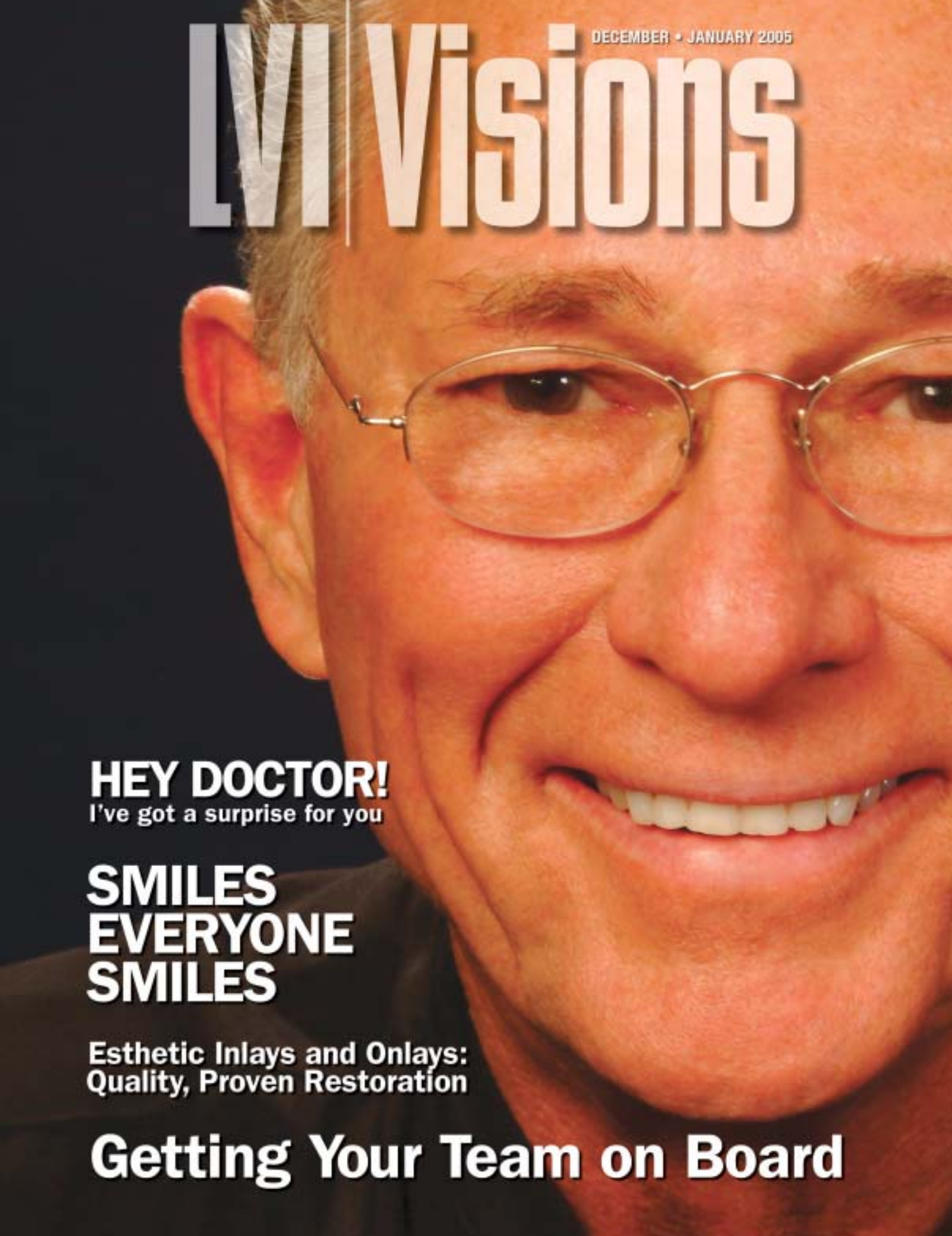
LVI Visions
DECEMBER • JANUARY 2005



