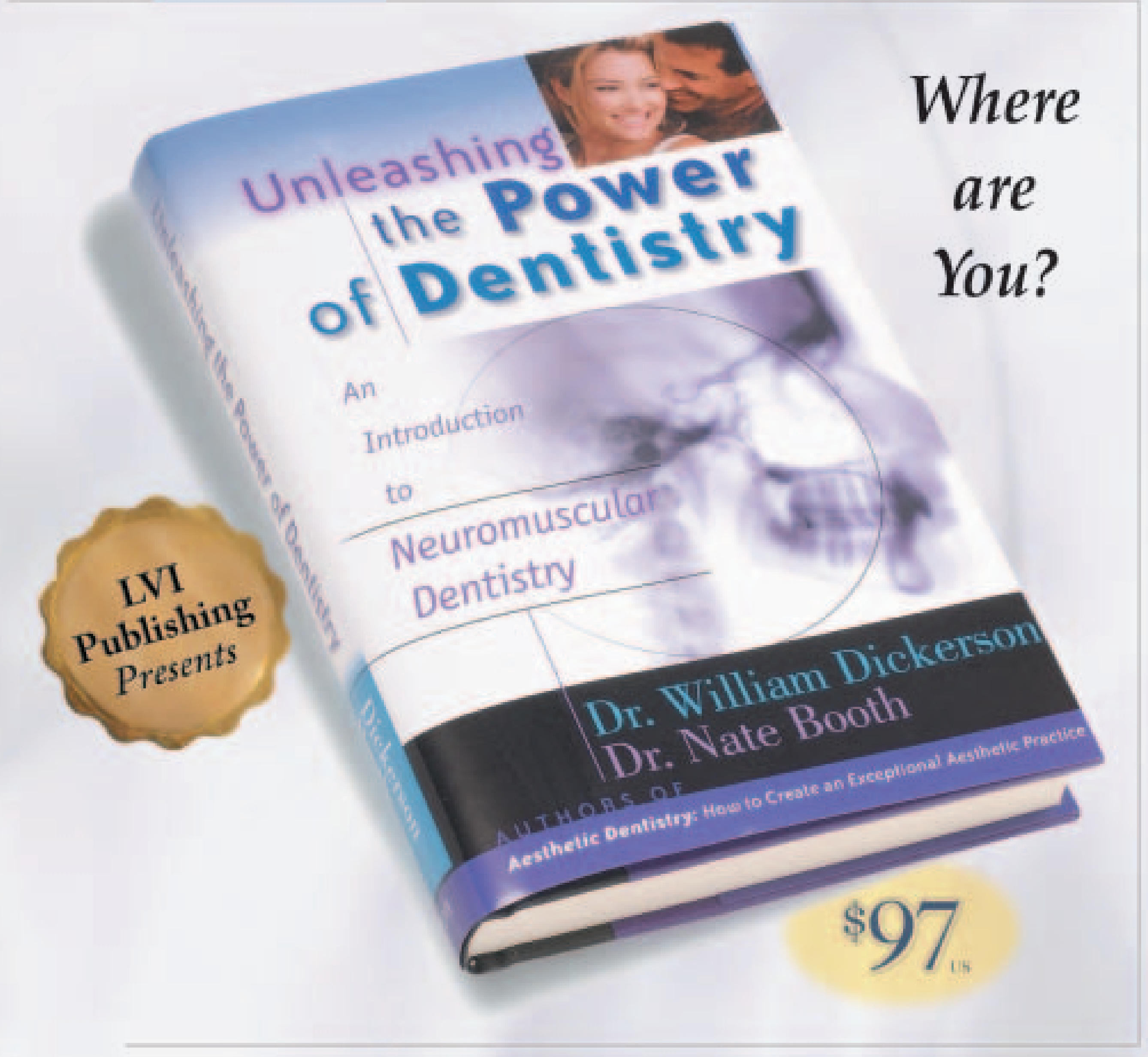

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Dear Heidi,
As a hygienist I do quite a few sealants. I hate to admit it, but I know that sometimes if I do not "feel" the decay w/ my explorer…that does not mean it is not there. I think sometimes when there is not a "sticky" area I assume all is well and do the sealant. However, I know that once in a while I could be sealing in decay. This completely bugs me! What can I do to check for decay so that I can get over my guilty feelings?

