APRIL • MAY 2005

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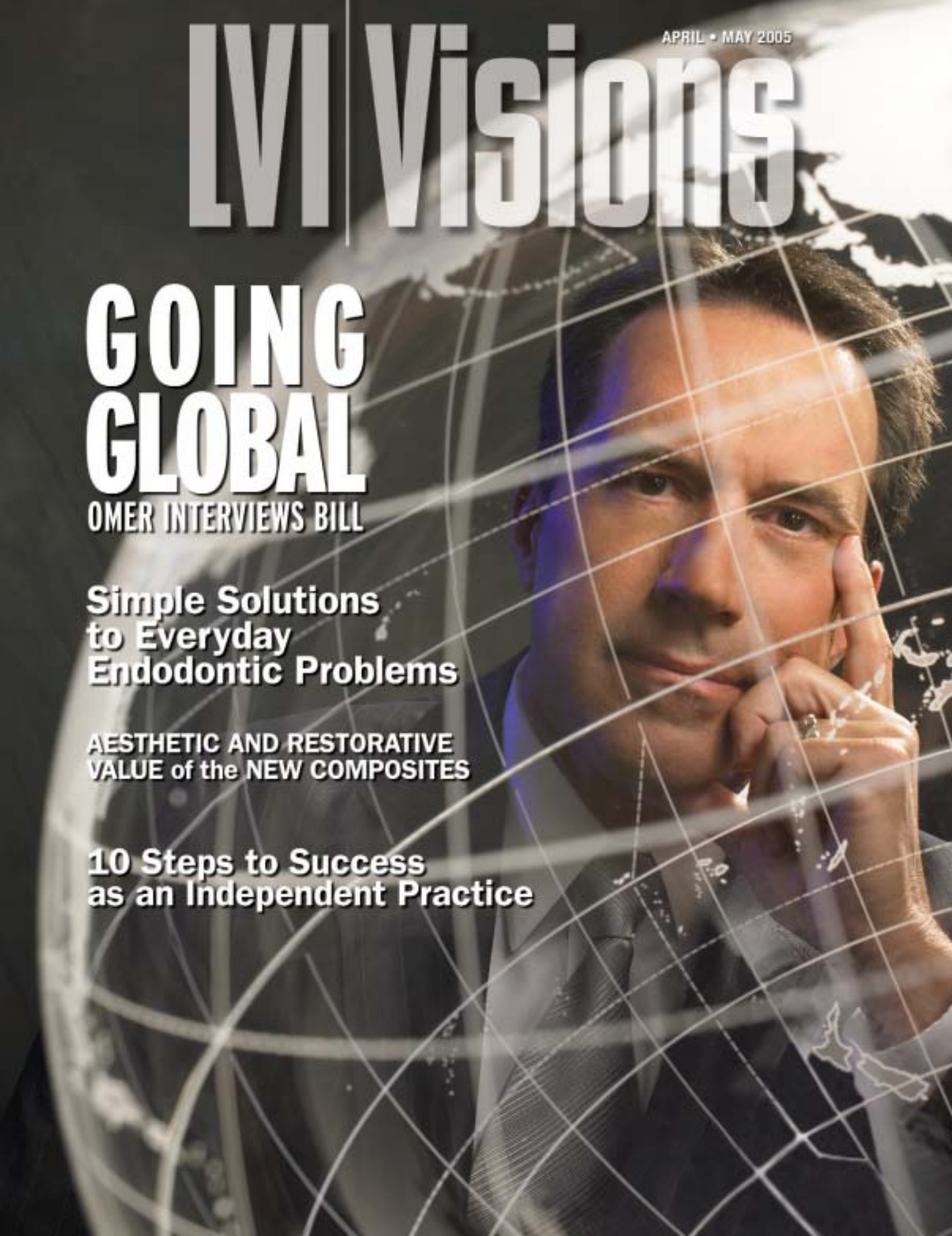

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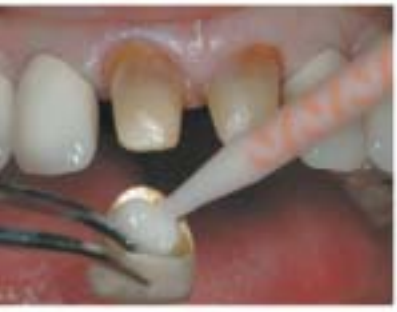

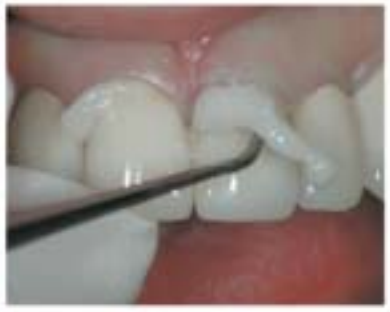

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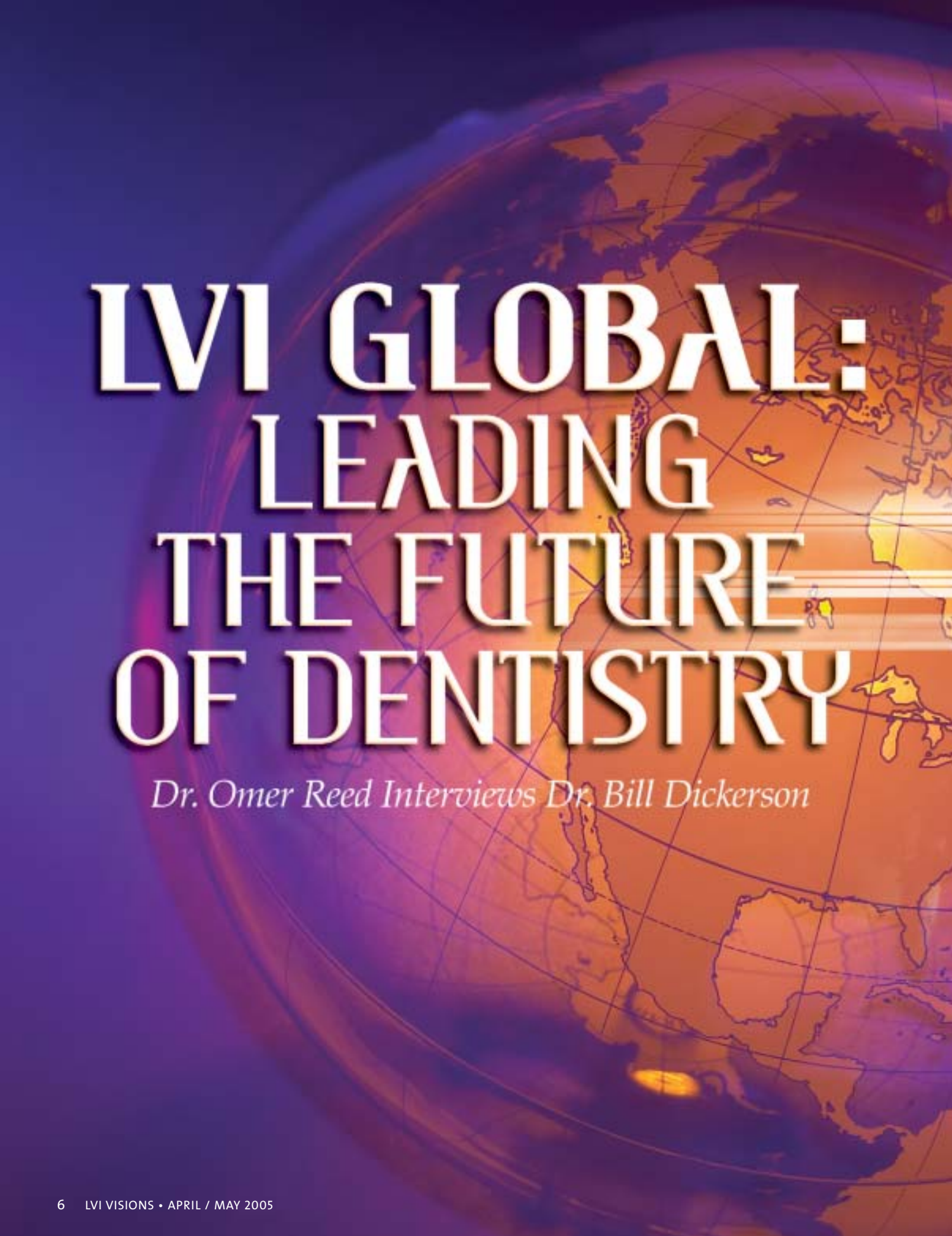

LVI GLOBAL: LEADING THE FUTURE OF DENTISTRY

Dr. Omer Reed Interviews Dr. Bill Dickerson

On February 11th, 2005, Dr. William Dickerson announced to the enthusiastic audience at LVI's Annual Gala that a new company called, LVI Global, has been formed. This ambitious plan has surprised the dental industry and has excited the LVI family of alumni. This **visionary** adventure has been made possible by the recapitalization of LVI by two investment companies who strongly believe in LVI's vision and purpose. Not only will there be the existing Las Vegas Institute for Advanced Dental Studies, but divisions of LVI that will further help educate and improve the profession of dentistry. Divisions such as, LVI Products, LVI Publishing, LVI Regional Centers, LVI International, LVIdeas, LVI Distance Learning, and LVI Labs, will help spread the message of excellence in dentistry.

Dr. Omer Reed interviewed Dr. Dickerson on this amazing accomplishment and progressive approach to education that has shocked the profession.

Wow! This is amazing news. As a result of the reverberations that have echoed through the membership and the public since your announcement at the Gala, which was an incredible event I must say, I have a few questions.

How did your vision for the future of LVI lead you to the formation of the new global company?

LVI has been so successful changing the lives of thousands of dentists and, subsequently, hundreds of thousands of patients. Our efforts have already expanded beyond North America to early stage opportunities in Australia, Japan, Singapore, Italy, Switzerland and England. That's why it really was just a natural progression to expand our horizons for quality continuing education and quality dental products to every corner of the globe.

But the idea of LVI Global was not just about taking the LVI curriculum abroad as that probably could have been done within the existing LVI structure. Everyone at LVI is passionate about the good we feel we are doing for the profession of dentistry and for the public that we want to increase the effort to spread the exciting message that dentistry can be so much more than it is. The recapitalization of LVI was necessary to acquire the capital to make the dramatic forward progression we were envisioning , spreading the word that dentistry can be a positive force in people's lives.

From our publishing division to our product division, we felt we could expand the mediums that educate or help dentists all over the world. I am so excited about the vision and direction LVI is headed. LVI will now not only be able to reach dental professionals in every corner of North America, but every corner of the globe and will be respected for teaching excellence, publishing excellence and product excellence. There is nothing in dentistry like this – and we are extremely excited about the possibilities.

Why did you accept financial partners? Does this mean you have sold LVI?

In order to achieve the expansion of LVI and our venture into the global marketplace, LVI needed well-funded, creative, experienced partners to share the LVI vision, passion and approach. We realized that the one thing that was missing in our "vision" was the capital necessary to make it a reality. The acquisitions we had planed, the infrastructure growth required, and the security desired to minimize risk were all indications that taking on a minority partner would be necessary.

Two financial institutions joined our effort, in a minority role, to propel LVI's growth. The partners are American Capital of Bethesda, Maryland (Nasdaq: ACAS) and Riverside Partners, LLC of Boston. American Capital is a $4.8 billion, internationally renowned, publicly traded company that is committed to help their partners grow. Riverside Partners LLC is a partner keenly aware of the nuances of the dental profession and the competitiveness of the dental industry.

So, no, I did not sell LVI. I attracted two amazing companies to our mission, our vision, while maintaining majority ownership. For the past eight months, we interviewed and were interviewed by various companies that were excited about LVI and our graduate community. However, we chose these two partners simply because we felt comfortable with their senior executives, our partners for the future.

I was incredibly impressed with your Board members, how did you create the board for LVI Global?

To create a more "proactive" company, capable of defining trends for the dental profession and the dental industry, we decided that LVI Global should be governed by a five person Board of Directors. We wanted the Chairman to come from the dental world so that someone else besides me would understand the needs of the profession and the industry. I was delighted when Paul Seid - CEO of Sultan Chemists and co-owner of Sultan Dental, accepted my invitation to become Chairman of LVI Global. Paul is the only two- time elected President of the Dental Trade Association and has vast global experience in the dental marketplace. Paul will be a tremendous asset in our effort to implement our vision for the future.

Our Vice-Chairman is Frank Do, Managing Director of the Los Angeles and San Francisco offices of American Capital, a $4.8 billion multi-national public investment fund. Frank earned his MBA from Harvard Business School before earning an impressive list of credentials in the investment world.

Our other investor, David Belluck, the Managing Director of Riverside Partners, LLC, will be joining our Board as well. David also has his MBA from Harvard and a wealth of experience in working with founder-dominated and family-owned companies.

We all wanted our fifth board member to be a well-published educator, experienced in the dental world and an astute business person. Finding someone like that was not easy. Yet, it turned out that we had someone right here at LVI. Teaching our courses in Emergency Medicine and the pharmaceutical aspects of dentistry module in our Endo program is our last Board Member, Leslie Shu-Tung Fang, MD, PhD. Dr. Fang is a teacher, a published authority in a field of dentistry and a graduate of Harvard Medical School. He serves on more company Boards than anyone else on the LVI Global Board. He is the Chairman of the medical advisory committee of a renown health care investment banking firm and the only person to have been voted "Best Teacher" by the graduates of Harvard Medical School five times.

And of course, as founder and CEO of LVI, I am a board member as well.

Pictured left to right: Paul Seid, Bill Dickerson, Leslie Fang, David Belluck, Frank Do

In the structural flow chart of LVI Global, I notice LVI is properly positioned. Does this change your responsibilities? Will the Board play a role in the day-to-day decision making at LVI?

No. The day- to- day operations of LVI will still be my responsibility as CEO of LVI Global. The best part of this adventure for me will be the ability to run LVI less on instinct and more in response to the business trends and metrics of our profession and our company. The Board provides an incredible wealth of business genius that we expect to count on for future growth. Can you imagine having the best and brightest at your disposal to help you run your dental practice or your business? It's an amazing addition to the company.

I've heard several dollar figures describing the potential economic contribution made by this "marriage". Will you clarify that for me?

No, but thanks for asking (big smile). But it's the capital that American Capital has at its disposal that is what is so significant. It's like having a rich uncle that will contribute to the growth of your business. As I've said for years and in the first chapter in my book, "In Search of the Ultimate Practice", the number one rule of business; you have to spend money to make money. Well, they are providing us a lot of money to spend.

How do your personal career objectives effect the future of LVI as we now know it?

That's the good news. The future of LVI is so bright. As I mentioned, I'm not going anywhere, but even if something were to happen to me, I've surrounded myself with wonderfully talented, gifted, successful people who will continue the LVI journey. From the day we opened our doors, I didn't call it the "Dickerson Institute". The point was to create a business that would be able to survive without me. I'm confident we are at that position. But, saying that, I'm here for the long haul. I'm having way too much fun and enjoying what I'm doing so much that I don't think I ever want to quit.

My business objectives are to continue to help as many dentists in the world be as happy as they can be at their chosen profession. To let the profession all over the world know that you can create a win/win situation for them and the patients. To let as many dentists as possible see that there is a wonderful world of dentistry out there. LVI Global is designed to obtain those objectives.

What does LVI Global mean for current LVI grads?

What this means to all of our graduates is that LVI is assured to maintain its position in the industry as the leader in continuing education. It means a lot to be a graduate of LVI now and it will mean even more to be a graduate of LVI in the future. As the LVI family grows, the network of support and intellectual input is spread around the world. The potential lifetime growth in being a LVI family member is forever guaranteed because of the guaranteed support LVI now has. It's a great time to be an LVI grad.

How do you see LVI global impacting the profession?

Over the past 9 years, LVI has been leading the movement in the quality of dentistry performed as well as the public's perception of the dental profession. Through its life-changing, hands-on, live patient treatment courses, LVI has positively influenced the quality of dentistry being performed. Through its educational seminars, LVI has been able to raise the level of dentistry by teaching modern, progressive techniques for optimal results. And for many, LVI has been the beacon of hope as it has taught them the possibility and benefits of a high quality practice as opposed to an insurance driven practice. Through its public awareness advertising campaign, the general population comprehends and values the services of a dentist. And now, due to the overwhelming success in North America and the assistance of financial partners, every dentist worldwide will have the opportunity to be exposed to the LVI teachings.

Describe the function of the regional centers and your projected outcomes from their existence?

You know, teaching dentists for the past 15 or so years, I think I've learned a thing or two about the thought processes of dentists. I don't think it's any secret that most dentists are not the best business people. We have no training in that area and even if they tried to teach us business principles in dental school, we wouldn't be ready for it, as we are too concerned about the technical skills we are trying to acquire. My point is that many dentists just can't see the return on their investment in traveling to take dramatic technique, philosophical and management- related programs, especially if they consider them to be expensive. Let's face it, as a group, we are not risk takers. The point is that many will not travel nor spend the amount that LVI requires for its tuition to teach in the way we've designed our programs for excellence even though you would be hard pressed to find an LVI graduate that didn't think his or her return on their LVI investment was worth it. One thing even our critics will attest to: LVI creates raving fans. I wonder why that is? (big smile) Therefore, we are welcoming a broader audience to find out about the LVI way without traveling far from home and "risking" an investment they might not be comfortable making. In 2005, we are launching about 25 Regional Centers throughout North America and Australia. In 2006 we hope to launch even more. They are all standardized programs under the control of LVI, so that it wouldn't matter where you take the programs, the content will be the same. The Regional Directors will come from our faculty of amazing clinical instructors spread all over the globe. Anyone can call LVI (888 584-3237) to find the LVI Regional Center closest to them.