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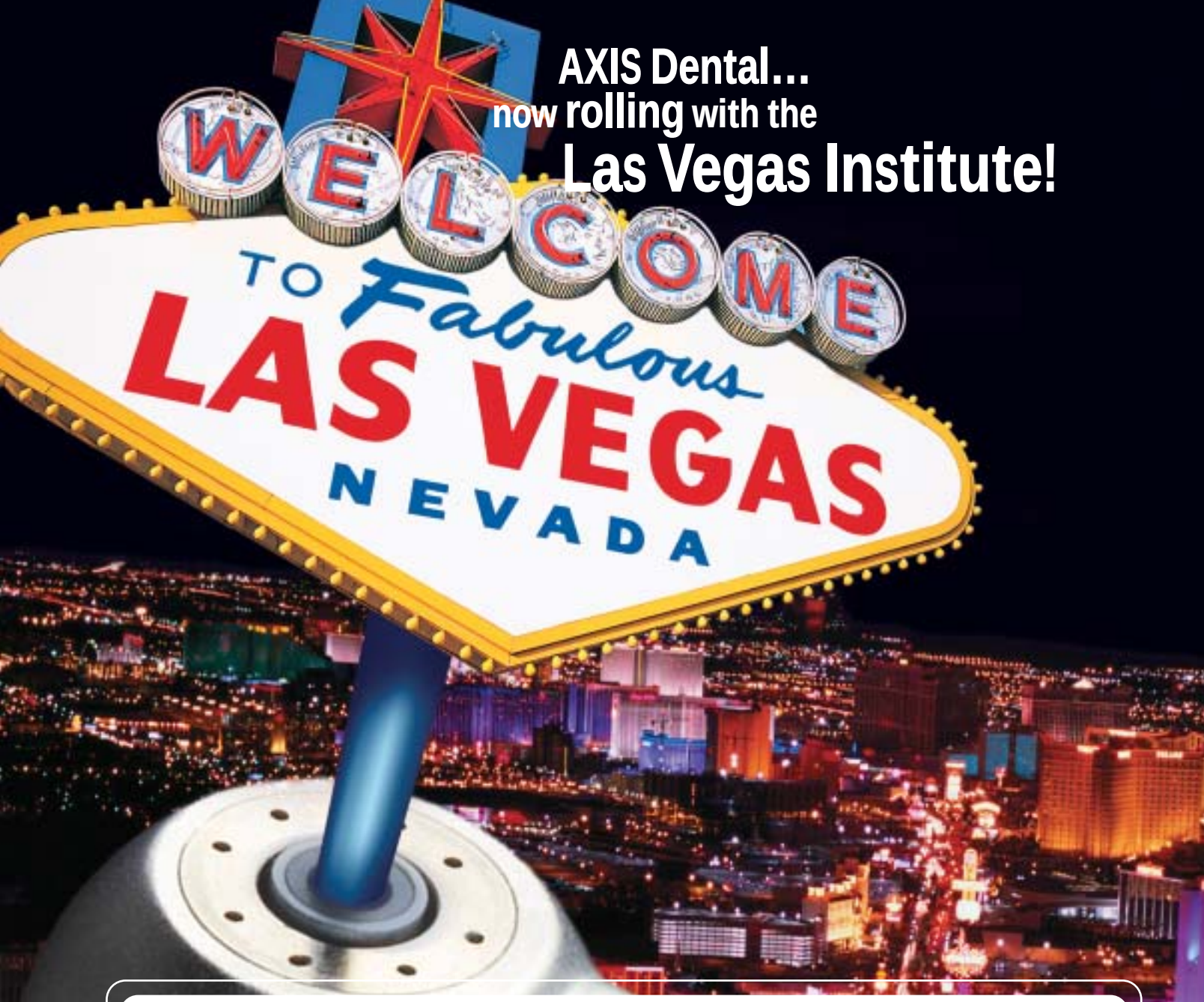