A.O.
Los Angeles, CA

Dear A.O.,
First and foremost I want you to rest well. The fact that you are doing so many sealants is a wonderful thing. I LOVE preventive dentistry. The service you are providing for your patients is fantastic. You are right. However, there are times we can "seal things in". Sometimes an explorer or even an x-ray does not show the beginning of decay that is starting in deep pits and fissures. Even if you use caries stain, you can miss it at times. I saw something for the first time at the 2007 ADA meeting. It was KaVo's new DIAGNOdent pen. Have you seen it? It is a handheld caries detector. I love it because it is light to hold, cordless, and easy to use. It accurately diagnosis caries using laser technology. How great is that? The laser extends your vision into the areas where caries can develop and grow. It works so well with incipient decay in pit and fissure areas. And as far as your explorer goes, it is 90% more accurate in detecting lesions not detectable with an explorer or bitewing. So, my advice is…get some laser technology and a good night of sleep!

My Best,
Heidi

Dear Heidi,
We routinely offer gift certificates to our clients. They are a great way to surprise someone with a gift of teeth whitening or even a larger service such as veneers. Our patient's husband purchased an eight-unit veneer gift certificate for her so that she could have her teeth restored before their daughter's wedding. How great was that? The issue is we do not know if we should include an expiration date on the gift certificates. Our fees are subject to change each year, and if the gift certificate is purchased and not used until five years later…our fees would be different. Do we put a dollar value on the certificate or a specific procedure/service? Thanks for your advice…these certificates were a big success during the holidays!

Cheers,
H.H.
Chicago

Dear H.H.,
I love your idea… gift certificates can be fun and work well, even in our dental offices. Especially when someone forgets to purchase a gift for a loved one! What a fantastic surprise that Mother of the Bride had in your office! I will share with you that 30 states have enacted laws banning gift cards and certificates with short expiration periods and requiring issuers to turn over cash from expired cards to the state! Eight states have added these laws in 2007 alone. Some states require the certificate to be valid for at least five years. This can hurt small businesses that have great intentions and thrive on using gift certificates. Due to these rules, my advice would be to have the certificate state a monetary value. That way if your fees change, it will cover a certain portion of the cost and the customer will be responsible for the rest. It will make it more of a win-win for you and your clients.

Happy New Year!
Heidi

Dear Heidi,
We do a lot of chair side and take home bleaching in our office. My patients always want to know exactly what color their teeth are when they start and then again when they end their bleaching regimen. I am not crazy about our current shade guides. Can you recommend a guide that works well for this purpose?

Thanks,
Dr. B
Pennsylvania

Dr. B,

This is a great question due to the amount of whitening that is done in dental offices today. We have so many ways to whiten our patient's teeth…in the office and at home. Many guides that come with a whitening kit, for example have inexpensive shade tabs for the patient and they are not very good. They offer only a few shade samples and sometimes none of the shades accurately reflect the color of the patient's teeth. However, I have seen a product that works quite well and my patients really see the actual color of their teeth with it. The VITA Bleachedguide 3D-Master is a new guide. This guide is highly recommended for monitoring the progress of teeth whitening. I like it because of the wide color range that it encompasses. The bleach shades that it contains mimic the results we see in contemporary aesthetic dentistry. What I mean by that is; they get really light! Get one of these guides and try it out to see if it is what you are looking for.

Hope this helps,
Heidi

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PUBLIC BASHING OF DIFFERING DENTAL PHILOSOPHIES

An Interview with Drs. Ronald Jackson and Omer Reed

Q: Why do you believe there is so much controversy surrounding the different dental philosophies?

Dr. Jackson: To some degree, this is always the case when the established order is questioned. Looking at history, and on a much larger scale, people were imprisoned or executed for questioning whether the world was flat. In addition, it took hundreds of years for it to be accepted that the earth revolved around the sun instead of the other way around. Scientists, starting with Copernicus who first questioned the idea, on up to Galileo who was able to prove it so because he measured it, were all considered heretics and ostracized by the establishment.

When a belief is held for a long time and an entire field of thought (geography or restorative dentistry) has been built around it, it can take on an almost sacred aura. It gets forgotten that the original premise, based on observations at the time, was often nothing more than an attempt to create a working model (the world is flat, an established occlusal concept), from which to operate and go forward.

Controversy is always the first stage of change.

Dr. Reed: Change is inevitable. Growth and learning, a choice. Change, growth and learning require giving up previous beliefs and patterns. When paradigms shift, everyone goes back to zero. Leo Tolstoy the great Russian author and philosopher summed it by saying – “I know that most men, including those at ease with problems of greatest complexity, can seldom accept even the

simplest and most obvious truth if it would be such as would oblige them to admit the falsity of conclusion which they have delighted in explaining to colleagues, which they have proudly taught to other, and which they have woven, thread, into the fabric of their lives."