Will you be using distance learning in this equation?

Yes. Beyond those that can't comprehend investing the funds required for adequate training in their educational future are a group of dentists that want to learn from home. LVI will work towards establishing online training for those people. But understand that that type of education is limited. What sets LVI apart is its live patient treatment programs. Can you imagine graduating from dental school without ever working on a patient? Of course not. The best way to learn is to hear, see and then DO! Without going to such programs, you will never get to do under the direction of the professions experts. However, there is a market for this type of learning and we intend to fill it.

What national centers have you selected for Regional Center markets for LVI Global?

We are launching 25 this year in most of the major states and probably at least another 25 next year. Our goal is to have at least one in every state with at least three is the larger states. We want to eliminate any reason for dentists finding out how wonderful life can be for them if they learned the LVI principles.

A large number of your close personal friends and followers have asked the question: What does Bill see through his window of reality for the future of LVI and dentistry in the next ten years?

With the financial investors and the LVI Global Board, there is no end in sight to what LVI can achieve. The combined genius of this group, with their diverse specialties, is incredible. With this team and expansion plan, LVI Global will lead dentistry's future. Who knows what doors will open. I could never have imagined that 10 years ago when I started LVI that I would be announcing LVI Global. But I will guarantee one thing, LVI will constantly be evolving, never resting on its laurels. I think that's the thing I am most proud of about LVI. We are a "dynamic" organization where ALL of us are constantly learning, willing to adopt any technique or issue, regardless of its risk, IF we know in our hearts it's the right thing to do or the right answer for a clinical situation. Our adoption of neuromuscular dentistry is an example of this. Although we knew we were going to be attacked by those that had a vested interest in conventional thinking, we knew from the science presented to us that it was the right thing for dentistry. Those that attack do so out of ignorance. Our success rate in convincing the masses, even the skeptics coming in, that we are right is nothing short of remarkable. The point is, who knows what the next "neuromuscular dentistry" is in our profession. Once again, if it's the right thing to do, we will teach it.

And we are forever committed to our graduates to give them the tools and support to become as successful as they possibly can. From launching our branding campaign to practically anytime access, our graduates know that we are here for them. I know this sounds corny, but you ask our LVI Forum members and they will tell you we are like an extended family. Everyone is there supporting each other. It's a great job and our organization is what it is because of our graduates. We will always be loyal to them for that.

As for our profession, I am confident the future is bright. And the prospects for dentists are promising. But I also feel that a division in our profession will occur. There will be those dentists that are disgruntled with the profession and are under the control and practice guidelines of the insurance industry. However there will be many that have removed the shackles that the insurance company has provided them and they will find the freedom that a progressive, high quality, high tech, patient centered practice can yield. There has been a rapid growth in this area in the past 10 years, with our profession finally keeping up with the cost of living or exceeding it. This is after 30 years of NOT keeping up with inflation. I see this trend continuing to the many examples of practices like this out there. As you said to me years ago; "if it's been done, it's probably possible." More and more dentists are finding out that it's possible.

The formation of LVI in the 1990s prompted a number of personal attacks on you. Early on, I warned you that when you're way out in front, even your friends may mistake you for the enemy and take shots at you. We've all observed your ability to use the Power of Impossible Thinking. How do you deal with the jealousy and the criticism, and remain so positive?

LVI GLOBAL

You did warn me about that. At first I thought you might be exaggerating. But I learned fast that success breeds contempt. It's an ugly side of society; not just in our profession. It's unfortunate that as dentists we feel such competition. There is certainly enough work for everyone. But the insurance industry has contributed to the negativity in our profession. Yet, as we teach at LVI, this competitive negativity is completely unnecessary.

I would be lying to you if I told you the negativity never bothered me. It did. Even your claim that friends will mistake me for the enemy proved true. I lost a friend or two over our occlusal beliefs. They refused to listen to any of the science we were teaching. I was surprised at some of them because I was their aesthetic mentor and even got some of them started lecturing. Why would an intelligent person be that closed minded? That baffles me.

Regardless of the attacks from the uninformed and the threatened competition, the positive energy on the LVI campus is so overpowering that there is no way I could not behave positively. People talk about the "LVI fix" because the positive energy on the campus is infectious. Well, it's infectious for me as well. I have a loving wife, incredibly great kids and the best job in the world for me. To be surrounded by the best minds in dentistry on a constant basis; to have friends visit you from all over the world; to routinely seeing the lights go on inside the heads of disgruntled dentists; what an incredible high! I wouldn't trade what I do for anything. It's why our 80 clinical instructors come from all over the globe to help us spread this message. They too get energized by "teaching" on the "electric" LVI campus. That is why I continue to be so positive in a sometimes negative world.

Thank you, Bill, for your honest and frank answers. I wish you nothing but success and happiness in your new adventure. And I'm glad to be part of it.

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In trained hands, these new composites are every bit as aesthetic as ceramic. The point of this article though is that composite resin doesn't compete with ceramic in the treatment plan, it compliments it. We have many techniques and materials to choose from today which enable us to provide our patients with health, function and aesthetics. The best dentistry is that which fits the procedure to the patient instead of the patient to the procedure. It takes a committed, fully trained dentist to do this.

If one were to ask if I do more veneers in ceramic versus resin, the answer would certainly be ceramic. However, if one were to total the number of patients in my practice who receive full or partial composite resin veneers as compared to patients who receive ceramic veneers, patients treated with composite resin would be significantly greater. The reason is because the "ear to ear" ceramic veneer is reserved primarily for complete smile makeovers. (Fig.1) I believe most practices have many patients with minor to moderate imperfections who, though perhaps not interested in a complete smile makeover, may be interested in the kind of smile enhancement that can be achieved simply (when you know how) with direct composite resin. This type of smile upgrade has the additional advantage of being accomplished conservatively and, because there is no laboratory bill, at a lower cost. I call this "nip and tuck dentistry" and there is lots of it in every practice. (Figs. 2 - 4)

In the past, we often avoided asking the patient if they would like some-

Figure 1A • This 42 year old male desired an improved smile.

Figure 1B • Stacked porcelain veneers (d·sign – Ivoclar Vivadent) were placed on teeth #6-11 and 22-27

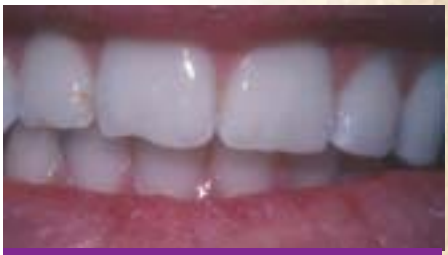

Figure 2A • This 40 year old female exhibits "wear and tear" on teeth #7 and #8.

Figure 2B • Without local anesthetic and with only slight roughening of the enamel the smile is upgraded with direct composite resin. (Esthet·X - Dentsply Caulk)

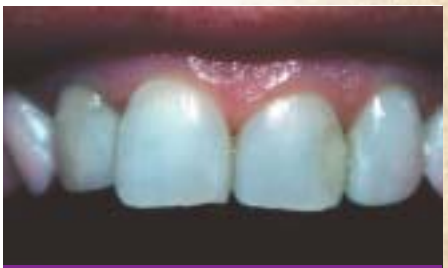

Figure 3A • This 50 year old female desired an improved smile but not a complete smile makeover.

Figure 3B • Direct resin veneers on teeth #'s 7 & 9, cosmetic contouring of incisal edges of 8 & 9 and a "tissue lift" using a diode laser on #9 was carried out in one appointment. View is two months post-op. (Point 4 - Kerr)

Figure 4A • This dental sales lady was self conscious of the slightly shorter tooth #9. Note the worn canine tips.

Figure 4B • After a slight roughening of the incisal 1.5mm of enamel, the tooth was lengthened with direct resin. The worn cusp tips on teeth 6 & 11 were replaced in the same manner to "protect" the incisal edge of #9 in left lateral excursive movement. (4 Seasons – Ivoclar Vivadent)

Figure 5A • This young person was hit with a tennis racket fracturing the distal incisal edge of #8 and slightly chipping the mesial incisal edge of #9. Enamelplasty only would still leave the patient with a "crooked" smile.

Figure 5B • Tooth #9 was smoothed somewhat with a disc and the distal incisal edge of #8 was conservatively restored with direct resin. (Renamel – Cosmedent)

Figure 6A • This teenager was congenitally missing tooth #11. Her mother asked what could be done about the diastema.

Figure 6B • A two minute "mock-up" quickly shows the patient what can be done in an "additive without subtractive" procedure using direct composite resin.

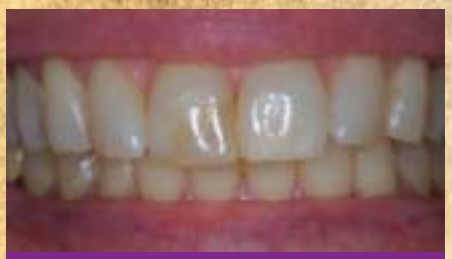

Figure 7A • This 50 year old female suddenly became dissatisfied with the appearance of the mesial incisal restoration in tooth #8 even though it had looked that way for many years.

Figure 7B • Using 3 opacities, a stratified technique and paying close attention to reproducing surface texture and characterization of the adjacent tooth, an aesthetic restoration that defies detection can be predictably placed. (4 Seasons – Ivoclar Vivadent)

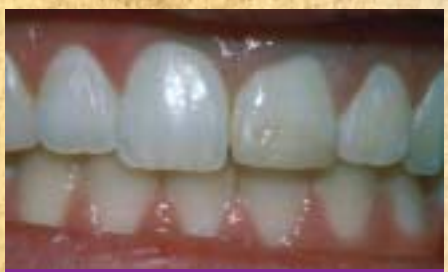

Figure 8A • This teenager was dissatisfied with a recently placed restoration in tooth #9.

Figure 8B • The incisal edge can be restored conservatively with two opacities of composite without veneering the entire facial surface. (Vit-l-escence – Ultradent)

Figure 9A • The orthodontist had allowed spacing in this young person for the restoration of the deficient "screw driver" shaped lateral incisor.

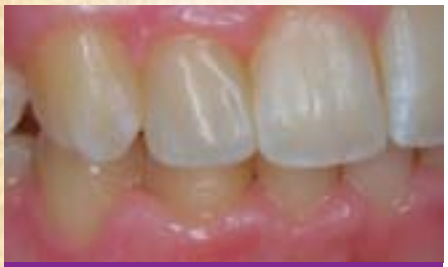

Figure 9B • Without removing any tooth structure, direct resin restores natural appearance and preserves the tooth structure for the future. (4 Seasons – Ivoclar Vivadent)

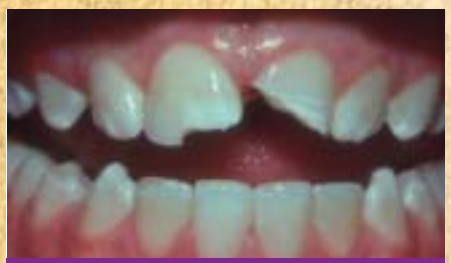

Figure 10A • This 12 year old male had an accident on the basketball court.

Figure 10B • Direct resin restored health, function and aesthetics without removing any additional tooth structure.

Figure 10C • The restorations have deteriorated slightly by age 20. They are easily "renewed" by micro-etching and re-surfacing, further delaying restoration with crowns. (Renamel – Cosmedent)

thing done about these minor (in our mind) situations because we lacked the materials or skill, or both, to improve things. If the patient asked, we either downplayed the problem to avoid having to do something or, if forced to treat, we reached for our single opacity "universal" shade composite resin and hoped that we could achieve an acceptable result. Sometimes, in the case of chips or small fractures, we could achieve a slight improvement by modifying the affected teeth (enamelplasty) with a bur or a disc. However, the result was often a compromise. (Figure 5)

The newer microhybrid composite resins are easy to sculpt, are easy to polish to an enamel-like luster and unlike the previous generation of hybrid composites, retain their polish over time. Today, whenever defects which can be improved with direct resin are observed, it's routine in my practice to quickly apply and cure composite in a direct mock-up so the patient can see what's possible. (Figure 6) Patients almost always choose to have the service done because a nice smile has a high value in today's society.

Besides elective "nip and tuck" cosmetic services, many patients are asking to have serviceable, but noticeable, Class III, IV and V restorations replaced. The fact is, the aesthetic

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Figure 11A • This patient is a 42 year old female dentist. Either ceramic or direct resin veneers could be used.

Figure 11B • She chose a direct resin approach to improve her smile. (4 Seasons – Ivoclar Vivadent)

Figure 12A • This 38 year old female desired aesthetic improvement of vital tooth #8.

Figure 12B • Communicating the shade as well as the numerous maverick colors to a dental technician would be challenging using an indirect veneer. In the direct approach the adjacent tooth is the model for the dentist using composite resin along with an opaquer and tints. (4 Seasons – Ivoclar Vivadent)

Figure 13A • This 28 year old female was getting married in 3 days.

Figure 13B • Direct resin veneers were placed on teeth #7-10 and cusp tips were restored on teeth 6 and 11. (4 Seasons – Ivoclar Vivadent)

Figure 14A • This 30 year old male desired an improved smile. Either ceramic or direct resin could be used.

Figure 14B • After discussing benefits and drawbacks of each approach, he decided to have 8 direct resin veneers from teeth #5 – 12. (4 Seasons – Ivoclar Vivadent)

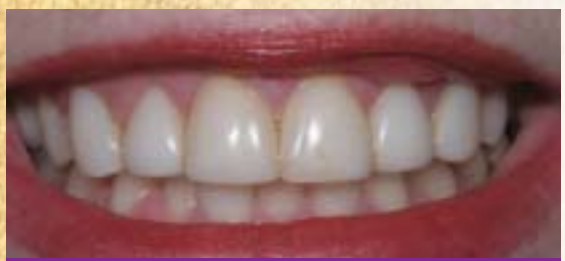

Figure 15 • These veneers are over 10 years old and although they are not as aesthetic as originally placed, the patient is still happy with them. Other patients may have chosen to have them redone.

standard is higher today and what was once "good enough" is not. Even patients who don't ask are frequently interested in having this previously good enough dentistry upgraded when they are shown what we can do now. (Figure 7 & 8) Fortunately, these versatile composite systems we have today allow us to satisfy even the most discriminating patient.

Other situations where I feel direct composite resin is the better approach because of its less invasive nature is when treating injuries or imperfections in kids and young adults. We have to keep in mind, that because of overall advances in health care as well as dentistry, these young people can be expected to live with their teeth well into their 80's and possibly beyond. It is important for the dentist and the patient to understand that all dentistry is "temporary" and every time we replace it, more tooth structure gets lost. So, for these people to keep their teeth over such a long life span, we dentists need to avoid, whenever possible, unnecessarily removing the enamel at a young age. (Fig. 9 & 10) I recognize that the word unnecessary is a relative term and has to be decided on a case by case basis, but I think you will agree that it shouldn't be decided by a lack of knowledge or training of the dentist.

Certainly there are many clinical situations where either ceramic or direct composite resin will work well. In these cases, it is incumbent on the dentist to explain the advantages and disadvantages (each approach has both) of each type of procedure and material so the patient can make their choice. Factors such as cost, time,

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Figure 16A • This 27 year old female had congenitally missing laterals. Composite resin veneers had been placed on the canines which had been orthodontically positioned into the lateral positions.

Figure 16B • Following crown lengthening, ceramic veneers were placed on teeth #5 – 12. (IPS Empress – Ivoclar Vivadent)

Figure 16C • Full face view before.

Figure 16D • Full face view after.

longevity, invasiveness, serviceability and desired look or outcome are just some of the considerations that need to be addressed in detail so the patient can make an appropriate informed choice as to what is best for him or her. Besides achieving an outcome a patient wants and how they want it, informed consent satisfies the ethical and legal requirements we have as health care providers. (Figs. 11 - 14)

My experience with the previous generation of composite resin materials led me to believe 6 to 10 years was a reasonable longevity expectation in the anterior. (Figs. 15) When properly bonded in functional harmony, the newer microhybrid and nanocomposite materials should easily give 10 years of excellent service. Along with 3 opacities, multiple shades and natural opalescence and fluorescence, these materials also have significantly better physical properties than the previous generation. Some examples of recently introduced systems are Esthet·X by Dentsply Caulk, Point4/Premise by Kerr, Vit-l-escence by Ultradent, Filtek Supreme by 3M/Espe, 4 Seasons by Ivoclar, Vivadent, etc. Ceramic materials, which have also improved significantly in recent years, can still be expected to yield a greater longevity when compared to composite resin and its use in the adult patient can change a life. (Figure 16)

It's a great time to be a dentist. The public today are obsessed with health and beauty and we can deliver both. The aesthetic and restorative value of today's composite resins is high. These newer materials are great, easy to use and any dentist can learn to

master the techniques in a short time. In addition, I'm convinced that learning to perform aesthetic anterior direct resin procedures significantly improves a dentist's ability to provide superior aesthetic anterior indirect services. The reason this happens is because ones' understanding of opacity, translucency, value, color, form, contour and texture becomes refined to a point that lab communications become more specific and complete. You communicate more because you see more. I would encourage every dentist to take the time to investigate these new naturally shaded composite resin systems available in the marketplace and attend courses to learn how to use them. Whether you take my hands-on course at the Las Vegas Institute for Advanced Dental Studies, Dr. "Bud" Mopper's at Cosmedent or Dr. Newton Fahl's in Brazil, you owe it to yourself and your patients to have these skills in your tool box. Not only will you attract more new patients and perhaps extend more services to existing ones, you will experience the satisfaction of creating beauty with your own hands. Finally, because patients see that you were the only one involved in creating their enhanced smile – you receive more than gratitude from them – you get admiration.