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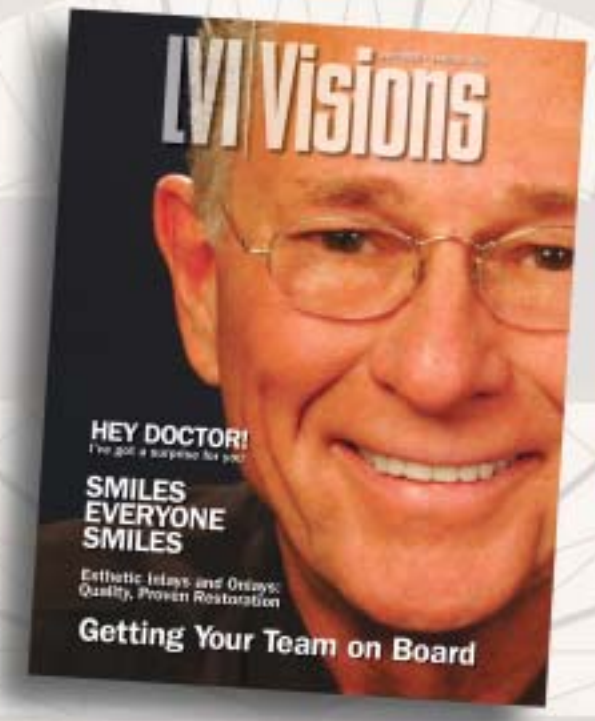

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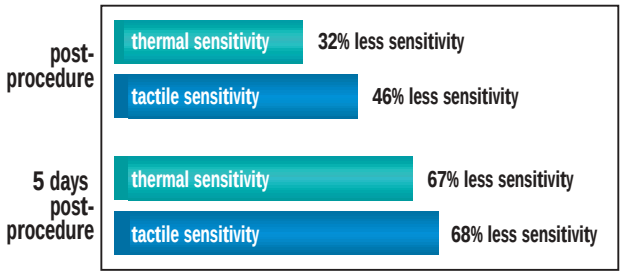

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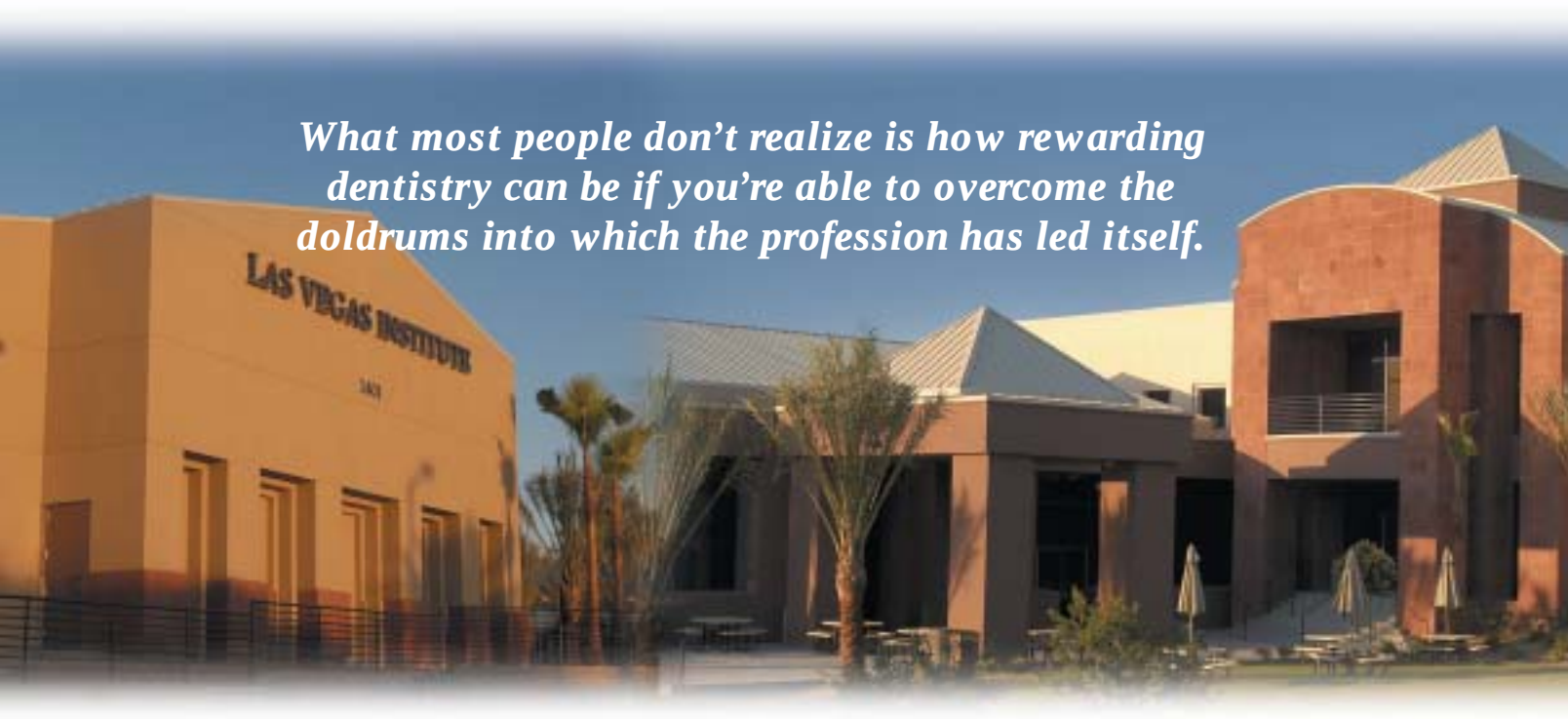