Q: It appears that within Dentistry, significant change is often met with ridicule and bitterness. Why is that?

"There is no question that whenever dentists "bash" each other in public, it lowers the image of the dentist doing it and the image of our profession in general."

Dr. Jackson: This is not unique to dentistry. I might add to my answer above that Galileo wouldn't allow his book to be published until after his death, for fear of being burned at the stake. At least it's not that bad in dentistry today.

Dr. Reed: It's the nature of man! I recall Thomas Jefferson saying "When a significant event brings change, it is first met with ridicule, then vitriolic bitterness...and then after negotiation, finally acceptance."

Q: In your opinion, how do public bashings affect the general public's view about dentistry and dentists?

Dr. Jackson: There is no question that whenever dentists "bash" each other in public, it lowers the image of the dentist doing it and the image of our profession in general. You only have to look at how the public views politicians who do this all the time.

It's not ethical and it's the ethics and maturity of the individual making personal attacks on another professional that is brought into question. Also it damages dentistry as a profession because the public begins to wonder if this is typical behavior. Our profession is based on trust and this gets jeopardized when we behave badly.

Dr. Reed: The dentist, in all the famous movie scenes, is cast as the village idiot. When this message arrives, it diminishes our professional image. Fortunately, public bashing is not the leading headline of the day to the general public.

Q: Why are people *down* on things they are not *up* on?

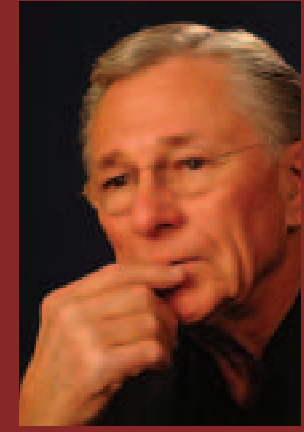
Dr. Jackson: There can be a lot of reasons. By definition, a new idea threatens the natural order. For some, the amount they are down on any new idea often depends on how much they have invested in the status quo. By the way, this is a form of self-protection and to an extent, normal. For others, it's a matter of change. A new idea can bring change and change can be difficult. It is challenging, risky, takes a lot of effort, and can be chaotic.

Dr. Reed: As early as 1551, a fellow by the name of Machiavelli commented on this phenomenon. "There is nothing more difficult to take in hand, more perilous to conduct, more uncertain in its success than to take the lead in intro-

ducing a new order of things...because the innovator will have as enemies all those who have done well with the old and will have lukewarm defenders among those who may do well under the new." Many of us believe we are thinking… we are merely rearranging our prejudices.

Q: There have been a number of articles written recently in which select dental professionals have demonstrated an apparent willingness to set aside ethics and moral values and participate in public bashing of their colleagues. Does this serve any meaningful purpose?

Dr. Jackson: I have read some of these articles and think it is so unfortunate. Not only does it not serve a meaningful purpose, it delays progress because it takes our eyes off the ball. It wastes energy and time which are better spent on finding solutions, proving facts and moving dentistry forward. This kind of behavior is unprofessional and reflects poorly on the person doing it. It is very important, if one even responds to it, to resist the temptation to respond in kind. The contrast between the high road and low road will do more than anything to diffuse/discredit the critic.



"Be kind to the people on your way up... you may meet them on your way down."

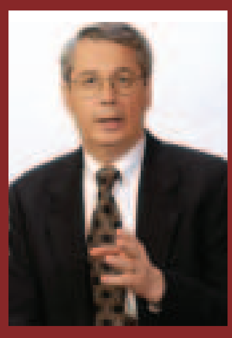
Dr. Reed: No. Shakespeare wisely said, "I despise the guys who criticize and minimize the other guys whose enterprise has made them rise above the guys who criticize and minimize." Be kind to the people on your way up...you may meet them on your way down.

Q: Do you foresee an end to the discord that exists among the advocates of differing dental philosophies in the near future? Distant future?

Dr. Jackson: Discord can be a good thing as well as a bad thing. It's defined both ways in the dictionary. Discord from disagreement is a good thing. It forces us to examine more closely, to search for better, to try to base what we think more on fact than opinion. However, discussion of differing viewpoints has to be done with respect. No name calling or judgment of motives. Just a search for truth. Discord is a bad thing when this is not the case or entered into for ego purposes. Unfortunately, as long as our profession is made up of people, ugly discord will wax and wane according to the times, becoming greater when competition is keener or the challenge is great.