Dr. Jackson gives a 2 day lecture, hands-on and live-patient demonstration course at LVI. Next course September 19 – 21 call 888-584-3237.

Disclosure: Dr. Jackson discloses that he acted as a paid consultant in the development of Esthet·X and 4 Seasons but retains no financial interest in either product.

Acknowledgement: Dr. Jackson wishes to credit the following technicians:Mr. Ken Jones, CDT and Mr. Quint Whipple, CDT

RONALD D. JACKSON, DDS, FAGD, FAACD

Dr. Jackson has published many articles on aesthetic, adhesive dentistry and has lectured extensively across the United States and abroad. He has presented at all the major U.S. scientific conferences as well as Aesthetic Academies in Asia, Europe and South America. Dr. Jackson is a Fellow in the American Academy of Cosmetic Dentistry, a Fellow in the Academy of General Dentistry, and is Director of the Advanced Posterior Aesthetics 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.

Ask Heidi

Clinical Questions and Answers

Dr. Heidi S. Dickerson is the Vice President of North American Operations. She is a 1994 graduate of the University of Illinois School of Dentistry. She had a private restorative practice in Philadelphia, PA before relocating to Las Vegas to accept her full-time position at LVI. Due to her commitment to excellence, spending countless hours mastering aesthetic and restorative dentistry, including the LVI curriculum, she changed her aesthetic-restorative dental practice into a neuromuscular based practice. As a Clinical Director at LVI, Dr. Dickerson instructs, lectures, and motivates LVI students through their curriculum, enhancing their educational experience. She also practices in the LVI Faculty Practice.

Send any of your clinical questions to her at:
LVI 9501 Hillwood Drive, Las Vegas, Nevada 89134 or via e-mail at hdickerson@lvilive.com

Due to the overwhelming number of questions from Team members… I have decided to answer some of their questions in this issue of LVI Visions.

Q

Dear Heidi,

Our doctor wants us to go on POP (Piece of the Pie) and we are scared to death! Is this a good thing for us?

V.A.
Oregon

A

Dear V.A.,

This is an excellent idea! With Piece of the Pie you are "part owners in the practice". As the practice grows and makes more money, so do each of you. It will help all of you as a team to keep motivated and to work together for the success of the practice. The best thing about it is there is a built in "safety net" each month so that you will always be able to pay your personal bills no matter what happens in the practice that month. In most practices the team's income goes up. They feel more responsible for everything and that is a good thing. For more information read Bill Dickerson's books, The Exceptional Dental Practice and In Search of the Ultimate Practice. These books will take you step by step on how to get this going. You will not be sorry…take your Doc up on this!!

Heidi

Q

Dear Heidi,

We have a very close knit team and consider ourselves as "family". Our doctor is a firm believer in C.E. and he takes us along to every course he attends. Currently we are going through a continuum of courses at LVI. When we get back into our office, we schedule a team meeting and go through all of the material that we have just learned. We decide what we want to implement, and plan a strategy to get there. Here is my dilemma…we hired a new team member and she is clinically very sound. She has a nice personality and our patients feel comfortable around her. So what is the problem? Well, she will not go to any courses with us. She has been in dentistry for 18 years, and she says, "I have heard it all before!" I will admit, she "knows" a lot; however, she does not know all of the new techniques that we are learning. And more importantly, she does not share in our office "philosophy". We are all "pumped up" and excited about the direction that our office is now taking. What do we do? It is a source of frustration for all of us.

Thanks for your advice,

S. H.
Texas

A

Dear S. H.,

First of all, I want to commend your doctor and your entire team for your commitment to excellence. All of you are dedicated to making your practice the best that it can be…and also, improving your individual knowledge and skill levels. That is absolutely fantastic. The problem is you have a "black sheep" in your "family." You really have only two alternatives: Fire her, or try to convince her that she needs to jump on board with all of you. Since it seems that she is qualified clinically, and her personality meshes with the patients etc., I would talk to her in a team meeting and let her know how all of you are feeling. Your doctor may want to express what his "goals" are for the practice and the need for her to be on the same page as all of the team. He should send her out to the LVI Team program to get her caught up and "fired up" as well. She can attend the Team Program any time it is scheduled. I guarantee that if she comes to the program, she will see that she does not "know it all". If you have given her the opportunity to learn and she still has philosophical differences than the rest of the team…it is time to part ways. I'd give her a chance though, she "doesn't know what she doesn't know", and perhaps she can come back into the family fold!

Heidi

Q

Dear Heidi,

Our doctor just completed an aesthetic course at LVI. He has changed many of the procedures we are doing and has completely stopped prepping for PFM crowns. I can understand the beauty of the all porcelain restorations; however, I am uncertain of what other benefits they have for the patient. Why is this a better restoration?

G.H.
Wisconsin

A

Dear G.H.,

I am happy to share with you the benefits of all porcelain restorations. As you noted, they are quite beautiful and our patients really like them. Besides their aesthetic nature they have many other great qualities that make them a wonderful choice. Let's compare All Porcelain Restorations to PFM Restorations. With PFM Restorations we need to be more aggressive in our preparation because we need to make room for the gold AND the porcelain. The look around the margin is more opaque and many times we need to place the margin subgingivally which violates the integrity of the tissue. Because these restorations block the light, this will create dark roots as well. Now, if we look at All Porcelain Restorations we can be more conservative in our preparation since we are only making room for the porcelain not porcelain AND metal. These restorations have a more natural translucency and our margins are invisible due to the light being able to get into the tooth. Because of this, we can keep our margins supragingival and that aids in easy finishing and NO need to pack any cord for impressions! With adhesive dentistry, think of it as replacing the enamel that used to be on the tooth with porcelain. I hope I have helped you understand the benefits of "All Porcelain" so that you can better educate your patients.

Heidi

Q

Dear Heidi,

I hope you choose to answer my question because I am at my wits end! There are three of us on the team: assistant, hygienist, and concierge. We think the world of our doctor, she is loving, kind, and has amazing skills (each of us has had "Smile makeovers" done by her). However, she has one tiny flaw that drives all of us nuts!!! She promises things and then does not deliver. For example, we are supposed to have yearly reviews/raises…that does not happen. We are promised "bonuses" on certain cosmetic procedures…we never receive them. We are promised new equipment that we need (i.e. a new computer system, and a new ultrasonic scaler) and she never buys them. We are constantly asking her, "when are we getting these things?" The funny part is, we love our jobs so much that it's not as if we are going to quit over it (don't tell her that!). What should we do? We feel that we deserve all the things "promised" to us. Can you suggest a good way to get them?

W.S.
California

A

Dear W.S.,

This is a tough one…the answer here is not cut and dry. I have an idea that may help. If your doctor "promises" verbally and does not deliver…try this. Write down what you have agreed upon in a written CONTRACT. You can do this individually, or as a team. Then sign it and have your doctor sign it as well. I would also include time lines/dead lines in that contract. Perhaps if your doctor puts her "name" to it, she will stick with it. And if she doesn't you can go to her, with the contract and remind her of what she agreed to. Now, keep in mind it is the Doctor's practice and she has every right to run it as she pleases. She may not like this idea, and things may or may not change. It is your choice then to either accept the fact that this is the way she is and look at her positive attributes, or to work for someone else. Go ahead and try this idea first, let's give your doctor the benefit of the doubt! Let me know how it goes.

Heidi

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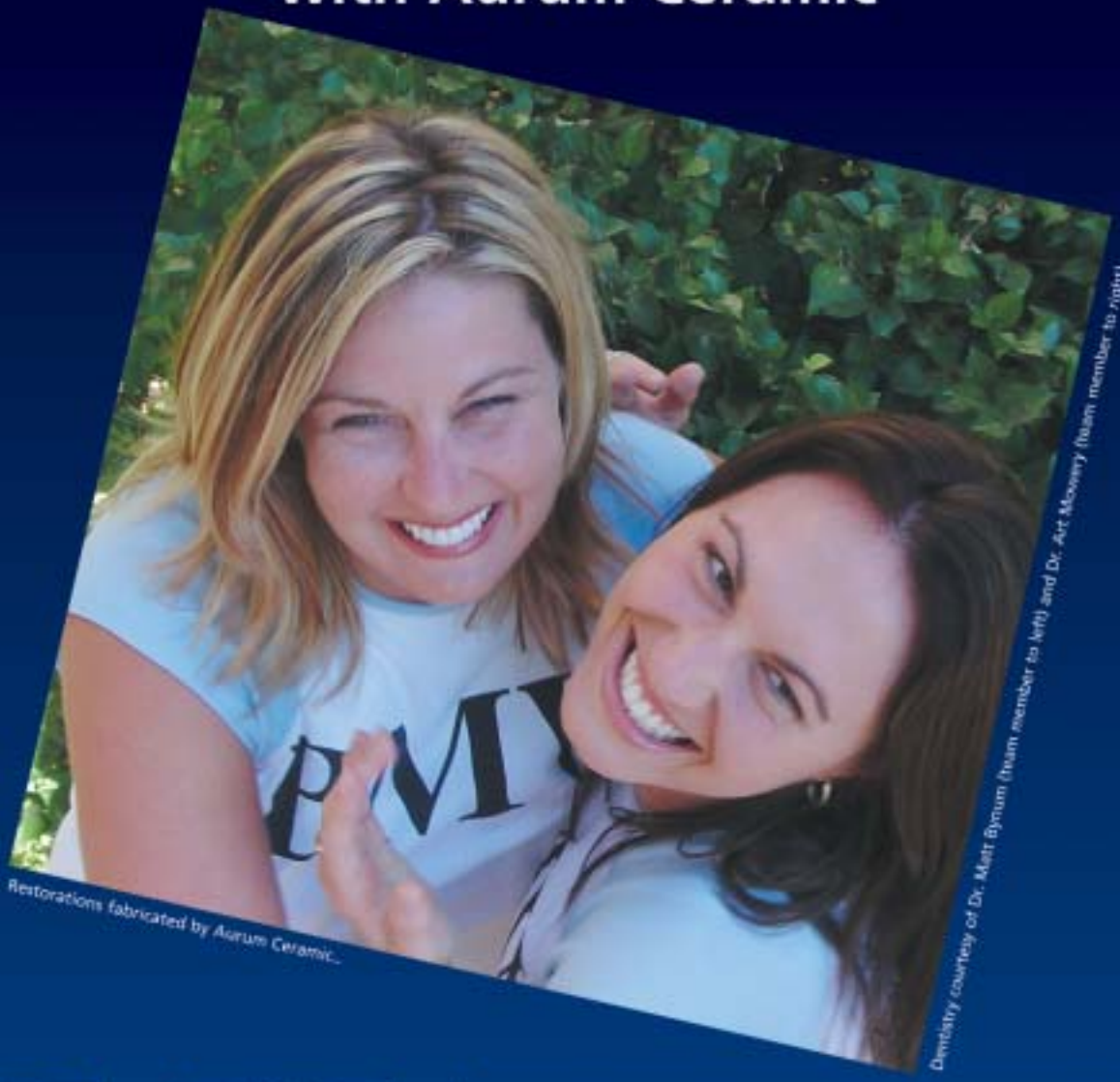

Restorations fabricated by Aurum Ceramic.

Dentistry courtesy of Dr. Matt Bynum (team member to left) and Dr. Art Mowery (team member to right).

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Gainsville, FL

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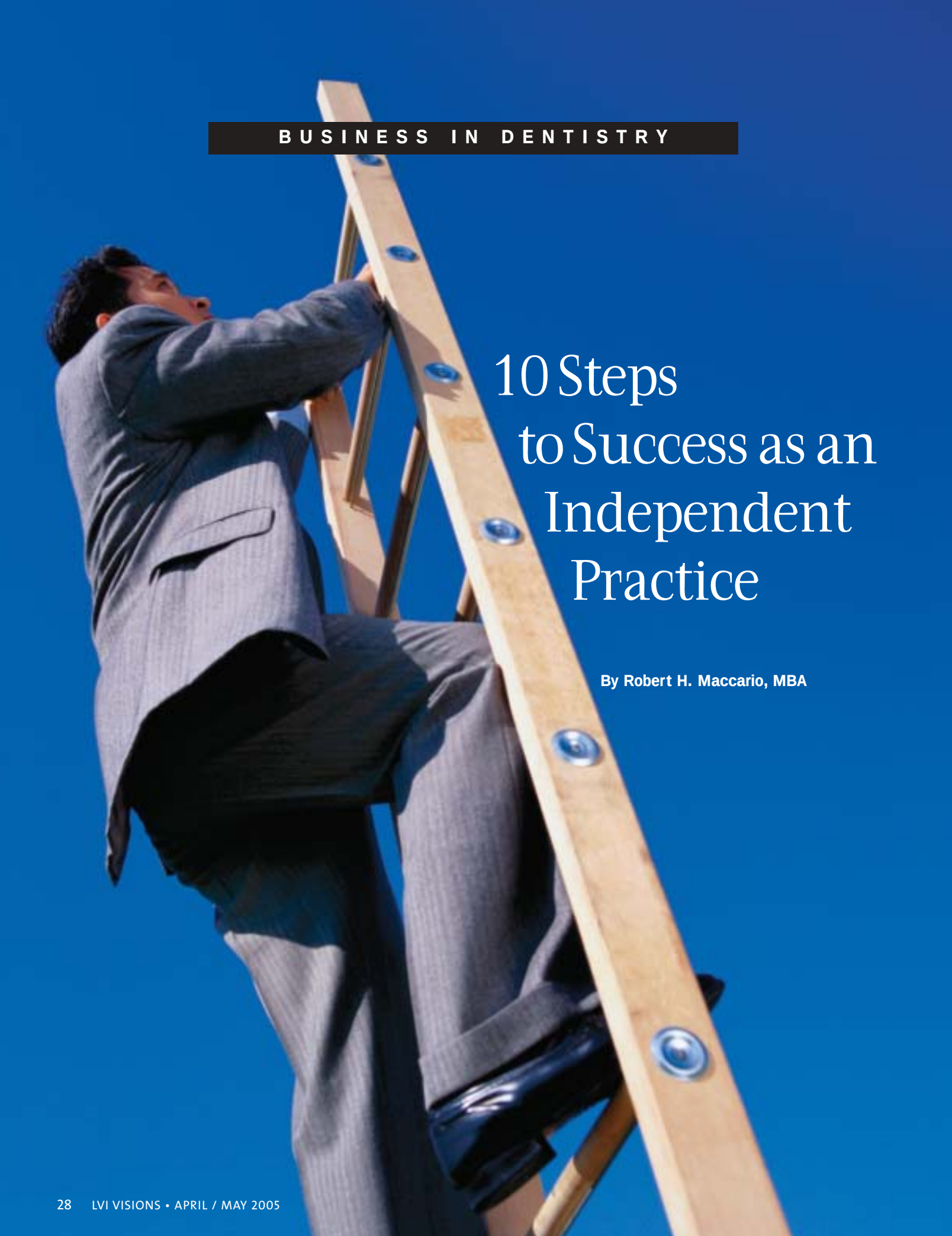

10 Steps to Success as an Independent Practice

By Robert H. Maccario, MBA

Electing to stop depending on insurance to send you patients is a business decision, not an emotional one. While there is a place for emotion in business, especially for enthusiasm, without sound business tools and education to guide that enthusiasm, calculated risks devolve to outright gambles.

As a businessperson, you should carefully plan both your timing and tactics to be consistent with the economic health of your practice. Think evolution, not revolution. Let's examine a 10-step process that will firmly plant your feet on the path toward achieving independence.

Step 1.
Start thinking and acting like an entrepreneur and independent business.

Develop the business skills and knowledge to run your practice as a stand-alone business, independent from any single referral source (i.e. insurance companies).

Ensure your thoughts and actions highlight the value of your care and services — not the value of insurance. Drop insurance vocabulary: You are not "non-participating"; you are an independent business. When you discuss fees, refer to them as your standard professional fees, not "UCR."

Step 2.
Apply financial rather than emotional criteria.

See insurance companies as they are: referral sources no different from the yellow pages, direct mail or a Web page. Make your business decisions about them as you would any other referral source: by using a sound business analysis. Ask yourself,

• What percent of revenue do they represent, and what percent of appointments do they represent?

• How will profitability be affected if we drop a referral source?

• How much are our contracted fees with this referral source inhibiting our ability to charge what our care is really worth?

• How much would we have to raise fees to offset the loss in profitability without this referral source?

Step 3.
Initiate an external marketing program.

Develop your own brand identity in the marketplace. Make sure the entire process of image making is consistent —your printed material, facility, team appearance, and so on must present a cohesive front. Start this process at least six to nine months prior to dropping the insurance company as a referral source. Realize that your marketing will take time and be reinforced by a variety of marketing vehicles.

Step 4.
Adopt customer service systems.

Retain your patients by raising the value of your care and services beyond the value of the insurance premium. Amplify your unique selling proposition (USP) to your patients/guests. Offer services like the VIP checkout and other amenities a guest would expect from a quality service organization. Understand how to use patient financing as a marketing tool.

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Step 5.

Create team commitment by addressing staff concerns / objections and teaching them how to address patient concerns / objections.

At a team meeting, answer your team's questions about the move to an independent business mind-set first. They are your internal customers: If they are skeptical, your external patient/guest customers will not be convinced. It can be a huge mistake to put a team member on the front line with patients if they do not believe that this evolution is in the patients' best interest.

Another of the biggest mistakes a practice can make in this evolution is to talk about the "change." Remember, most of us do not like change. Reframe your approach to emphasize that you are staying the same: "The insurance company is changing, not us! We have the same commitment to care and well-being, and we will not violate patient trust."