What most people don't realize is how rewarding dentistry can be if you're able to overcome the doldrums into which the profession has led itself.

EDITORIAL • **BY WILLIAM G. DICKERSON, DDS, FAACD, LVIM**

LAS VEGAS INSTITUTE *for* ADVANCED DENTAL STUDIES

Where Is Your Practice Headed?

The dental profession has suffered a serious devaluation and we have no one but ourselves to blame. Several years ago, Forbes magazine ran a cover story titled "Why Everyone Is Smiling But the Dentist." Why so glum? Dentists' incomes had not kept up with the price of inflation since 1972.

Yet, at the same time, organized dentistry actually bragged about dentists' incomes like it was some badge of honor. Does that make sense? Consider this: How many trade unions would boast that its members' incomes did not keep pace with the cost of living? If one did, the union president would be out of office as fast as you can say, "Teamsters." But it seems dentists keep being led around by the nose and made to feel guilty if they desire to be successful by any other industry's standards.

How many trade unions would boast that its members' incomes did not keep pace with the cost of living?

Dentistry is a tough business. Of those who feel drawn to it, most don't pursue it because of the cost in the early years, and compensation for the average dentist is at best, mediocre. Calculate the real return on investment of becoming a dentists by subtracting all the expenses (loss of income for four years, practice start-up costs, tuition, etc.), and according to the ADA's figures, the average dentist's hourly salary is pathetic. For this reason, the best and brightest don't usually consider our great profession any more.

What most people don't realize is how rewarding dentistry can be if you're able to overcome the doldrums into which the profession has led itself. Some of the most miserable people I know are dentists, but some of the happiest people I know are also dentists. What is the difference between these extremes? It's attitude and practice philosophy. The miserable dentists have let insurance companies dictate the delivery and fee structure of the care they provide. They continue to give away their services because that is what everyone else is doing and insurance dictates what the treatment should be. Happy dentists, on the other hand, have a progressive, quality-based practice and answer to no one but their own conscience. They strive for perfection and let their patients know it. They put in their patient's mouths only what they would put in their own. They know they can't serve everyone and are comfortable with that. They especially don't let insurance companies dictate treatment, as they're well aware that they know more about their patients' needs than the insurance company. They don't care if their peers are jealous or judgmental; they are proud of their work and love their job. Most important, they are rewarded for their efforts. They know they provide a valuable service and are worth their fees.

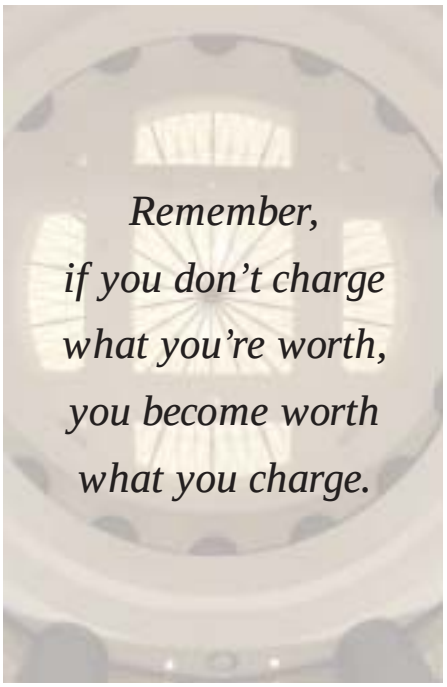
Dentistry's Evolution

It's true that our practices have grown more complex, both in terms of what we need to know and the bureaucratic necessities of our business. However, if you step back and look at the resources you now have available, and the unlimited possibilities for what you can accomplish with expanding skills, you'll see that this is truly an exciting time to be a dentist.