Dr. Reed: The end of discord in conflict resolution will come as the Scriptures instruct us...when forgiveness becomes a useful tool in personal interrelationships. People find it much easier to see your side of an issue if you first understand their side. To have a creative life, one must lose the fear of being wrong.

Q: What would be your personal recommendation to those that make sweeping judgments without examining the facts?



"The bottom line is that judging others is arrogance and something none of us has the right to do. My advice to those that do it is "judge not lest you be judged"."

Dr. Jackson: Without hesitation, first and foremost, I ask that they grow up, and act professional. Second, I invite them to examine for themselves, with an open mind, that which they condemn. There can be no other purpose in a discussion than to find a better way to treat our patients.

I wrote an editorial recently responding to this kind of unprofessional behavior which has not only been perpetuated in print but from podiums as well.

In addition to what I have said above, I remind these authors that, acting as judge and jury, espousing vitriolic condemnations from a distance, looking only at photos in an article, or hearing only a patient's story, is not effective in ridding our profession of suspected maltreatment. Action is required and that action should take an ethical, professional approach. If there is still concern after calling the treating dentist to learn the facts of the case, our profession has a peer-review system in place. Likewise, angry accusations that malfeasance is taught at certain learning centers (only those which the author has no connection with, of course) is ridiculous. No institute could stay in business, much less thrive, if its graduates were being taught to do harm and not good.

The bottom line is that judging others is arrogance and something none of us has the right to do. My advice to those that do it is "judge not lest you be judged".

Dr. Reed: Geothe refers to this phenomenon as "active ignorance". I quote Bernard Jankelson, the renowned South African dentist who has done so much for American dentistry: "If it can be measured, it's a fact and quite simply, it if cannot be measured, it's an opinion." We're all entitled to our opinions and constitutionally proved the freedom to express them, however erroneous they may be. The sage advice to me by my father when I was quite young: "The older I get, the fussier I am about what upsets me (or who likes me)." I have watched in dismay as I have observed colleagues attempt to destroy each other and when I look for the payoff, I find it wanting in the scales. Without questions, the Golden Rule still works magic among us, doesn't it?

"If it can be measured, it's a fact and quite simply, it if cannot be measured, it's an opinion."

Ron Jackson, DDS, FAGD, FAACD, is a 1972 graduate of West Virginia University School of Dentistry. He has published many articles on esthetic, adhesive dentistry, and has lectured extensively across the United States and abroad. Dr. Jackson has presented at all the major U.S. scientific conferences as well as to Esthetic Academies in Europe, Asia, and South America. He is a Fellow in the American Academy of Cosmetic Dentistry, a Fellow in the Academy of General Dentistry, and is Director of the Advanced Adhesive Aesthetic Dentistry, and Anterior Direct Resin programs at the Las Vegas Institute for Advanced Dental Studies. Dr. Jackson maintains a private practice in Middleburg, Virginia, emphasizing comprehensive restorative and cosmetic dentistry.

Omer K. Reed, DDS, maintains a thriving dental practice in Phoenix, Arizona. He is the originator of Napili (Ohana now) seminars – workshops created to enhance success in dentistry, socio-economically, intellectually, and technically. Dr. Reed has been an inspiration to thousands of dentists facing new professional and personal challenges. He has counseled practitioners on how to open fresh horizons of opportunity for personal, professional, and economic enrichment. He is a frequent guest on national and local radio and television programs, and has been the subject of numerous newspaper and magazine interviews. He is a faculty member of the Las Vegas Institute for Advanced Dental Studies, and serves as an adjunct Professor at the University of Minnesota.

Kevin Houck at IDS meeting in Cologne Germany.

K7 RECEIVES INTERNATIONAL RECOGNITION

In February of 2007, Japan's Health Ministry recognized Myotronics' K7 Evaluation System as one of the few products that can provide diagnostic testing to justify certain types of orthodontic treatment and to validate the effectiveness of such treatment for patients that participate in Japan's National Health Insurance program. Specifically, the 700 orthodontists who are part of this program are required to submit "before and after" diagnostic information obtained using the K7 device before reimbursement for the treatment can be issued. Required information includes both surface EMG data and the diagnostic information provided by jaw tracking. Myotronics offers both electromyography and jaw tracking in one instrument.