Your patients will have three main objections. You and your team need to be acquainted with these issues, both to avoid any awkward feelings and to help your patients understand.

1. "I don't know how to do the paperwork." You will still need to assist your patients in filling out forms, but that doesn't mean you have to wait for your money. More and more practices are paid prior to care, with the insurance check going directly to the patient. Help them set up their personal line of credit with your "outside billing service." (Don't mention credit card companies or finance companies — call them your "outside billing service.")
2. "I want the best coverage." Your staff and your patients want optimum coverage for the quality of care you are committed to providing. Use such phrases as, "Our experience has shown the insurance companies are much more responsive to the people who pay the premium, like you, than to us. We have seen patients receive reimbursements faster, and in many cases with better coverage when the check goes directly to them."
3. "How fast will it pay me?" This question can be answered as in number 2, above. Give them the information to call the insurance company, "Should you have any questions or concerns about your coverage or payment, please call this number (the insurance company) for the most immediate response." It makes no sense for the patient to call you, so you can call the insurance company and then call the patient back. Have the patient call the insurance company directly so they experience first-hand the rudeness and lack of attention dental offices have tolerated for years. When the patient complains to you about the level of service the insurance company is providing, agree with them and state, "I understand how you feel. If I paid this premium and experienced such poor service, I would make sure the person at your company who contracted this insurance program knows how bad it is." Finish with a polite smile.

Step 6.

Write a letter to patients.

For example, the letter might start out with something like this:

Because of our long-standing relationship with you, our valued patient, and in consideration of the trust you have put in us over the years, we are writing to let you know in advance that we are changing our contractual status with XYZ Dental Insurance.

For practices like ours, staying at the forefront of clinical excellence, patient care, and service is the basis for our success. We will not waiver in our commitment to provide you with the best clinical care and the most current dental services available. Please be assured, we are severing only our contract with XYZ, the insurance company, not our relationship with you, our valued patient.

Use your benefit statements to write your letter to the patients, but DO NOT SEND IT YET! Wait until after you have tested and refined your benefit statements.

Step 7.

Test the scripts.

Test the scripts/benefit statements you created in Step 5 over the next few months with your patients. Talk to one another about how they are working. The intent is to let the patient know that we are about to "sever our contract with the insurance company, not our relationship with our valued patients." Remember, it's evolution — not revolution.

Step 8.

Send letters.

Now you can send your patients the letter. When they receive it, if you've done your job right, your patients should be saying, "Oh, I knew they were going to do this." By this time, they should have had a personal ex-

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planation of your practice's commitment to their care. If patients receive this letter and respond with surprise, you have not communicated your position clearly, and they will probably request their charts.

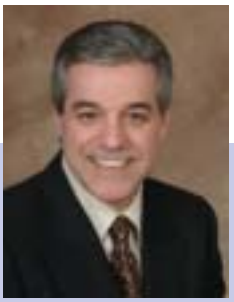
At this time, also send your termination letter to the referral source (insurance carrier).

Step 9.
Make telephone calls to scheduled patients.

Review your schedule to identify patients involved with the referral source you have dropped. Call those patients to confirm their appointments. Some patients may think they cannot continue coming to your practice, so reiterate that you are looking forward to seeing them. Review your financial arrangements with these patients. You may have to honor the contracted fee with the insurance company or get a signed financial arrangement with your "standard professional fees." At this time, accepting the contracted fee as a tool to ease the conversion to your fees should be a minor cost — consider it tuition. But do not let this opportunity to discuss your fees slip by.

Step 10.
Double your efforts on quality of care and customer service.

Go back and review the quality of your care and service — you are now competing in the world of discretionary dollars. You are on your way to becoming an independent business, enjoying your patients/guests — not someone else's subscribers.



Mr. Bob Maccario, MBA has 35 plus years background and experience in the dental field. In 1982, Bob graduated from Pepperdine University with a MBA degree. He transitioned his career into practice management and in 1985 opened his own practice management company, Professional Management Sciences, Inc. (PMSI). As a private practice consultant, Bob has evolved a marketing and management program based on proven customer service skills and sound patient financial arrangements. He is a popular and entertaining lecturer on a national basis. Bob teaches the "Dental Concierge - How to Turn Your Patients into Guests" program at LVI.

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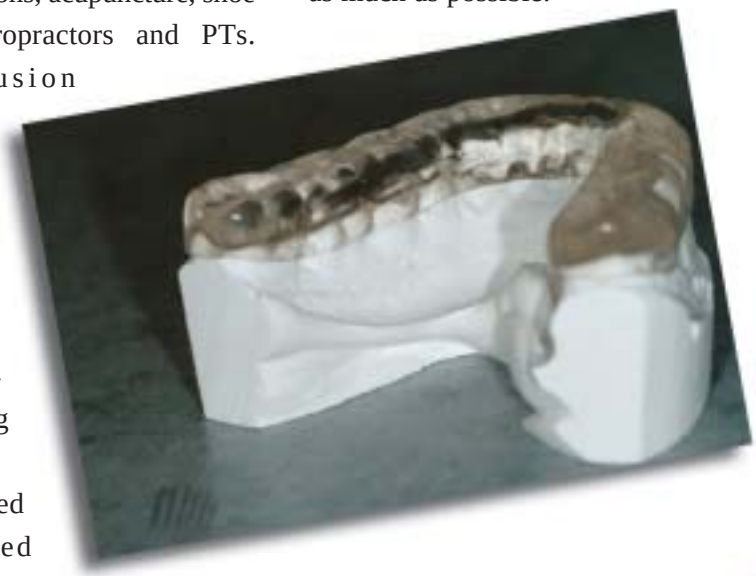
Occlusal Repositioning Appliances... Fixed or Removable

The Difference Was Huge For Me

Beth Snyder, DMD

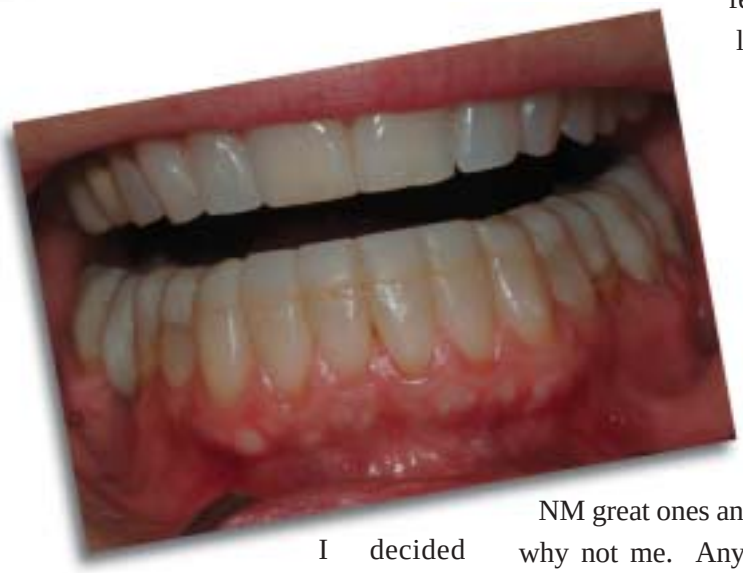
"Oh my gosh that's me!". I said this the first 30 minutes after hearing Bill Dickerson lecture. I could not believe the results Bill Dickerson, Clayton Chan and Bob Jankelson attained for patients who, like myself, were in long term life altering pain. After introducing myself, the wonderful trio quickly and lovingly took me under their wing as the "demo girl". I received my first removable occlusal repositioning appliance in May 2002, and started my path in NM dentistry.

As long as I can remember I had headaches, diagnosed as cluster type. The pain radiated from behind my right eye, up over my head and down my neck (or the other way around?). Pain overwhelmed my neck, shoulders, hands and my low back. I tried everything from Dawson's CR techniques to Botox, cervical facet injections, acupuncture, shoe orthotics, chiropractors and PTs. Every occlusion course I attended placed me in front of the class as the prime example of a pain patient (including Dawson).



As a devoted and committed patient, I wore my occlusal repositioning appliance 24/7, removing it only for brushing. After wearing the same one for 2 years (with much adjustment and resurfacing), I needed a new one. As a clinician, I would have been the first to say that a removable occlusal repositioning appliance is the way to go due to its ease of adjustments and its potential reversibility. With a new Chan Scan, I had both a removable and a wax-up for a LVI fixed occlusal repositioning appliance created.

The day my lab case arrived in my office, I placed the removable in my mouth and with a few adjustments to the class I interferences, I felt better. I felt more at home in the more anterior position. However my speech was highly impaired. As good as my speech got with my old occlusal repositioning appliance, I had a struggle with my new one and had to alter it by thinning the lingual flange as much as possible.



I decided the time had come to convert to a fixed LVI occlusal repositioning appliance for several reasons. I was tired of the embarrassment with how it looked (especially when I would go to dental events with my local CR/CO friends and it would bring attention to my lack of total improvement). I tired of having it slip while I was eating, catching food underneath. I wanted to lose my lisp, which was exhausting in itself. Additionally, another problem of long-term therapy can be decay. I did in fact suffer from breakdown and decay (class 5s) because the removable occlusal repositioning appliance held food along the ledgy margin. I tried to have good homecare, but it is not always convenient to brush or even rinse immediately after eating. Lastly and most importantly, I was still disappointed that my anterior temporalis and SCMs were still so painful.

I had suffered in pain for a long time, and yet I had heard of so many others having success from their occlusal repositioning appliance and relief from their pain. I sat in lectures of the NM great ones and cried wondering why not me. Any of you who had seen me examined in front of the class knew of the supreme pain I had in my neck, shoulders and head.

In mid November, we placed my LVI occlusal repositioning appliance and the next morning, to my amazement I had a profound change in my muscles. Every morning as I would shampoo, I would massage my scalp to ease my pain, but this morning the pain was gone. I could turn my head side to side and my SCM's were calm. My speech instantly improved.

Now that I have had success with my fixed occlusal repositioning appliance, not only do I feel better physically, I honestly feel more self-confident with the way I look and the way I sound. Most people are unaware I have it unless I point it out. Eating meals is more comfortable. Although I cannot floss with my fixed occlusal repositioning appliance, I use the Hydrofloss. I find it to be a much cleaner feeling because the margins are closely feathered to my teeth.

Why the difference between the fixed and removable? For me it was the encroachment of my tongue space (even though I had more volume by the increased vertical) that caused an intolerance of my digastrics, which then affected the SCM's and the anterior temporalis. I challenge you while you are reading this to pull your tongue back as if to create space for an occlusal repositioning appliance and see where you feel it in your neck.

Until recently, I had only heard that the benefit of a fixed occlusal repositioning appliance was compliance. I had the impression that there is no difference in the result one can get when using a removable vs. a fixed. I now do not feel this is always the case. As I review the many cases I have done over the last couple of years, I believe the majority would have been happier had they been treated with a fixed, even though they greatly improved with a removable. Several of my patients whose jobs depended on speaking, continually removed it during those times. It wasn't because they lacked a desire to be compliant- they just couldn't. Others were unable to comfortably eat with their occlusal repositioning appliance due to loss of retention.

My practice has grown through a paradigm shift. We evaluate each and every case to decide which type of occlusal repositioning appliance would be best for that patient. We find that the majority of our patients are now being treated with fixed.

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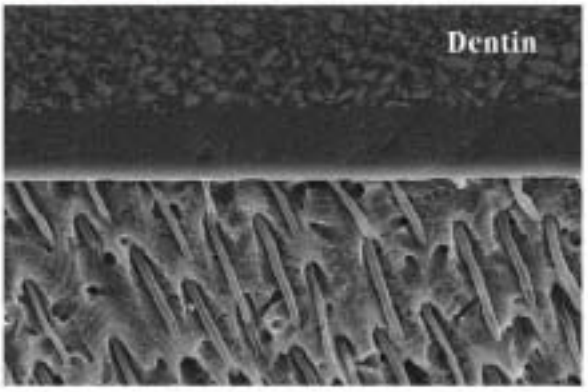
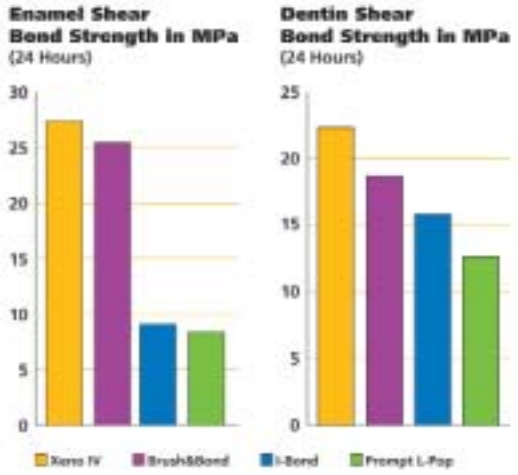


Hybridization of dentin and resin/dentin interface with Xeno IV Adhesive



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THE INCREDIBLE AND UNFORGETTABLE

2005 Gala Review

Michael Miyasaki DDS, LVIM

Dr. Michael Miyasaki is LVI's Vice President of International Operations. A 1987 graduate of USC School of Dentistry, he developed a highly successful reconstruction practice in Sacramento, CA. Following his passion to teach and mentor other dentists, he became associated with LVI in 1996 where he now works full time. Michael practices in the LVI faculty practice, lectures and publishes articles on the latest aesthetic, occlusion and materials available.

PRODUCT REVIEWS

How Two Create A Bond

In this issue I'm going to go back to some products that have been around for years and have been proven in the LVI laboratory (our personal work and the work done during our live-patient treatment courses), but I also want to give you some tips to help ensure success in their use to create the optimum bond.

Kerr's OptiBond Solo Plus

The first product is Kerr's OptiBond Solo Plus single component adhesive system. First, let's talk about why we use it. OptiBond Solo Plus has a film thickness of 10 microns making it a product that can be used for both direct and indirect restorations. It has a relatively high filler load being 15% glass filled which should translate long-term into lower microleakage scores. OptiBond is also ethanol based, which means there is a greater acceptable working range of dentin moisture working even if the dentin is slightly over-dried or slightly over-wet. OptiBond also affords us the ability to pre-cure it before the luting cement and restoration are placed which means once done, if there is any contamination of the surface of the cured adhesive the contamination needs to be removed, the surface of the preparation is dried, a fresh layer of OptiBond is brushed on, air thinned, and the restoration is cemented. There is no need to go back and re-etch, and begin the whole process over again. Another advantage of pre-curing the adhesive is that the dentin is sealed and will not desicate which could be a source of sensitivity. One tip is to watch out for the viscosity of the OptiBond Solo Plus. It is a relatively viscous adhesive which means you must thin it aggressively before pre-curing. This means using a strong stream of air to evaporate the ethanol carrier and thin the resin. If you see any "waves" of resin created by the air, stop and physically thin with a brush, air thin again, and when you have nice uniform coverage, cure with a curing light for 5-10 seconds.

We use the the OptiBond Solo Plus unidose rocket capsules for its infection control advantage, it guarantees reliable, fresh material for every use, and one capsule will do an entire arch. One word of caution is not to remove the unidose rocket capsules from the outer packaging before use as the ethanol carrier will leach through the capsule and be depleted.

Okay, so many of you are using a self-etching primer/adhesive and are having good success when defined as less sensitivity and you may be asking why LVI hasn't gone along with the seemingly easier to use self-etch materials. Let me highlight just a couple reasons. First, when we total etch, we are removing the smear layer or debris from the tooth surface before sealing. With a self-etching system, this debris is incorporated into your adhesive. We don't like that. Second, when we total etch with our thirty-something percent gel etchant, we are etching the unprepared enamel adjacent to our preparations ensuring we are sealing past our margin and during our finishing process we have a smooth sealed margin. With a self-etching system, the unprepared enamel is not etched so one has to worry about the marginal integrity. Why do many use the self-etching material or should I say "Why do you have less sensitivity with a self-etching system?" Lets explore this. With a self-etching system, the depth of the etching is self-limiting. With the total etch technique the clinician needs to simply prevent over-etching. What does this mean? Etchant should only be applied to the enamel for 15 seconds and the dentin for 10 seconds with most 30-something % etchants. Many of us are overetching which can lead to post-operative sensitivity. Another problem avoided with a self-etching system is the clinician doesn't rinse it off meaning the dentin is never dried. When using the total etch technique, the etchant must be

rinsed off and if in the process the dentin is desiccated, the collagen fibrils collapse and the dentin tubules are dry meaning it is now going to be more difficult for the primer/adhesive to penetrate the tubules to create a good seal, hence, the probability for sensitivity. The easy solution is applying an anti-bacterial rewetting agent to moisten the dentin before placing the Optibond Solo Plus. What this means is technique is important, but once mastered, Kerr's OptiBond Solo Plus will afford a predictable bond with virtually no patient sensitivity.

Dentsply Caulk's Calibra Esthetic Resin Cement

Another time proven product we use at LVI is Caulk's Calibra resin cement. Calibra has been Bill Dickerson's favorite cement for years for primarily one reason - it's easy to clean up. Ever had a large piece of resin cement that you've cured between your new veneers and after some coaxing with your interproximal carver or Bard Parker it still just won't come off so you're left to resorting to use a bur or dynamite? Calibra, typically, in that situation would peel off.

Calibra is a visible light cured, dual cured or self-cured resin cement and with a film thickness of just 12-18 microns, it is indicated for use with adhesive cementation of ceramic, porcelain, composite inlays/onlays, veneers, crowns, posts, as well as their metal counterparts.