In so-called better times, cosmetic dentistry was considered a less-than-ethical profession. The dentist who performed aesthetic work was thought to sacrifice function and quality for something inferior. It was believed that dentists who were concerned with aesthetics would create expensive restorations that looked good but were not as sturdy or reliable as those done through more conventional methods. Cosmetic dentistry was considered to be an unnecessary treatment available only for the rich or vain, and not a valid part of the average practice. In the last decade however, aesthetic pioneers have changed the face of dentistry. Advances in technology, materials and techniques have yielded procedures that rival or surpass conventional treatment. Far from being a fad, cosmetic dentistry has moved into the mainstream of private practice.

And now a new revolution is occurring in dentistry, the aesthetic/occlusion connection, which allows dentists to become mouth doctors, rather than mere molar mechanics, as viewed by the public. With this knowledge, our profession has been provided with a powerful and rewarding new avenue for dentistry. Dentists have the ability to help many people with headaches, neck pain, back pain and many other ailments. Both cosmetics and pain elimination are want-based procedures instead of the customary need-based procedures.

So why are so many dentists unhappy, unable to incorporate progressive, quality-oriented dentistry into their practice, and what has dentistry done to compound our problems? Nothing—and that's the problem. As an organized profession, we have failed miserably in educating the public about the value of the mouth and teeth. In my opinion, the fact that 90% of children in the U.S. don't have sealants is a crime. The fact that 85% of Americans have periodontal disease is tragic. The fact that much of the public has no clue what porcelain veneers are is also ridiculous. Ask what liposuction is, and the vast majority will know. Shows like ABC's "Extreme Makeover" and other physical improvement programs are helping to educate much of the public, and they have dramatically increased the demand for quality aesthetic services.



Educating the public is the key to creating a value for dentistry. At LVI, we have developed a $12 million image/branding campaign to educate people about the training our graduates have received. This national campaign will help guide the public to those dentists who have the skills necessary to provide quality treatment for their patients.

So why has our progress been so stunted? I don't think you have to look much farther than the influence of insurance. The maximum annual benefit for most insurance policies has not changed in the last 40 years, yet the premiums have risen. It's about time our industry's leaders wake up its members and get them to smell the coffee. Although I do not like the amalgam filling, raise your amalgam fees if you are going to continue doing these restorations. Those people who attempt to be the cheapest dentists in town do nothing for themselves and worse, hurt the profession as a whole. Remember, if you don't charge what you're worth, you become worth what you charge.

Dentists provide a valuable service and therefore, we should be fairly compensated for the time, money and effort we put into it. Yet we devalue our services by lending people money so they can have dental work completed. What do I mean by "lending"? When people don't pay at the time of service, we are in effect extending them a loan. How many places can this person buy something without having to pay when they receive it? Not many!

The insidious problem is that we

create awkward relationships with our patients by lending them money. The old adage never to loan money to friends and family should have included patients. If you want someone to be your friend or a loyal patient, don't make loans, because he or she will try to find reasons not to pay. Quite simply, people do not like creditors.

The relationship with my patients improved immensely the day I stopped lending money to them. If the patient needs to finance, do it with a third-party lender, such as the Citi Health Card. Banks have a hard enough time in their business; dentists have had no training in loaning money, and therefore, we have no business being banks. If your patients owe a third-party company the money for the work, they will still love you. One dentist I know objected, "But the problem with the third-party companies is that they occasionally deny someone credit." I don't see that as a problem at all - you have no business lending money to someone especially when an experienced and trained company says that person is a poor risk.