The Japan Health Ministry implemented this requirement upon the recommendation of a consulting committee. All 29 dental universities in Japan have the Myotronics K7 Evaluation System. A number of these universities have several K7 units that are used in various departments. Two of these universities (Osaka Dental University and Okayama University) have used the K7 in their clinical training curriculum. In addition, twenty-three of the 60 medical schools in Japan are equipped with at least one K7 Evaluation System. These K7 systems are primarily used in the oral surgery program of these medical schools.

For more information contact Myotronics
800-426-0316
info@myotronics.com
www.myotronics.com

A Comfortable Evolution

Josh Bernstein, DDS

At a recent dental meeting, a famous panel of dentists and consultants fielded questions about how to improve our practices. Leadership, teamwork, vision, communication, strategic planning, focus, and many other great buzz-word ideas were discussed. When the dust settled after the discussion, I realized that we are completely out of touch with our patients.

Comfort is the new frontier in dentistry. As dentists, we think we have overcome this hurdle but we have not. Luckily there are materials, equipment, and techniques to make our patients completely comfortable. All we have to do is make a commitment to improve, invest appropriately in our practices, and avail ourselves of the education to provide our patients with consistently comfortable experiences. It is time for us to surprise our patients with comfort. Imagine how fabulous it would be if dentistry was universally known as the most comfortable area of health care. It can be. The reputation of our profession depends on each of us - every day.

As we evolve and behave like business owners, we sometimes forget that the patients are still thinking the same old thing - ***they hate the dentist!***

While we are excited about various occlusion philosophies, new materials, and high technology, the patients are still ***afraid of the shot!***

While we are dinking around refining the perfect crown margin, the patients hate ***the sound of the drill!***

While we are concerned about diagnosis and treatment, the patients are ***worried about gagging, drowning, smelly tooth dust, pain, germs, scary noises, sharp x-ray films, scolding hygienists, sweaty palms, dentists with halitosis, and getting the heck out of the chair!***

Dentists want to work on more teeth, but patients want to be comfortable!

Dentists deserve a lot of credit for inventing local anesthetic, high-speed hand-pieces, and many other techniques, materials and equipment. However our reputation runs deep in the minds of the public. Movies, television, jokes, and popular culture depict dentists as sadistic, painful, and altogether dreadful. "As bad as a root canal" and "like pulling teeth" are obvious similes. Every day, new patients come into our offices and say, "Nothing personal, Doctor, but I hate the dentist."

We should be taking this personally and seriously. Research shows that 50% of the public does not see a dentist even if they have dental insurance. It is up to us as a profession to work hard to earn a better reputation. All of us should be learning everything we can to make a dental visit completely comfortable so that patients will get the care that they need. We now know that this is not just about saving teeth. All the latest research shows that dental health reflects conditions throughout the body, so it is really a matter of public health.

Complacency would be easy. After all, most of us think we are doing a pretty good job in the comfort area. It would be so hard to change our reputation when we could just keep laughing about it in good-hearted, self-deprecating humor. However, we could learn from the Japanese. After World War II, the words “Made in Japan” were branded to mean poor quality. Today, the Japanese have turned quality into a science and everyone knows that Japanese products set the standard for reliability. Dentists can similarly change reputations by proving ourselves anew.

I have been treated by many dentists in my life, all of them conscientious and some of them famous. I am certain that they all thought they were comfortable and painless, but only two of them really were. Some of the experiences were downright unpleasant. I have had blocks that hurt like a tetanus shot. I have been gagged by impressions. I have had anesthetic wear off then reassured that “we’re almost done.” I have weathered a two-hour crown prep. I have had a root canal without being completely numb. I have had repairs done with no anesthetic at all. I have had my tongue nicked, my lips bruised, and my throat jabbed! The interesting thing is that I am not a dental phobic and I do not hate the dentist. I just want to have the pleasant, comfortable experience that I know is possible. After all, I have experienced comfortable dentistry in the past. My wife, Allison, wisely says that it does not matter how great the dentistry is if we hurt the patient, the pain is the only thing they will remember. She is absolutely right.

Each of us owes it to our patients to do everything we can to make each visit completely comfortable. If a patient is genuinely phobic or simply prefers to be sedated, we should be trained in oral conscious sedation. But for the vast majority of procedures, we should carefully begin earning the reputation of being painless and comfortable. There is so much we can do. It starts with genuine compassion. We can be on time. We can use a great topical and allow time to let it work. We can revisit our “painless” injection technique and do it every time with The Wand. We can be gentle in our manner. We can be comforting in our communication. We can provide our patients with pillows, blankets and video glasses. We can teach our team to be friendly in interactions, comfortable in assisting, and gentle in hygiene techniques. We can buy equipment and materials that make the experience comfortable. Microultrasonics and lasers reduce the need for scaling and for perio surgery that patients despise. Digital x-ray sensors are now rounded for comfort. New implant techniques eliminate flap surgery. Rubber dams and Isolites provide comfort and relaxation, while reducing gagging and drowning. Intraosseous anesthetic guarantees profound numbness in difficult situations. Rotary endo techniques are quick and painless. New bonding protocols reduce sensitivity. And so do new whitening products. Proper medication eliminates post op pain. The list is endless.