The cement comes with try-in gels, and separate base and catalysts. With just 5 shades (translucent, light,

medium, dark and opaque) finding one that will satisfy you and your patient is not difficult. In a high-quality restoration, typically 80-90% of the color will come from the restoration with the cement accounting for just a small portion of the final shade. With this in mind, we typically use the 'translucent' shade and allow the natural warmth of the tooth to come through the porcelain, but when needed, the 'light' shade is used to lighten the color of the restoration while the 'medium' shade might be used to enhance the gingival blend or warm the color of the restoration. While on the topic of color, we always try to use the light cured component or 'base' portion of this system for most of our restorations. Whenever you mix the 'base' and 'catalyst' portions together, there is a chance of the shade of the cement changing over time depending on the completeness of the amine-peroxide reaction that must occur. Another advantage of using just the 'base' is that you are in control of when the cement sets, and this is especially important as you begin doing larger cases. So would there be a time when the 'base' and 'catalyst' should be used? Sure, with indirect resin-type restorations or thick porcelain restorations that may not allow the curing light to penetrate, then by all means use the catalyst to ensure the cement is set, but typically these will be used in the posterior areas where a possible slight color shift is not a concern. A unique feature of the Calibra system is that there are two viscosities of the catalyst. A thicker (high) viscosity paste that will stay on your restorations if you are placing small, difficult to handle restorations and a regular (low) viscosity for use under crowns and bridge restorations.

So here are two time tested products we use at every course at LVI in the many different hands of the doctors coming through the live-patient treatment programs that help us achieve predictable clinical success. If you are having any problems, I'd recommend coming and learning during one of our hands-on programs how these materials are used.

Note:
In the September/October issue of LVI Visions Magazine, I reported on Ivoclar's new OptraGate lip retractors. Some of you reported trouble getting these - I've spoken to Ivoclar and OptraGate should now be available more readily through your dealer.

Take at look at these products. After you do I'd love to hear your comments. Your suggestions always are welcome-please send them to me at:
mmiyasaki@lvilive.com

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Meta

As I look back over my career, I realize that I've been on a continual search for the exceptional dental practice. I just didn't know how to define it. I was seldom satisfied with the way things were and was constantly looking for a better way. As I recall my journey, it's clear that this quest for excellence was causing a "driven-ness" that would never be fulfilled until I finally created the kind of practice I envisioned. Please follow my journey and feel free to learn from it.

Man, did I hate dental school! I was taught by some mighty arrogant and frustrated dentists. Early on I decided that my game plan was to keep a very low profile. I survived the experience and moved south to Savannah, Georgia in the summer of 1982.

Just before I took my boards, I received a phone call from a Savannah dentist who proceeded to tell me that the local dentists had arranged it with the board of examiners to automatically fail me! Although I easily passed both the Georgia and South Carolina boards, this phone call had a huge affect on how I looked at my "colleagues", so much for the welcome wagon treatment! I constantly had dentists tell me that I wasn't wanted or that I should be practicing differently.

Brad Durham, DMD

My goal quickly became to prove them wrong! Later on, in 1989 when the FDA approved lasers for dental use, all the local periodontists tried to get me in trouble with the state board for implementing this technology into my practice. After educating the board on role of lasers in dentistry, they told me the only problem I had was a professional relations problem. I already knew that! I quickly learned from these experiences that I would probably never be one of "the good ole' boys" nor become a stereotypical dentist either. Truthfully, these events did a great deal to positively shape my career. Now I could make any practice decision I wanted and not fear professional disapproval. I had nothing to lose as I already was an outcast!

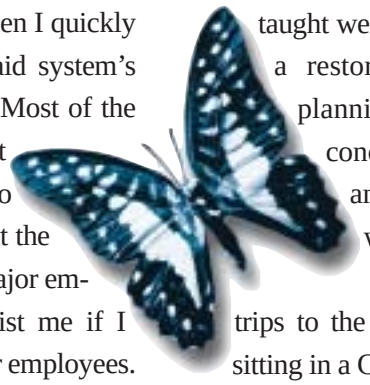
In the late 80's, the management mantra was Bigger is Better. I took several practice management programs and strapped on the roller skates. I had an associate, a staff of

morphosis

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

sixteen, and two sets of overhead (offices). We cranked out a lot of dentistry and paid a lot of bills, but still something was missing. The practice was primarily composed of Medicaid, insurance patients and was primarily emergency driven. For awhile, I thought I had it made. Then I quickly grew tired of the Medicaid system's red tape and dropped it. Most of the insurance patients left when we expected them to take care of their co-pay at the time of service. I had a major employer threaten to blacklist me if I didn't cut my fees for their employees. I didn't. Guess what? They all left too! I was learning quickly that patients, who see you for your low fees or insurance coverage, don't really care about you, just the cost factor. Surely there had to be more!

Finally I saw the light. I wanted a practice based on quality, not price and volume. I unloaded the associate along with most of the staff, sold an office and started searching for some technical skills. When you live in the southeast, you automatically go to a well known institute in Florida. I learned a lot down there. The bimanual manipulation techniques they taught were confusing, but from a restorative and treatment planning standpoint, their concepts were excellent and started working well for me.



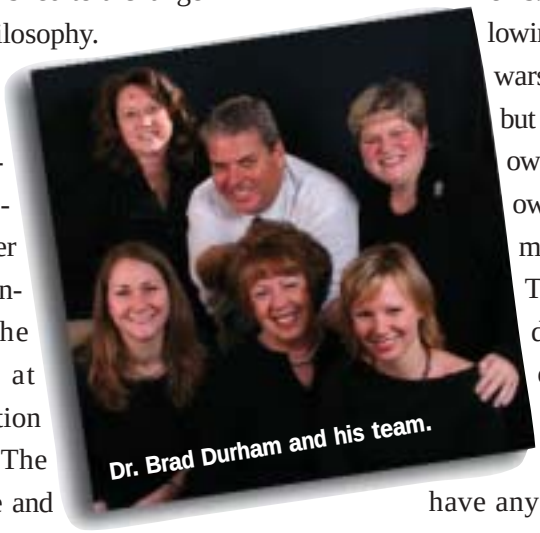
During one of my trips to the institute, I remember sitting in a CR class, clenching my teeth to try to make them fit together in the most retruded position and anteriorally displacing my right articular disc. Ouch! Thankfully, it recaptured itself or I'm sure I would have been equilibrated into that position. I thought to myself, "Maybe CR isn't comfortable!"

I'm glad I had the CR experience. I met and learned from a lot of passionate and excellent dentists, but I didn't appreciate how they constantly badmouthed neuromuscular dentistry. Actually, it made wonder what they were hiding from me! Additionally, their practice management systems were inadequate, and there was a prevailing poverty mentality when it came to practice profitability. I realized there was still a lot missing from my ideal practice so my search began again.

One day it was mentioned that our study club needed to meet Dr. Bill Dickerson. We traveled to Baylor to attend Bill's first cosmetic course. It rocked our worlds! I went home and applied what I had learned. I quickly discovered that my patients wanted the best I had to offer and that cosmetic and permanent were not mutually exclusive dental terms. My patients really didn't like the way my gold restorations looked. The age of cos-

metic dentistry was dawning. Predictability was assured in the new techniques I was learning and I found out that I actually liked making people feel good about themselves by improving their smiles. My practice grew with every course I took, and I found that I was able to perform the more difficult cases with ease. We quickly took all of his courses given at LVI. I now found myself developing a specialty practice in cosmetic, restorative and bite-related dentistry.

I was eventually invited to become an instructor! This led to a change in my occlusal philosophy. At first, it was a struggle to switch to the neuromuscular philosophy, but after meeting and learning from all the quality people at LVI, the transition went smoothly. The science was there and all of the techniques were properly documented. LVI came to Savannah for a multi-speaker presentation. This gave me the opportunity to understand neuromuscular dentistry on a new level. Now, I was hooked, and I knew I was finally getting close to my goal of an ideal practice.


Dr. Brad Durham and his team.

After a year of practicing neuromuscular techniques, I realized that my patient records contained some valuable information. After all I had 15 years of CR cases, and now a years worth of NM cases. Interestingly enough, most of my new NM cases were failing CR cases. The "precious CR science" just wasn't working for all of my patients. I began comparing the mandibular position of CR cases to that of NM cases to that of nonrestored dentitions. I had always heard that NM moved the mandible forward (which was described by the CR guys as "bad"), but what I found out was that when compared to the nonrestored group, NM did little more than decompress the joints, but the CR treatment retruded the mandible significantly, actually compressing the joints. This explained why I was seeing so many joint problems. I had been following the "occlusal wars and debates" but I now had my own proof, in my own practice, with my own hands. There is a lot of debate going on out there by "experts" who really don't have any dental experience or a clue for that matter. I made up my mind based on my facts. That was reassuring for me!

In the fall of 2003, LVI announced the Las Vegas Institute Mastership (LVIM) award. At the time, I had nine patients in neuromuscular treatment, so I decided to go for it. The next thing I knew, I was on the stage at the annual LVI Gala accepting one of the first LVIM awards. What an honor! Wow, an ex-CR guy getting the first LVIM, for neuromuscular dentistry!

Through all of this transition, I focused both on technique and practice development, always moving toward my ideal practice. I was now practicing the type of dentistry I wanted to, was taking no insurance, and seeing a smaller volume of patients. My net income had almost quadrupled, my work week had decreased to three days, and I really was performing some excellent dentistry. When I would deliver a quadrant of gold inlays the patients would comment "nice". Now, when I would "reveal" their new smile, I was met with tears of joy and hugs. What more could I ask for? For me this is my ideal practice.

Then, in May, 2004, my good friend Dr. Nelson Clements set up a meeting for me to discuss my management philosophy to our study club. We talked about managing your patient base through the use of a very specific set of dental value questions, the value of having a smaller more purified patient base, effective marketing and management systems, and team development. The meeting was a big success, and the popularity of that material has grown into a new LVI course that is being taught here in Savannah. My team and I have been honored to be asked by LVI to teach what we have learned to other offices. *The Achieving the Niche Dental Practice* course is a how to "nuts and bolts" explanation of how to transition your practice into an aesthetic and/or neuromuscular model.

As a result of my career long search, I feel that I have finally arrived at my ideal practice. I learned and applied the following concepts in order to achieve my goal:

• You can develop a specialty practice limited to aesthetic and neuromuscular services.

Continued on Page 78

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Improving on an Old Veneer Case: A CASE REPORT

TIMOTHY C. ADAMS, DDS, LVIM

The following case report focuses on the improvement of a 12 year old veneer case. The patient presented to the author with the desire to improve on her existing veneers and to solve the problem of a veneer continually coming off.

Upon my initial examination, I found:

- tooth number 12 was without a veneer due to inadequate occlusal reduction (figure 1)
- anterior veneers were very bulky due to inadequate preparation of tooth structure (figure 2-3)
- golden proportions and width to length ratio were off (84% as compared to a normal 75-80%) (figure 5)
- arch form was less than ideal (figure 5)
- midline was properly positioned and no canting was evident (figure 2)
- axial inclination and zeniths were less than ideal (figure 3)
- incisal edges of the maxillary anterior teeth followed the lip line, although they were about 1mm too long (figure 6)
- tissue contour and symmetry were also off

To add to the challenges just mentioned, the teeth were mildly tetracyclined stained and the patient was a candidate for an orthosis due to her retruded mandible (class II division I dental profile) and minor signs and symptoms.

After putting all of these challenges together and listening to the expectations of the patient, I set out to improve on this compromised case. These cases are always difficult, but with proper planning and great lab communication, the end result can put a smile on everyone's face. It is imperative to note that the patient had no interest in correcting her occlusal pathology. She was also informed that this was not going to be a perfect case but she could expect a dramatic improvement.

After a lengthy discussion on the pros and cons of restoring her to her current occlusion, the patient did agree to a TENS bite orthosis to wear during nocturnal hours (figure 8). Another consideration was the fact that we were actually going to shorten the anterior teeth to give a more ideal golden proportion and she had worn these veneers for over 12 years with no chipping or breakage noted. The only reason tooth #12 kept coming off was due to inadequate tooth reduction (figure 1).

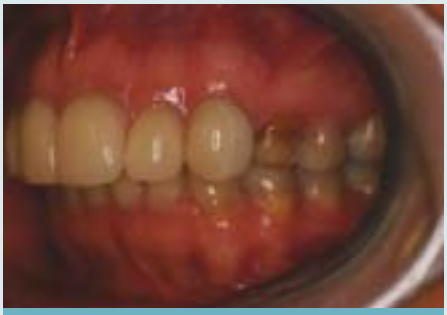
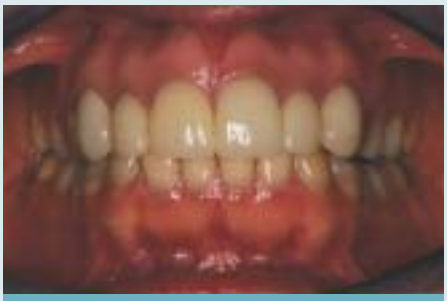


FIGURE 1

FIGURE 2



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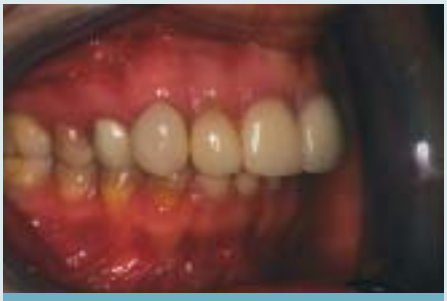

Figure 4

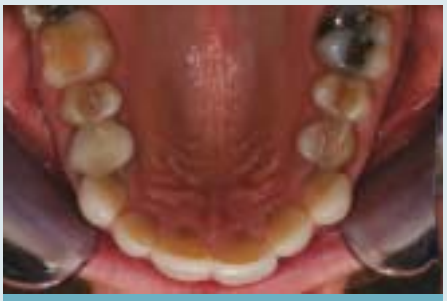

Figure 5

Figure 6

Case Report

A 37 year old female presented the desire to improve the aesthetics of her existing veneers (figures 1,2,3,4,5). The patient was in excellent health and was periodontally stable. She had no other restorative needs except for a lower molar that required a small direct resin. We discussed the musculoskeletal signs and symptoms form and palpated her muscles (some of which were sore), but her desire was to only address the aesthetics of her maxillary arch. We addressed realistic expectations about shape, color and the challenges associated with tetracycline stained teeth.

With a full mouth series of radiographs, good study models from PVS impressions, pre-operative photography, including good facial shots and retracted views, and a properly prepared patient (expectation – wise), the case was ready to be prepped.

Tissue contouring with a diode laser (Diodent, Hoya Con-Bio) was performed with tissue symmetry, height, contour and zenith taken into consideration. If these factors are not taken into consideration, despite fabulous looking veneers, the case would be an aesthetic failure. We were not able to achieve perfection but a dramatic improvement noted.

These cases are always difficult, but with proper planning and great lab communication, the end result can put a smile on everyone's face.

Anesthetic was administered (1.8cc 2% lidocaine with 1:100,000 epinephrine x 3) and the teeth were ready to be prepped for Empress porcelain veneers or crowns where indicated. Due to the arch form, width/length ratios and the golden proportions being off, the teeth were sliced prepped through the interproximal going back to the distals of both canines.

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This allows the lab the room to be able to create the ideal width/length and golden proportion ratios. One of the problems with the initial veneers was that there was not enough tooth reduction coupled with the lack of interproximal space to set the ideal golden proportions due to the fact that the teeth were not sliced prepped. This caused a bulky look to the veneers and a less than ideal arch form (figures 5). In our quest

FIGURE 7

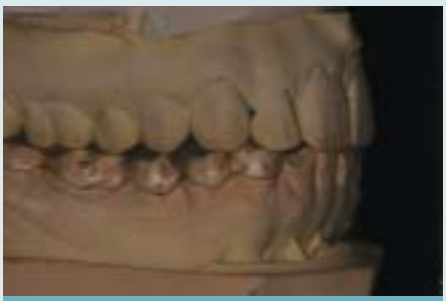

FIGURE 8

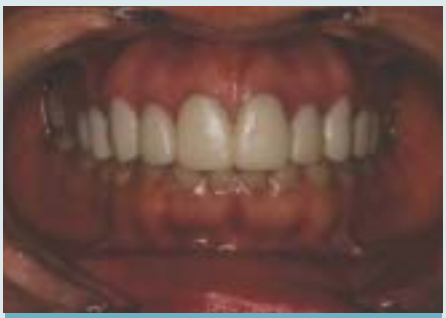

FIGURE 9

In our quest to create conservative preps, we sometimes lose sight of the ultimate aesthetic goal.

to create conservative preps, we sometimes lose sight of the ultimate aesthetic goal. Without a wax-up and prep stent to visualize where we are prepping to, the aesthetics desired just can't be achieved. The wax up and the prep guide were used from the lab to aid in the proper reduction facially, incisally, lingually and creating the ideal arch form.

During the prep phase, the decision to mask out the underlying darkness was discussed with the lab. It was decided that the lab would be able to pick out an appropriate ingot with the right amount of opacity to properly block out the color difference. This is a difficult decision to make and the author will usually try to control the color chairside by composite resin blockout if there is any question as to whether the lab will have difficulty in blocking the color discrepancy out. In this case, the lab was comfortable with controlling the color with the proper ingot (E020) selection. To aide the lab in this decision, the teeth were prepped a little more aggressively facially and the margins were placed right at the gingival crest. Due to the thickness of the tissue at the gingival crest, the necessity to "Dickerson Ditch" the cervical areas was not necessary.