To help you get started, here are some essentials:

Topicals

EMLA (AstraZeneca)
before injections
Oraquix (Dentsply)
for localized scaling

Anesthetics

Use a little Citanest plain first, then Septocaine for local infiltration.
For blocks, after a little Citanest plain, use Carbocaine followed by lidocaine.

Syringe

Do not use one except for intraosseous injections!
Get The Wand (www.milesci.com) for every operatory. In fact, get a spare! A slow injection is a comfortable injection.

Intraosseous Anesthesia

When you can not get them numb, use the X-Tip (www.x-tip.com), invented by Dr. Kit Weathers. (Stands for Total Instant Profound Anesthesia—and they are not kidding.)

Video glasses

www.i-vue.net. Patients will laugh while you work—if you show them the right DVDs. Office favorites are: Jerry Seinfeld Live on Broadway, Robin Williams Live on Broadway, Kings and Queens of Comedy, Blue Collar Comedy Tour.

Hygiene

80% of your hygiene procedures should be done with microultrasonic scalers. We use a Pro-Dentech piezo

scaler (www.prodentec.com) with warm water and a cap full of mouthwash such as Tooth and Gum Tonic by The Dental Herb Company (www.dentalherbcompany.com).

For laser perio, get a diode laser by Hoya ConBio (www.conbio.com), or get the new cordless diode laser by Ivoclar Vivadent (www.ivoclarvivadent.com). Patients do not like “the scraper” or “gum surgery.”

Speaking of lasers, throw out that painful, time-consuming retraction cord and use your diode laser to trough, when necessary, around your preps. Better yet, keep your preps supra gingival. Biolase even has a laser that eliminates the high speed for caries removal. (www.biolase.com)

X-rays

Digital x-rays are superior to film in so many ways and they cost less. Look at products by Dexis (www.dexray.com) and Schick (www.schicktech.com). Patients will like the low radiation and comfortable sensors.

Implants

New implant systems by Zimmer, Dentsply and Nobel Biocare allow for flapless implant surgery when used with implant planning software by coDiagnostiX (www.nis-inc.us/codiagnostix.htm). Make sure you see the third dimension by using an iCAT image. Flapless implant surgery means your patients will have a comfortable recovery without sutures.

Rotary Endo

If you do endo, you can do it faster with rotary instruments. Call EndoSolutions and get their Endo Magic kit. All patients want their root canals completed quickly and comfortably. www.endomagic.com

Isolite

Rubber dams are great and should be used for bonding, but get yourself an Isolite for prepping. It is a single unit that is a bite block, a retractor, a light and suction. www.isolitesystems.com

Bonding

Technique is everything when bonding so get the training you need. Then look carefully at bonding agents, luting cements and composites by Ivoclar, Kerr, Dentsply, Discus, 3M, Clearfill, and Parkell.

Burs

A fresh diamond bur is more comfortable on your patients and shortens the procedure. Take a critical look at your burs through your patients’ eyes, and then see what Axis (www.axisdental.com) and Brasseler (www.brasselerusa.com) are offering these days. Get some nice, clean new bur blocks, too.

Orthodontics

Braces are uncomfortable, they are ugly, they cut your lips, they are difficult to clean, and some people are allergic to the metal. In many cases, braces are necessary but when they are not, Invisalign is a great option. (www.aligntech.com)

Sedation

If you want to offer sedation, the Dental Organization for Conscious Sedation or DOCS (www.sedationdocs.com) can give you the training you need to offer this outstanding service. You have more phobic patients in your practice than you think. Sedation allows them—and you—to relax through the procedures.

Whitening

Sensitivity from whitening is a common problem, which can be overcome with proper technique and materials. Discus Dental (www.discusdental.com), Ultradent (www.ultradent.com) and Rembrandt (www.denmat.com) offer excellent products to comfortably whiten your patients’ teeth. To get your patients’ teeth their absolute whitest and do it comfortably, learn the “Deep Bleaching” technique by Dr. Rod Kurthy at www.rodtheideaguy.com.