One unexpected problem encountered when prepping the an-

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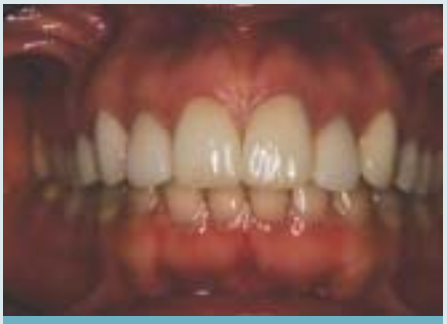

Figure 10

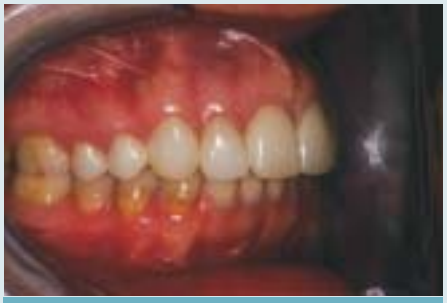

Figure 11

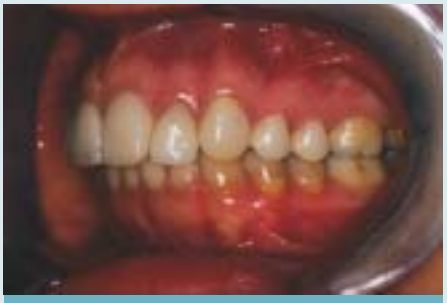

Figure 12

terior 6 teeth was the fact that the teeth were narrower facial-lingually than anticipated. This didn't allow as smooth an incisal edge as normally desired. If a smoother incisal edge was achieved, the teeth would have been shorted significantly. Tooth # 5 had a preexisting crown, but the remaining three posterior teeth (#'s,4,12,13) were conservatively prepped to allow for the conservation of as much tooth structure as possible. Interproximal contact was only broken on the mesial of tooth # 5 due to existing decay.

Once the final preps were refined and finished, a polyvinyl solixane impression (Take One, Kerr) was taken. The teeth were now ready to be temporized. A SilTec putty/wash stent was fabricated by the lab from the wax up to be used for the temporaries. The teeth were desensitized with Super Seal (Phoenix Dental), lightly air thinned and then coated with a layer of Consepsis (Ultradent) to disinfect the teeth. This layer was air dried (not rinsed) and the teeth were now ready to be temporized. The SilTec stent was tried in for fit and orientation. A midline mark was made with a scaler on the stent to allow for proper orientation once the stent is filled. The temporary stent was then filled with Integrity B-1(Dentsply Caulk) and tapped hard on the counter 3-4 times to eliminate air voids. After placing the stent in the mouth and allowing for approximately two and a half minutes to set, the stent was removed placing finger pressure on one side as the opposite side was peeled off. Because of the use of an accurate impression material (PVS), the cleanup was minimal. A half hollenback and enhance cups (Dentsply Caulk) were used to finish the temporaries. A thin diamond was used interproximally to open up the embrasures cervically and eliminate tissue impingement. The occlusion was adjusted and polished with an enhance cup. A light cured glaze was then placed on the temporaries with a multibrush and light cured. Final inspection of the temporaries revealed great shape and form. The patient was seen three days later for inspection of the temporaries. She felt the length was slightly long and wanted to make that adjustment in the final restorations. That was noted by the lab and the appropriate adjustments were made on the final restorations.

Color mapping was completed and communicated to the lab along with pictures of the shade tabs for lab communication. A blend of 020, 030, 040 (Chromascope-Ivoclar Vivadent) was selected with 040 in the cervical one third, 03 in the middle third and 020 in the incisal third. Light translucency and a halo of white opaque was selected along with the appropriate stump

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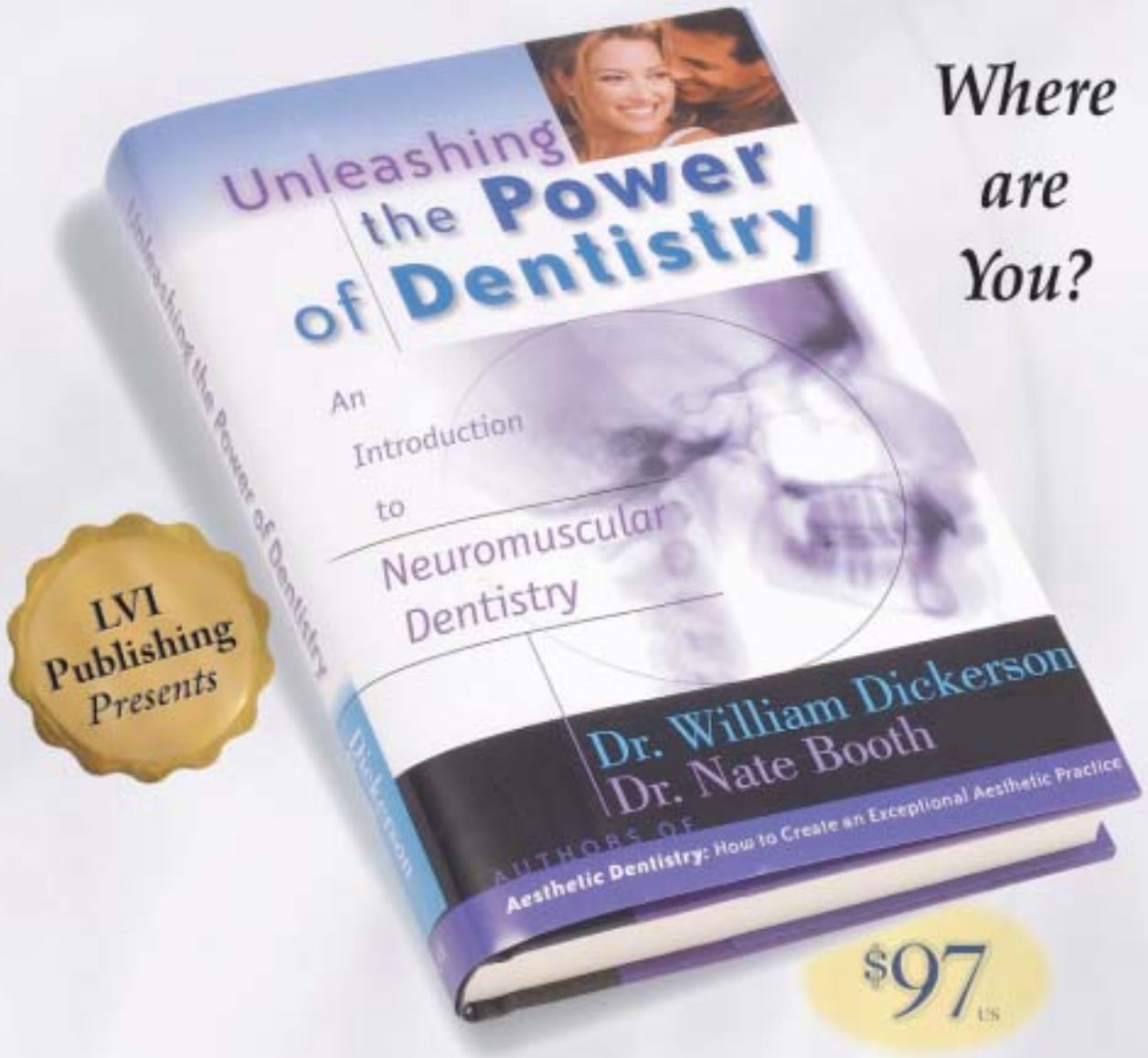

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shades. Due to the tetracycline staining, the lab selected the E020 ingot for maximum aesthetics and opacity.

Four weeks after the prep appointment, the patient returned for the placement of the final veneers. No staining or sensitivity was noted and the patient was eager to receive her final restorations temporaries (figure 9). After anesthetic was administered (1.8 cc 2% lidocaine with 1:100,000 epinephrine x 3), the temporaries were easily removed with a spoon excavator and the teeth were debrided with hydrogen peroxide, rinsed and ready for a dry try-in of the veneers, checking for marginal fit, interproximal contacts, shape, size and contour. Upon my approval, the veneers were filled with a light yellow try-in

Figure 13

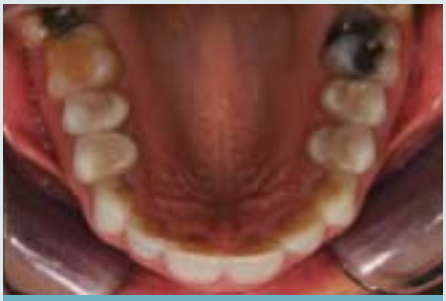

Figure 14

Figure 15

Because of the use of an accurate impression material (PVS), the cleanup was minimal.

paste in veneers 6-8 and a translucent in veneers 9-11(Appeal - Ivoclar). The hue, chroma, value and translucency were evaluated and the patient picked the light yellow try-in paste (6-8). She liked the way the light yellow gave the veneers warmth. The veneers were removed and rinsed with copious water spray and air dried. The veneers were then acid etched (Ultradent) with 37% phosphoric acid, rinsed with copious water spray and air dried. The internal aspect of the veneers were then coated with Kerr's Silane Primer and allowed to air dry.

At this time, a rubber dam was placed and the teeth were cleansed with Consepsis, rinsed with copious water spray, and lightly dried. 37 % phosphoric acid was then applied to the prepped teeth (first on the enamel for15 seconds then 10 seconds on the dentin). The prepped teeth were moistened with Tublicid Red (Global) and the excess wetting agent was blotted off with a multi-brush. The teeth were then coated with four coats of OptiBond Solo Plus (Kerr) and lightly air thinned. Care was taken to make sure there was no pooling of the primer on the margins, facially and inter-proximally before it was light

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FIGURE 16

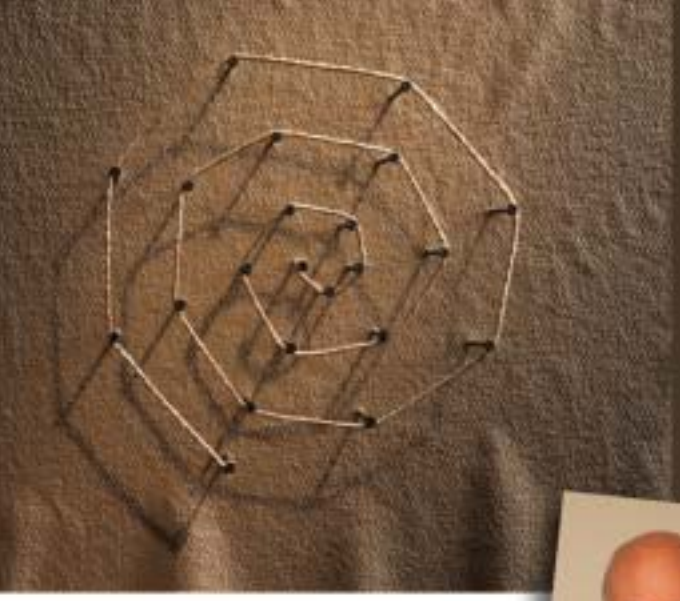
FIGURE 17

FIGURE 18

cured for 10 seconds (Optilux 501 and Demetron LED, Kerr). The veneers were then filled with a luting resin (Appeal - light yellow) and placed on the prepped tooth and gently seated. Excess luting resin was cleaned off using a rubber tip (Butler) and disposable brush, and the veneers were ready to be spot tacked into place (3 seconds facially at the margin and 3 seconds lingually at the lingual margin). Starting with the two centrals, the veneers were firmly seated using finger pressure and the end of a disposable brush pressing incisal-cervically and facial-lingually simultaneously. This allows for proper seating of the veneers and eliminates the possibility of suck-back and potential leakage. Once the two centrals were spot tacked, the veneers were flossed inter-proximally. The laterals and canines were seated next starting with the right side first then the left side. The same sequence was followed when spot tacking the premolars into place. The final cure was performed (40 seconds on the facial, lingual and incisal). Final clean up was carried out by removing any gross excess with a scaler then an enhance cup was used lightly for final marginal clean up. The occlusion was checked and the final polish was completed using porcelain polishing points and cups and porcelain polishing paste. The final inspection by everyone involved revealed a major improvement from the old veneers. (figures 13, 10, 11, 12, 14, 15, 16, 17, 18).

Reviewing a case with old veneers makes one appreciate how far we as a profession have improved in our ability to enhance aesthetics and function. From observing the basic principles of smile design, arch form, tissue symmetry, the routine use of lasers, lab communication and occlusion, we have constantly improved upon and implemented these changes to improve on the outcome of our patients' demands and desires. This constant fine tuning has allowed the dental profession to honestly and realistically meet the demands of an intelligent and sophisticated public. This has helped the profession to eliminate false expectations and to gain a trust in our patients that will propel us to a new level professional growth and satisfaction.

Dr. Timothy C. Adams is a Clinical Director at LVI. He is a graduate of Indiana University School of Dentistry where he taught clinical dentistry for 5 years. He maintained a highly successful, full-time, private practice emphasizing aesthetic-restorative dentistry for 17 years. He followed his dream of teaching and moved to Las Vegas to join the full-time LVI faculty. An enthusiastic lecturer, instructor and author of many articles on the latest aesthetic-restorative procedures, Tim is part of the LVI Faculty practice.



SIMPLE SOLUTIONS TO EVERYDAY ENDODONTIC PROBLEMS

Arthur "Kit" Weathers, Jr. DDS

Having presented hundreds of endodontic programs to dentists from all over the country (as well as overseas), I've noticed that certain questions come up repeatedly. I'd like to share some of the most common endodontic questions about problems encountered doing root canals, along with the solutions to these problems.

How can I tell which tooth is causing the pain?

If no tooth is positive to percussion, tap harder, and then harder still. Endodontically involved teeth almost always feel differently to percussion than teeth with normal pulps. If more than one tooth is positive to percussion, the tooth that is most positive is the one to treat first. It is possible that both teeth need endodontic treatment.

Multiple maxillary posterior teeth testing positive to percussion is an indication of sinusitis – pain not coming from a tooth. Additional signs that pain may be coming from another source include no history of thermal sensitivity and a history of multiple visits to a dentist and/or physician for the problem.

If the patient has taken analgesic medication prior to the visit, this medication may be camouflaging test results. Have the patient return the next day, this time without taking any medication for six hours before the visit.

If the patient complains of pain to cold, duplicate this symptom. Use EndoIce (Endoco) or Component Cooler from Radio Shack. If the patient complains of pain to heat, isolate individual teeth under the rubber dam and bathe them in hot liquid.

Find a cracked tooth with a Tooth-Slooth (available from EndoSolutions). It allows the patient to bite on one cusp at a time.

What happens when I can't make out the working length on my radiograph?

Digital radiography, such as the Dexis Digital Radiography system that I use, makes retakes a snap. The image is displayed four seconds after pushing the button. With digital imaging, the contrast and brightness can be easily adjusted for optimal viewing. Digitally viewing the image in the positive mode often makes the position of the file in the canal easier to discern.

I recommend using an electronic apex locator (EAL) in all cases, and if its reading is different than what the X-ray suggests, in most cases, I would trust the EAL.

A #15 file can be easier to distinguish on a film than a #10. Always use the largest sized file that will go to the length you want. Using a larger file will also help eliminate errors when using an electronic apex locator A file that is too small may not contact the periodontal ligament as it exits the apical foramen, leading to inaccurate readings.

Adjunctive alignment devices, such as the Endo-Ray, can make taking radiographs underneath the rubber dam easier.

For conventional x-rays, proper processing is essential. Make certain the KVP is set high enough and that the processing solutions are fresh

The #9 "butterfly" clamp can be used on any tooth in the mouth with two slight modifications. Bend the jaws until they line up, and enlarge the lingual hole slightly to make it easier to get on and off the tooth.

What can I do when the tooth won't get numb?

For a mandibular block, first verify that you've "hit the block." Ask the patient if the lower lip feels fat on the side of the block. The lower lip must feel fat not only on the corner (which indicates anesthesia only of the long buccal nerve), but all the way to the middle.

For maxillary teeth, give more than just an infiltration of the individual tooth. For posteriors, inject extremely posterior, where the third molar would be. Also inject in the area of the palatal apex. For anteriors, inject high above the canine.

The Oral Light is perfect for transilluminating the tooth to diagnose cracks or help locate canal openings on the pulp floor.

An Intraosseous System, such as X-tip or Stabident can be an invaluable aid in anesthetizing "hot" pulps – pulps that remain sensitive even after other signs of numbness are evident.

If you give an intrapulpal injection, use a 30-gauge needle, and inject with as much force as you can. The pressure anesthetizes the pulp.

What if I can't get the rubber dam on?

The rubber dam can be installed on any tooth in the mouth by utilizing one of only three clamps (12A, 13A or #9). The #9 is a universal clamp, and it will fit any tooth, posterior or anterior. If there is not enough tooth structure to clamp, clamp deep on the gingiva. I recommend punching a single hole in the dam and slipping it over the tooth prior to placing the clamp.

What if I can't find the pulp chamber?

Stop and consider anatomy. If there is a single canal, the pulp chamber will be in the exact center of the root. Look at the CEJ encircling the tooth. Aim your bur for the center.

Use a periodontal probe around the entire tooth to get a better idea of root angulation and contour.

The mesial-buccal canal on an upper molar is usually located directly beneath the mesial-buccal cusp. It may be necessary to remove this cusp.

The distal-buccal canal on an upper molar is most often found in the center of the tooth. Pre-curve the tip of a stainless steel file to help enter it.

Transilluminate the chamber with an instrument such as the Oral Lite by EndoSolutions. Hold the light on the side of the tooth rather than shining it directly into the access. Orifices will appear as dark spots if they have already been uncovered.

If the pulp chamber is calcified, the PulpOut bur from Essential Dental Systems (EDS) will eliminate any possibility of going too deep and entering the furcation area.

What are my options if I can't negotiate the canal?