Payment

To really reduce your patients’ anxiety (and yours), offer comfortable payment options. Care Credit (www.carecredit.com) and Capital One (www.capitalonehealthcarefinance.com) have excellent options with no down payment, no interest and low interest.

This is only an abbreviated list. If you are interested in providing increased comfort to your patients, please contact me at www.allnewsmiles.com.

Dr. Josh Bernstein is the founder and president of The Academy of Dental Arts and Sciences, Dental Professionals Dedicated to Patient Comfort. He is a Senior Clinical Instructor at the Las Vegas Institute for Advanced Dental Studies. Dr. Bernstein maintains a private solo practice in Piedmont, California, where he focuses on cosmetic dentistry, TMD, and sedation in an atmosphere of outstanding service.

SPREADING THE WORD

Are Your Patients Generating Positive Word-of-Mouth For Your Practice?

As a dentist, the thought of thousands of people talking about you and your practice probably makes you feel one of three ways: Exhilarated. Terrified. Or both.

No matter how you feel about it, though, it's going to happen. It's called word-of-mouth, and it exists for virtually every product or service in existence. To further illustrate my…

Oh, hang on. Just got a text message from my brother about a restaurant he and his wife went to last night. Well, he gave it a thumbs-up. I'll have to store that one for future reference. Better yet, let me add the restaurant's website to my Favorites list. And to MySpace, of course. My friends and I always like to share information like this.

Anyway, where was I? Oh, yes. Word-of-mouth. Like it or not, it's been around forever, and it's not likely to go anywhere anytime soon. Even as far back as the days of the caveman …

Wait. Sorry. Email from Mom. I've been asking her about a recipe she made last week. And … oh, good, she's given me the name of the specialty food store where she got the tasso ham, and a Google map link to locate the store. And, she's made a wine recommendation. Not sure I can afford her taste, but I'll check it out because I remember her saying it was phenomenal. Thanks, Mom!

Sorry for all the interruptions. It's a multi-task world. I guess this is just the product of so many new ways to communicate with each other. The days of talking over the backyard fence are long gone.

Remember the good ol' days? Three TV networks. A local newspaper. Independent radio stations. Yellow Pages advertising. Pretty much all news and information was carefully filtered, packaged, and presented to us in the ways that they wanted us to have it.

The options were fewer, but it was certainly easier to market a dental practice back then. A radio spot here, a direct mail coupon there, maybe a

cable TV ad, if you could afford it, and you were good to go. You knew that a certain percentage of your patients would tell a certain number of their friends and family members about your practice, and that would bring a certain stream of new patients through your door each year. Now, people are texting, blogging, Googling, posting, Twittering, Stumbling, emailing, and IMing … a far cry from when word-of-mouth took place around the water cooler!

Good or bad, like it or not, word-of-mouth happens. And, with communications being what they are nowadays, it's easier than ever to spread. So, as a dental practitioner, you have a couple of choices: Ignore word-of-mouth, or embrace it. But just remember, whichever choice you make, it's going to happen – with or without you.

A November 2007 article in *AdAge.com* reported on word-of-mouth's "meteoric rise," as defined by PQ Media – who conducted what is believed to be the first in-depth study of word-of-mouth marketing. The billion dollar a year industry is expected to grow to $3.7 billion by 2011.

An excerpt from the article states:

"Equally important to the success of word-of-mouth marketing may be the research suggesting it is more effective than other forms of advertising. For instance, a recent Nielsen Global Survey of over 26,000 people found that nearly 78% of respondents trusted "recommendations from consumers," a total 15 percentage points higher than the second-most credible source, newspapers." – *AdAge.com,* 11.15.2007

Traditional media, in terms of advertising and marketing, will always have their place. But given the fragmentation of media over the last several years, its no wonder even the biggest advertisers are turning to word-of-mouth as a path to success.

They call it creating buzz. Doing extraordinary things that give reason for people, news organizations, and bloggers to talk about their products and create excitement.

In his best-selling book, *Buzzmarketing,* author Mark Hughes regales the reader with his story of how he convinced a small Oregon town to change its name from *Halfway* to *half.com* (for one year) in order to draw attention to a startup website of the same name. The stunt resulted in the kind of buzz you could never buy, with appearances on *Good Morning America,* the front page of *USAToday.com,* as well as radio and TV exposure throughout the United States and the world.

"To ignore word-of-mouth is to ignore your most lucrative and most targeted source of new patients."

Computer giant Apple has a knack for creating buzz by NOT telling you what they're up to. This creates mystery as to what their next move will be and has sprung up a cottage industry of websites like www.thinksecret.com that speculate on the company's next moves. Apple fans everywhere can't wait to join into the online discussions.

Maybe you don't have the time, money, or market presence of some of these companies to generate buzz. But in your own small ways, you have everything you need to give your patients something to talk about. And your current patients represent your best, and most targeted, opportunity to connect with potential new patients.

So, how can you encourage your patients to generate positive word-of-mouth for your practice?

Start by creating a top-notch experience for your patients. Are you and your staff caring and focused? Does your practice offer the most popular services? What's your waiting room experience like? Do you respect your patients' time? Do you explain treatment options fully and in a way that's easy to understand? Is your office environment comfortable and relaxing? Does your staff make patients feel welcome? Do you offer flexible payment options?

These are all things that patients can and will comment on outside of your office. Plenty of practices go the extra mile in order to give their patients something to talk about. The emergence of the dental spa, offering pampering services like paraffin hand treatments, facials, or even Botox® treatments, can really help differentiate your practice from others.

And that's what it's all about. To create a thriving practice, do buzz-worthy things so your patients have plenty to talk about.

It's more than just treating your patients well. Just as important is keeping your staff motivated and producing at the highest level. A happy staff is a productive staff. And a productive staff creates a welcoming, caring, relaxed but focused office environment that leads to great word-of-mouth.

How else can you encourage people to talk in positive ways about your practice? Get involved in your community. Participate in voluntary programs where your dental expertise can make a difference. Join the chamber of commerce or other local business organizations. Be the "go to" expert that local publications call upon when they need a quote on a story that involves dentistry. Getting out in the community builds word-of-mouth in positive ways.

The best way to encourage word-of-mouth for a dental practice (and often the toughest way for many dentists) is to simply ask your patients for referrals. Many dentists just don't feel comfortable asking for referrals, but believe it or not, you're sending lots of happy patients out the door every day that would be very happy to tell their friends about your practice, if only they were to think about doing so.

The fact of the matter is that if you ask any dentist what their number one source of new patients has traditionally been, they'll invariably answer, "Referrals." Yet, when asked if they have any sort of formalized patient-to-patient referral program in place, the answer is almost always, "Well… no."

I suppose spending tens of thousands of dollars on splashy magazine ads, billboards and direct mail campaigns might seem like the easy way to market your practice. But that doesn't necessarily make it smart. Word-of-mouth – the oldest form of marketing – is the new mainstream. And to ignore it is to ignore your most lucrative and most targeted source of new patients.

With all the communications tools available to your patients, encouraging word-of-mouth ultimately comes

5 things you'd rather do than ask patients for referrals:

1. Chug a giant bottle of hot sauce. You know, the kind with a warning label.

2. Move next door to a 24-hour police siren test factory.

3. Stare directly into the sun for two straight hours. (No fair blinking!)

4. Negotiate with a team of used car salesmen.

5. Breakdance naked in Times Square at lunchtime. In January.

The ***A Reason to Smile***® word-of-mouth marketing program makes it easy, fun and rewarding for your patients to refer their friends to your practice. And you don't even have to ask!

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1-800-414-0940

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down to two things: 1) Run the best practice that you possibly can, so your patients will have something positive to talk about; and 2) Take advantage of the “digital age” we’re in. Make it easy and compelling for your patients to refer their friends by giving them the means to do so using tools they like to use.

Hey, I just got a text message from my best friend. I had mentioned to her that I wanted to see the new movie that just came out, that was based on a book we both just read. Funny, the ad I saw online said it’s “The must-see movie of the year!” My friend is telling me to save my money. Now, what do you think is going to have a greater influence over my decision to see it?

Cheryl Parrish is the President of CDs-2-GO, Inc., an 11-year-old interactive marketing firm serving dental practices throughout North America since 2004. Headquartered in Tampa, Florida, CDs-2-GO is the creator of the “A Reason to Smile” Word-of-Mouth Marketing Program (www.AReason-ToSmile.net), now available through Henry Schein Dental. Ms. Parrish can be reached via email: cparrish@cds-2-go.com or by calling 1-877-258-3771.

> **“Nearly 78% of respondents trusted *recommendations from consumers,* a total 15 percentage points higher than the second-most credible source, newspapers.”**
>
> – AdAge.com, 11.15.2007

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Dr. Roger Levin *The Power of YES: How to Increase Cosmetic Case Acceptance*
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