Pre-curve the tip (and only the very tip) of a small stainless steel K-file. Number 10 files are usually best, but in rare cases, a #8 or even a #6 may be necessary. The five-sided

The PulpOut bur has a plastic stop to prevent perforation into the furcation area. It is especially effective when the pulp chamber is calcified.

EndoMagic! stainless steel handfiles (EndoSolutions) work especially well in certain smaller canals due to the fact that they're slightly stiffer than most handfiles.

Some rotary files can negotiate certain canals even better than hand files. The #1 EndoMagic! or Hornet rotary file is a good orifice opener, but the #2 can be even more useful in negotiating difficult canals. Although the #2 is equivalent in size to a standard #15 hand file, its cutting tip can negotiate some canals that cannot be negotiated by hand.

What do I do when I've ledged and I can't get around it?

The only way to bypass a ledge is to pre-curve the tip of a small stainless steel hand file and "watch-wind" it back and forth until it finds a place to go. Once you bypass the ledge, do not remove the file, but use it for several minutes to smooth the ledge. You can then proceed with larger files and progress to rotary files. The EndoGripper reciprocating handpiece from EndoSolutions can greatly speed up the process of bypassing and enlarging the area of the ledge.

What do I do if I'm short of the working length, and I've blocked myself out?

Hand-filing techniques using K-type files tend to pack debris in the apical area. When filing by hand, it is important to recapitulate (go to length with a small file) and irrigate frequently. Once the canal is blocked with debris, the only treatment is to use a pre-curved, small stainless steel hand file to attempt to renegotiate. Rotary techniques tend not to pack debris apically, but instead can very easily go further than the length desired.

What do I do when I separate an instrument?

First, calm down. Broken instruments seldom cause the failure of a case. Be certain to explain the incident to the patient before the patient leaves the operatory, but not immediately after the breakage occurs.

Removing separated instruments is beyond the scope of this article. If you have a good relationship with a specialist, he or she can handle the case and reassure the patient.

How do I treat perforations?

Regardless of subsequent treatment, perforations dramatically decrease the prognosis of the case. Although perforations are not initially painful, a periodontal defect will eventually develop.

If a perforation does occur, it should be repaired immediately. Mineral Trioxide Aggregate, or MTA, is the most effective material currently available for repairing perforations. Older, more standard techniques include placing dry calcium hydroxide powder followed by a glass ionomer or composite core material.

Inform the patient that an extra hole was created while searching for a canal, and explain the alternative treatments that can be pursued (treating and observing, extraction and replacement, or referring to a periodontist or endodontist).

No single article can address all the potential problems that can arise during endodontic treatment. I hope that the solutions presented will be helpful to you if you encounter the problems mentioned in this article.

The safe-ended, PulpOut Diamond is a great instrument for enlarging and refining the access cavity.

ARTHUR "KIT" WEATHERS, JR. DDS

For more than thirty years, Dr. Kit Weathers has lectured and published papers on technologies, products and processes designed to simplify the practice of endodontics. Dr. Weathers pioneered a simplified system of nickel titanium files to enhance patient comfort with a one visit endodontic procedure. His popular Endo Root Camps, presented at L.V.I. and the C.E. Magic! multi-media learning center in Griffin, Georgia, offer multi-day hands-on training to improve dental techniques while explaining the theory of "Endonomics," the economics of endodontic case management.

Dr. Weathers can be contacted at 770-227-3636, or by e-mail, at drkit@ce-magic.com. You can also visit his website at www.CE-Magic.com.

Secrets to the Successful Practice

Josh Bernstein, DDS

Would you like to drop insurance and provide state of the art treatment on fewer patients who are willing to pay premium fees?

Would you like to have a practice that is less stressful, more rewarding and more profitable?

You may have heard of practices like this and thought of a variety of reasons why this kind of dream practice would never work for you. The fact is that many dentists pursue their dream practice - and they succeed. What is the secret to their success? While each dentist's vision of an ideal practice is different, there are certain elements that are consistent among the most successful practices. In traveling to many of the most successful practices, I have uncovered many of their secrets.

A commitment to excellence is the driving force behind every successful dentist and it begins with continuing education. LVI has the educational resources to transform the new dental school graduate - or even a 20-year dental veteran - into an expert. I often have the privilege of meeting with new dental school graduates that visit my office and my advice is always the same - "Don't start out your career as a beginner. Start out as an expert." If educational programs such as LVI existed when I was a new graduate, the smartest thing I could have done would have been to take the entire curriculum before going into practice. Post-graduate education is hardly exclusive to new graduates, however. It is mostly the seasoned veterans who appreciate the value of what these programs have to offer and many have gone through major transformations well into their careers. I visited the practice of a "retiring" Lake Tahoe dentist in 1985. That dentist has recently taken nearly the entire curriculum at LVI and now, 20 years later, he is still practicing. The point is to always keep learning so you can provide your patients with the best possible care. Your dream practice will be built with patients who value excellence.

Perceptions shape each individual's reality and this is especially so in the exceptional facility you will need for your dream practice. Consider the differences between a carnival and Disneyland, a used car lot and a Lexus dealership, a barbershop and a Rodeo Drive salon, Motel 6 and the Ritz Carlton. Your office must evoke a feeling of quality for

Perceptions shape each individual's reality and this is especially so in the exceptional facility you will need for your dream practice.

every "guest" that visits. Consider every detail carefully. Your office is the stage for your performance. The most successful offices are very visually appealing in a way that is unique to each dentist's style while being mindful of who the audience is. In many areas, the successful, female baby boomer is a primary target market so the office is designed for them. Remember to consider the perfect background music, comforting textures and colors and relaxing aromas such as lavender. Be creative to allow your guests to indulge in luxurious surroundings that differentiate you from the average office. It goes without saying that you must have the latest in technology. A word of caution: just because you build it, doesn't mean they will come. Do not overspend your budget, and pay careful attention to the other secrets to the successful practices.

If it has been done before, it is probably possible.

Outstanding customer service is a hallmark of the successful practice. You and your team must be genuinely warm, helpful, friendly, and professional. Re-read the previous sentence. No one can fake being genuine. I have had technically competent people in my office that chased off a lot of business because they were unfriendly or moody. You must differentiate your practice from the old fashioned stereotypical dental office. Otherwise, how will anyone perceive the increased value of your practice? Oftentimes, the patients have no idea how superior your dentistry is, but they absolutely know how it feels to be treated as though they are flying first class. There are many ways to do this and many resources to learn about it. A few basic points to get you started are:

- Run 100% on time – but if you're behind, apologize and tell your patients when they will really be seen.
- Call your patients after treatment
- Offer movies during treatment
- Be polite and friendly to all
- Write thank you notes
- Be a good listener
- Greet your patients immediately upon arrival
- Always escort them in the office
- Keep only brand new magazines
- Serve refreshments
- Provide an "exit tray" with hot towel, Advil, post op instruction sheet
- Keep your office clean and uncluttered, especially the bathroom
- Have plenty of giveaways

Walt Disney said, "The guest is not always right, but the guest is always the guest." Imagine how Walt Disney would have you treat your "guests." Visit hotels such as The Ritz Carlton, stores such as Nordstrom's, then discuss how you can implement the outstanding service these top businesses provide. Even if you are still developing your clinical skills, you can immediately begin providing great service.

Insurance is a form of marketing that you must replace with other marketing if you ever hope to eliminate insurance from your practice. And if you have a distaste for marketing, consider the marketing messages the insurance companies are using:

• Dentists are all the same.
• Dentists charge too much.
• Dentists recommend unnecessary treatment.
• The insurance company will protect the patient from the dishonest dentist.
• The insurance company will help you find a "preferred" dentist.

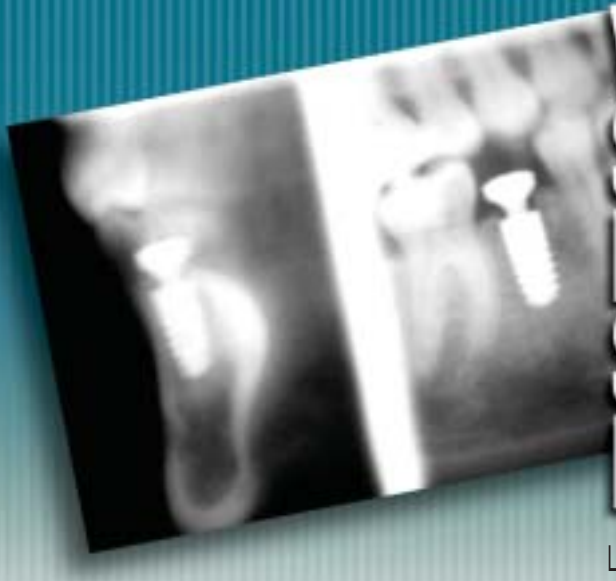
It is advisable to have a successful marketing plan in place well before you ever consider dropping insurance. The most successful practices are investing 5-10% of their monthly budget on marketing. LVI graduates are incredibly fortunate to have the LVI Branding Campaign available to them in this effort. The LVI Branding Campaign is a revolutionary concept in dentistry. Many graduates have agreed to pool resources to brand LVI dentists as the source for smile makeovers. Savvy dentists are marketing locally in conjunction with this campaign to maximize return on their marketing investment. It only takes a few big cases each month to meet even the loftiest production goals. Nevertheless, to get those few big cases, you need to aim for 100 new patient phone calls every month. A successful marketing plan will get you the qualified calls you need.

When those calls come in, there are a few things to remember besides great service in order to get the cases. You can't be everyone's dentist, so choose your cases wisely. It takes time to create value, but some patients simply don't value their teeth. Move on to the next prospect. When you do get a great prospect (an "A" patient), many patients require time to come to trust you, so beware of presenting a big treatment plan and a big fee during the first visits. Wait until "after a thorough diagnosis." There are exceptions to this rule, such as quick decision makers who know your reputation and are ready to schedule a straightforward treatment plan. Most often, it takes a number of visits before the doctor patient relationship has developed to the point where the patient will accept a comprehensive treatment plan and write a big check.

Lastly, the most successful dentists "practice what they preach." The dentists and their teams have healthy, beautiful teeth, gums, muscles and TMJ's. After all, how can you expect your patients to accept your treatment proposal if you have your own dental problems? Personally, when I had Bill Dickerson restore my mouth, I learned a lot, my TMJ problems were solved, and my teeth turned out beautifully. Almost as important, my enthusiasm for the treatment I recommend to my patients skyrocketed along with my credibility.

Dr. Omer Reed said, "If it has been done before, it is probably possible." Many successful dentists are living their dreams every day. Creating your dream practice is absolutely within your reach - all you have to do is take action starting today.

Dr. Josh Bernstein is a Clinical Instructor at LVI. He is a nationwide author and lecturer and was recently awarded "Dental Practice of the Year" by the Richards Report. Dr. Bernstein has a private practice in Piedmont, California, emphasizing cosmetic dentistry, TMD, full mouth rehabilitation and sedation, with a focus on outstanding customer service. He can be reached at jbbdds@hotmail.com.



WHAT'S STOPPING YOU FROM BEING SUCCESSFUL WITH DENTAL IMPLANTS?

Leo J. Malin, DDS

Dental implants have become the "Standard of Care" for missing teeth worldwide. Each year there are more implants placed and restored than there were in the previous year. This growth rate has been estimated to be at 10% to 15% each year. Patients are becoming more educated about the possibilities of implant treatment as a solution to their clinical cases and are requesting implant dentistry. The dental profession is challenged to provide optimal care for these patients. Unfortunately, many dental professionals choose alternative treatment options for their patients simply because they are not prepared to provide this service or they don't believe they can control the outcome of implant dentistry. We, as a profession, need to accept this challenge and prepare ourselves to provide optimum care for our patients - it is in our duty and privilege to provide this care for our patients.

The majority of dentists in this country and abroad are not involved in implant dentistry. Why? What are the barriers in implant dentistry that keep many in our profession from providing this fantastic service? Ask yourself the question, "If I was missing a tooth or teeth, would I rather have an implant supported restoration, a bridge, or a partial?" The answer to that question should determine your involvement in implant dentistry. Offer and treat others as you would prefer to be treated. This is our responsibility as dental professionals.

I have been given a unique opportunity at LVI to develop and teach an implant curriculum. We always start the course by asking each doctor in attendance, "What is stopping you from being successful in implant dentistry?" The top five responses are:

1. ***I feel a lack of control during the implant process***
2. ***The implant process is too complicated***
3. ***I sometimes get poor aesthetic results***
4. ***The treatment times are long***
5. ***I feel there is a lack of training opportunities***

It is my intent to remove these five barriers to success. With the appropriate treatment plan and diagnostic tools, implant dentistry can become extremely predictable and reliable. All one has to do is simplify the process and control the case to ensure optimal clinical results.

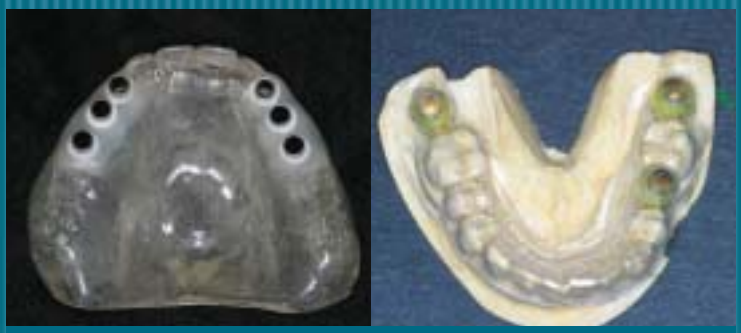
The implant process is complicated, out of control and lacks aesthetic outcomes only when there are unknowns in the process. The fundamental question that has to be answered first and foremost is "where do I need the final restoration and do I have the proper bone to place an implant in optimum position to support

that restoration?" Both of these questions have to be answered prior to doing any surgery. Unfortunately implants are often placed in less than optimal positions because the focus on bony structure leads to an inappropriate implant placement selection. The improper implant placement is often not discovered until the final restoration is fabricated. With improper implant placement comes two major negative results:

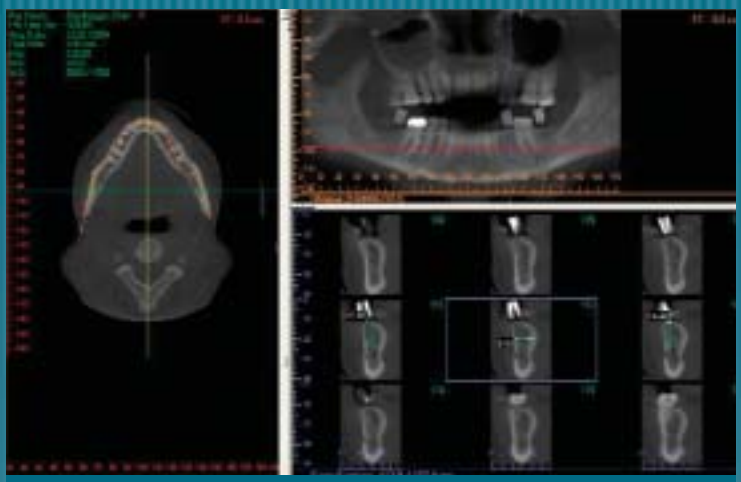
- limited function due to improper occlusal forces acting on the restoration
- poor aesthetics.

The proposed restoration should dictate where and at what angle the implant should be placed. Implant orientation should not be determined solely by bone availability. A common complaint that I've heard from general dentists is that they don't get back from the surgeon (implant placement) what they expected. Fundamentally what they were saying was that the communication between the general dentist and the surgeon was not adequate, therefore the diagnosis, subsequent treatment plan, and surgical processes were flawed.

Two things are required in order to guarantee proper position of every implant placed. First, an adjustable surgical stint is required. Second, the surgical stint must be used when taking the appropriate radiographs to evaluate the proposed site. That radiographic evaluation needs to be either a tomographic x-ray or a CT scan to determine all three dimensions of the implant site. This adjustable surgical stint and three-dimensional view of the implant site removes all of the unknowns associated with the implant site. This protocol is a

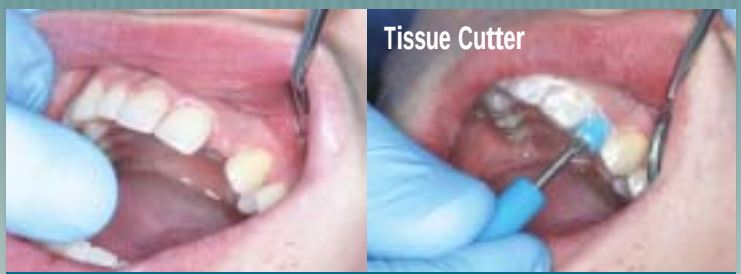


Fabricate Surgical Stint with Adjustable Guides.

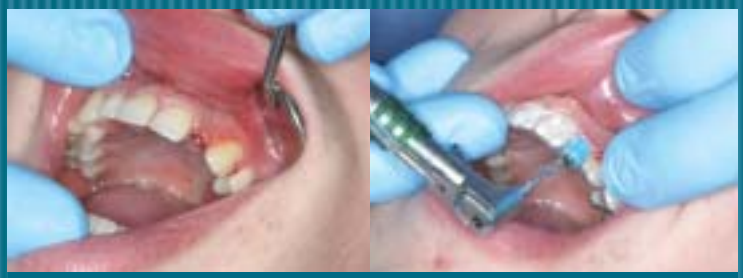


Determine Placement Angle and Select the Implant Size using a 3 Dimensional View of Each Implant Site.

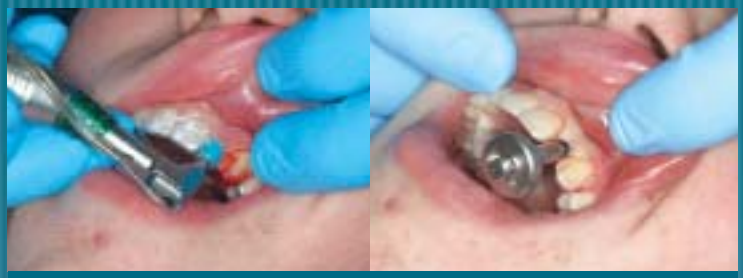
Implant is Placed.



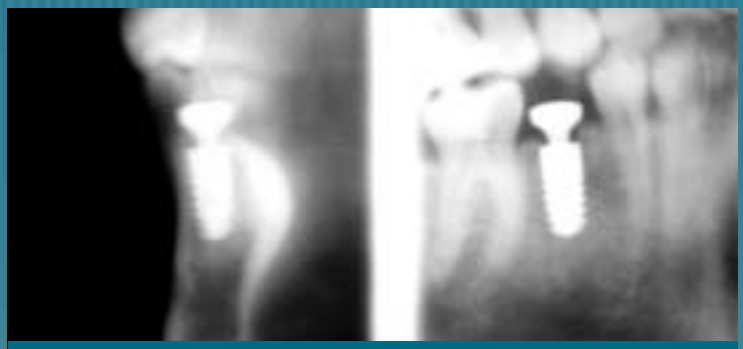
Single Implant Case Presentation Example.



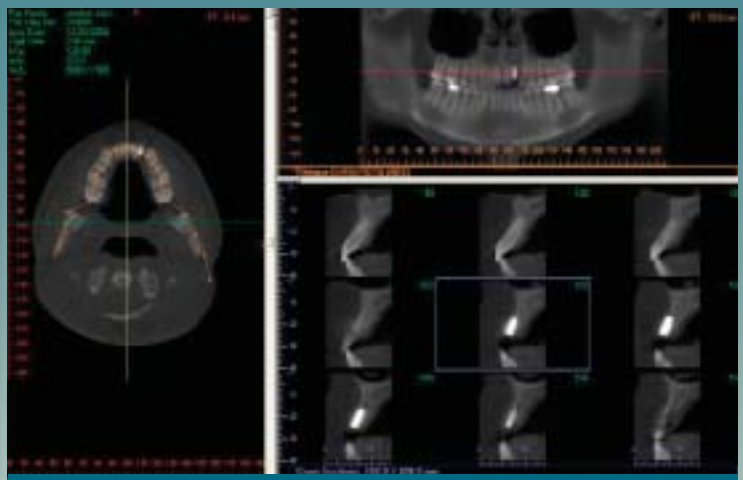
Remove Tissue Tag. Prepare Osteotomy.



Enlarge Osteotomy and Place Implant.



Verify Final Placement. Ankylos Subcrestal Placement Protocol.



Verify the final placement with a CT scan showing the implant placement.

complete blueprint to a successful aesthetic and functional implant result. It takes away all surgical surprises and guarantees proper placement. A surgical stint that is made on a model and not related to the underlying bone by the use of three-dimensional radiography is an inadequate stint and destined for disappointment. In short, the surgical stint is the guide to success. It absolutely has to be both constructed appropriately and used effectively. The surgical stint ties the implant and restoration to the bone and opposing occlusion in its most optimum position.

An additional advantage of this guided surgical process is that it is completely reproducible whether you are treatment planning a single implant or performing a full mouth implant reconstruction. Furthermore, since all the unknowns have been discovered and accounted for prior to surgery, laying a surgical flap is reserved for bone grafting or bone recontouring situations only. A punch technique for implant placement is the preferred method if proper treatment planning has occurred prior to surgery. This type of surgery is much less invasive, less traumatic, and of short duration. Post operative pain is almost nonexistent when surgical flaps are not required.

The time required to place and restore implants is also a concern for patients and doctors. Implant dentistry requires some additional treatment time to obtain optimal results. In cases where there is inadequate hard and soft tissue available to support an implant, treatment times will be extended to enhance those missing tissues. It is appropriate to ask for help from dental

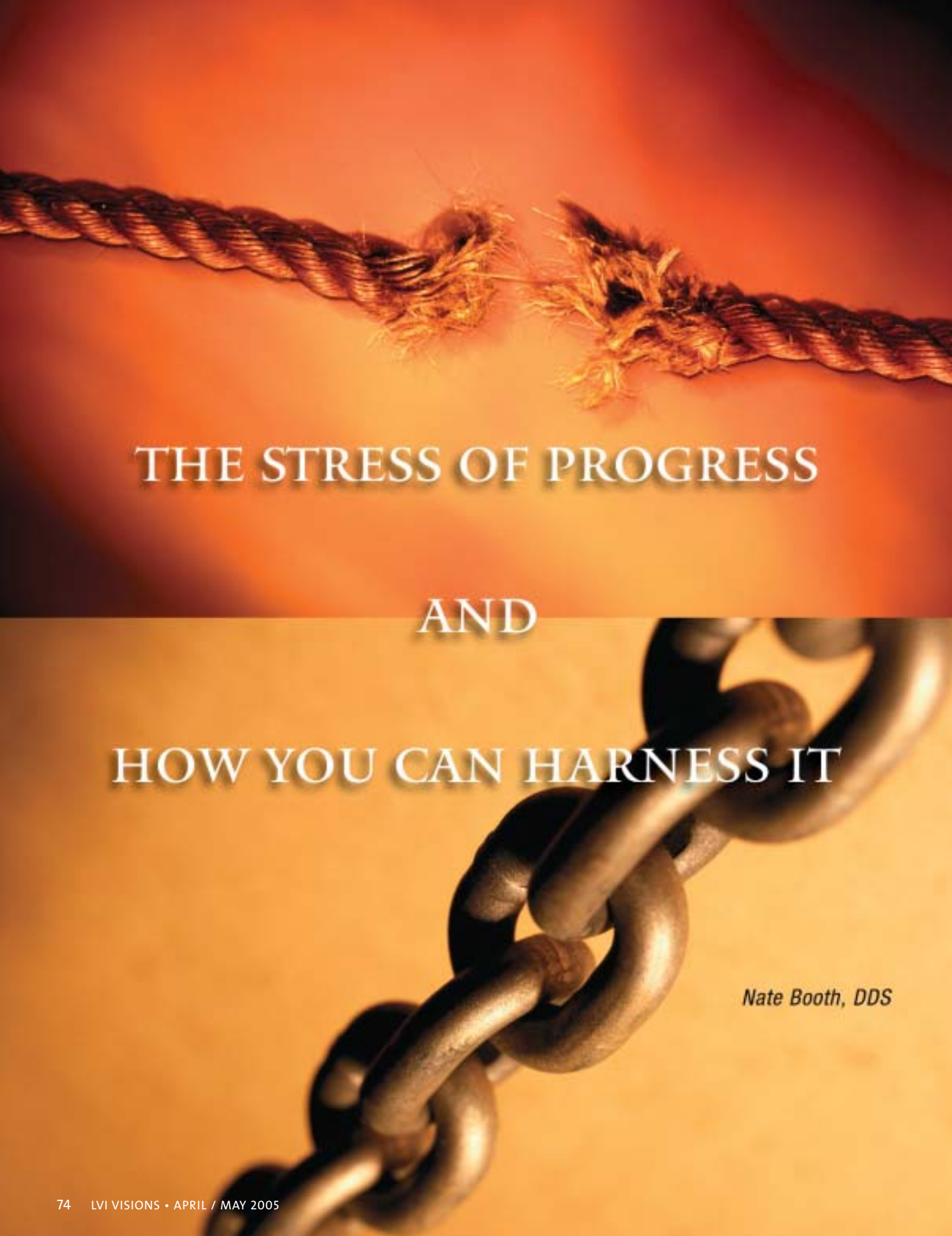
specialists if providing hard and soft tissue support is outside your comfort range or ability. A dentist should never provide services for patients they do not feel comfortable performing. However, that fear or inability should not exclude a patient from receiving optimum care when that patient desires it. Diagnostic tools are available today which help us very accurately assess patients limitations prior to treatment. Treatment disappointments will be avoided with the proper diagnostic protocol.

In my opinion, it is time for our profession to accept this implant challenge and encourage optimal clinical solutions for all our patients.

Many cases that have adequate hard and soft tissue can be immediately or early loaded following implant placement, dramatically reducing treatment time. Implant dentistry is not always the fastest treatment, but it is often the best clinical treatment. We as a profession should be obligated to provide that treatment modality to our patients. Our fears, disappointments and confusions should not limit the majority of the dental population from ideal treatment. If dental implant therapy is an appropriate treatment at offices nationally and internationally, would it not be appropriate in your office? Implant dentistry has been determined to be the standard of care; furthermore, we are required to offer this service to our patients. It makes sense that we as dental professionals need to get ourselves prepared to perform that standard of care. In my opinion, it is time for our profession to accept this implant challenge and encourage optimal clinical solutions for all our patients. Informed patients are asking about implants as solutions. Our fears, confusions and concern about control should not keep them from receiving ideal treatment.

There are many training opportunities around the country to help you get involved in the implant process. If you leave an implant course more confused than when you came, you are less likely to provide implant services for your patients. We at LVI want to give you an implant protocol that allows you to simplify the implant process and gain complete control of the case before you begin. Control removes the unknowns and disappointments that are associated with dental implants.

Dr. Leo Malin graduated from Marquette University in 1991. He maintains a private practice in LaCrosse, WI, where he has been utilizing occlusal based dental concepts since 1998. With the help of other experts in the fields of radiology and occlusion, he has developed an implant placement technique which focuses on occlusion (and cosmetics) for implant placement and crown restoration. Dr. Malin lectures throughout North America on full mouth reconstructions and implant placement.



THE STRESS OF PROGRESS AND HOW YOU CAN HARNESS IT

Nate Booth, DDS

I travel around the country and meet dozens of stressed out dentists each year. I often have a conversation with SOD (Stressed Out Dentist) that starts something like this. "Nate, I'm making a lot of changes in my office right now. All in all, things are going well. I'm making good progress. My numbers are improving, but I'm really stressed out. I thought it would be easier than this." From three angles, let's take a look at why SOD is stressed out as he's making progress in his practice, and what he can do to harness the stress.

Angle #1: Stress Level

There's no doubt about it, SOD is feeling some pressure. But is this good or bad? According to the father of stress medicine, Dr. Hans Selye, there are three levels of stress.

1. **Hypostress.** This is not enough stress. People who have too little stress in their lives are either dead or deadbeats.
2. **Eustress.** This describes the kind of stress that fuels us to be more, do more, have more and give more.
3. **Distress.** This is the point where stress is so high that it diminishes health and impairs behavior.

Take a look at the diagram to see this laid out visually. The vertical axis measures Long-Term Effectiveness, and the horizontal axis indicates Stress Level. Hypostress occurs in Zone 1. Eustress occurs in Zone 2. Distress occurs in Zone 3. Where do you think SOD lies on the bell curve? He's definitely becoming more effective in his practice, but his stress level is becoming a source of concern. Most probably, it's slightly on the downhill slope of the Eustress Zone. I've marked the spot with an X.

What can SOD do to lower his stress level? He could:

1. Slow down the pace of his restaffing, retooling, restructuring, remodeling, re-educating, reorganizing and brain rewiring. That would pull back his stress level and increase his long-term effectiveness. Creating the practice of your dreams is a marathon, not a sprint. If you're running a marathon, you don't want to push yourself so hard that you become exhausted in the middle of the race.
2. Work smarter by getting a coach. A coach can help improve performance with effectiveness-enhancing advice. Tiger Woods has a coach. Michael Jordan had a coach. Dentists need coaches too.
3. Increase his stress tolerance with exercise, meditation, proper nutrition and supplements. Far too many dentists attempt to cover up their stresses with all sorts of mind-numbing substances and activities.

Angle #2: The Three Stages of Change

SOD's stress also comes from dealing with significant changes in his practice. I know something about change; I've presented a program called Thriving on Change: The Art of Using Change to Your Advantage to over 500 audiences world-wide. I believe there are three stages of change:

1. Letting Go of the Old
2. Transitioning Between the Old and the New
3. Embracing the New

Stage One: Letting Go of the Old. As strange as it might seem, the starting point of all change is an ending - the ending that you have to make to leave behind the old way of doing things. Trapeze artists have to be effective change artists. Their lives depend upon it. They swing on bars high in the air, but in order to do their tricks, they have to let go of the first bar. Letting go of the bar in the circus tent or in life happens in a second, and even though it's quick, it's not easy to do. It takes guts. It takes a decision, a word whose Latin root means to cut away.

Stage Two: Transitioning between the Old and the New.

This stage is the limbo period between the old and new ways of doing things. It's always a time of great emotional intensity. It can also be the time of the greatest creativity and growth because there are no solid attachments. In Stage Two the trapeze artists — and you — are flying through the air.

It's interesting to watch people as they fly through the air in life. Some people are constantly looking back at the old bar ("the good old days"). But if they look back, what are their chances of catching the new bar? Zippo. Some people are always looking down at the ground because they're afraid of what will happen if the transition isn't successful. What are their chances of catching the new bar? Nada. But what do all successful trapeze artists do as they're somersaulting through the air? They check out the new bar with every rotation. They keep their eyes on the goal. That's why all successful change artists must have a vision for themselves and focus on it daily.

Stage Three: Embracing the New.

The first stage of change is an ending. The last stage of change is a beginning. The trapeze artist has released the old bar. He's flown through the air with the greatest of (un)-ease. He's a doer, not a watcher like the people in the audience. He feels exhilaration and freedom instead of the boredom and butt blisters of the bench-sitters. Now the artist can finally catch the new bar and ride on it for a while. But guess what? Pretty soon he'll probably want to release it and soar toward a new bar of his own choosing.

In which of the three stages do you think SOD is now? It's pretty obvious he's in Stage Two, Transitioning between the Old and the New. He's released the old but hasn't fully embraced the new, yet. Sometimes SOD longs for the good old days even though he would never go back. He needs to focus on his vision, keep flying and catch the new bar.

Angle #3: The Effort/Reward Ratio

On the path to their dream practices, dentists expend effort and receive rewards. The Effort/Reward Ratio will vary depending where they are on the path. At the beginning, they expend ten units of effort and receive one unit of reward. Most dentists give up at this point. They say to themselves, "It's not worth it! This is too much effort and not enough reward. I must be on the wrong path. I'm going back to where I started. It's safer and easier there." They don't realize that if they just keep moving forward, their Effort/Reward Ratio will improve.

Halfway down the path, they expend five units of effort and receive five units of reward. Now, it feels like the quest is worth it. They also discover that the effort/reward ratio improves the more they focus on their dreams and keep moving toward their realization.

At the end of the path, they expend one unit of effort and receive ten units of reward. All their effort is paying off handsomely; they've finished their quest and are reaping the rewards. Some people may look at them jealously and say, "That's not fair. Look at all they're receiving with so little effort!" The critics don't realize all the effort these dentists put into the beginning of the journey.

If it were easy, everybody would be doing it. If it were easy, the rewards at the end of the road wouldn't be as compelling. If it were easy, they wouldn't keep growing as dentists and as people.

Where do you think SOD is on the path to his dream practice? He's probably at the beginning of the journey. His effort level is about 8 and his reward level is about 2. He's made good progress and there are many more steps to be taken. Now, SOD needs to:

- Appreciate all he's achieved to date.
- Associate with the other dentists who are marching on the road with him. All the dream questers are there to support each other.
- Ignore the complaining and jealous dentists who are sitting on the side of the road.
- Continue to learn and grow so he becomes a more effective quester
- Relish the challenges he inevitably will face along the way. After all, challenges are life's way of letting him know he's making progress.
- Keep his gaze firmly on his goal of a great practice.

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I admire the SOD's of the world. They're the ones who move dentistry forward. They keep putting one foot in front of another because they know there's a better way to practice dentistry, a way that gives their patients, their teams, their families and themselves better lives. Their journeys aren't easy, but easy isn't all that it's cracked up to be. If it were easy, everybody would be doing it. If it were easy, the rewards at the end of the road wouldn't be as compelling. If it were easy, they wouldn't keep growing as dentists and as people.

I hope you see that SOD's present situation is just a stage that he (and maybe you) are going through as you march down the path of life. I hope you realize that he and you must keep marching. The practices of your dreams await you.

Dr. Nate Booth is the author of the books, Thriving on Change, The Diamond Touch, and 555 Ways to Reward Your Dental Team. With Bill Dickerson, he is the co-author of the book, How to Create an Exceptional Aesthetic Practice. His in-office, video-based training program, The "Yes" System: How to Make It Easy for Patients to Accept Comprehensive Dentistry has helped hundreds of dentists do more big cases. Through his telephone coaching program, Nate assists dentists in creating the practices of their dreams.

M E T A M O R P H O S I S • *Continued from Page 48*

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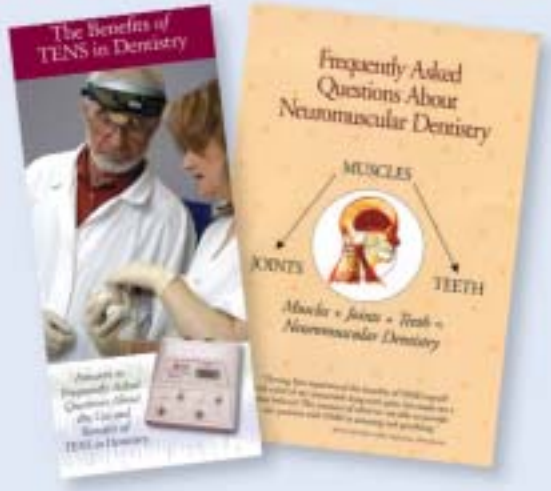

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