I really believe dentistry's problems have risen from one basic fact: Dentists are not adequately compensated. As I mentioned earlier, dentists' incomes have not kept up with the cost of living in 23 out of the last 30 years, due to the intrusion of insurance. It's had a profound effect on our profession by keeping fees low and dictating inferior treatment. It has also affected the caliber, quality and quantity of those wanting to be dentists and impacted all of the adjunct professions in dentistry as well. You see, the dentist is plankton in our industry's food chain. If a dentist isn't making enough income, who else suffers?

1. The manufacturers of advanced technology suffer if the dentist can't afford the products they produce, which stifles progress in equipment. Improving dental supplies and materials is hampered, as the companies cannot afford the research and development necessary to create such products since their customers can't afford to pay for them.

Dentists provide a valuable service and, therefore, we should be fairly compensated for the time, money and effort we put into it.

2. The dental schools suffer because they cannot get their alumni to donate contributions. As I mentioned, seven dental schools have closed the last 15 years due to the cost of operations. If a dentist is not adequately compensated, they cannot afford to donate money to their dental school.

3. Lab technicians suffer because they can't charge enough to take the time to do a quality job since the dentists won't pay the necessary fee such work would warrant.

4. But most important, the patients suffer. When the dentist is worried about paying bills and keeping overhead down, service and product quality declines. When need of money is the incentive to do anything, ethics are pushed to the breaking point. When the dentist can't afford the new technology, the patient doesn't get the advantage it would provide. And when dentists don't make enough money, they can't afford the education that would dramatically improve their capabilities and skills, which in turn would improve the treatment the public receives.

Unfortunately, many people think that keeping dental fees down is better for the public than improving treatment. It's their goal to make dentistry cheap and inexpensive, which they believe is good for society. They are so wrong. We have seen what low fees and the ultimate in managed care (socialized dentistry) has done in England. We have seen what lowering fees has done to our American colleagues in other medical professions and the horrors that have been created by the emergence of HMOs. The worst thing that can happen to the dental patient would be for dental fees to remain low. Indeed, the worst thing about today's dentistry, with the intrusion of the insurance industry, is that low fees have kept the standard of care so low.

The only way to improve that is to teach dentists to value their worth, provide the possibility to make a good living, and then give them an incentive to excel. Value-added, excellent quality, aesthetic-based dentistry is

CONTINUED ON PAGE 64

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SMILES EVERYONE SMILES

The Science of Creating FANTASY smiles

Heidi Dickerson, DDS, LVIM

The success of Television Makeover shows has done one thing for our dental patients… EDUCATED them! These shows have shown our patients what "is" possible.

Gone is the day when a patient came into our office for some "anterior veneers" and we planned very little… perhaps taking an impression of their existing teeth, prepping, and then temping them with temporaries that looked like the teeth they came in with. Explaining to them that the permanents would "look much better", and trusting us that they would. Now our patients are informed. They know about whitening, lasers, gingival recontouring, they may even request a certain kind of porcelain veneer!! What does all this mean? Well, I know one thing for sure… we all better be on top of our game! Since patients are aware of what can be done for them, many are flocking to "cosmetic dentists" to have their work done. According to the *USA Today* (July 8, 2004), $15 BILLION per year is spent on cosmetic dentistry! For those of you who do not know how to do this work correctly, you better get educated! Take a live patient treatment course for optimal learning of aesthetic principles and learn how you can create Fantasy Smiles for your patients.

One of the factors that can limit the possibilities for altering the appearance of teeth involves soft tissue contours. Some cases will never result in an exceptional aesthetic appearance without gingival or osseous surgery. Severely misaligned teeth, where orthodontia must occur prior to the placement of restorations, is another restriction. Noting that most minor orthodontic corrections can be made through restorative means, we need to take both of these limitations into consideration when treatment planning. Most of the time patients will accept "almost perfect" rather than having ortho or gingival surgery. However, we must make them aware of all treatment planning options.

To get you started on your journey, I have summarized some **Smile Design Guidelines** that will help you evaluate and facilitate the creation of an aesthetic smile. By finding out your patients expectations, preplanning your cases, and following these guidelines, you are sure to get an aesthetically pleasing result every time.

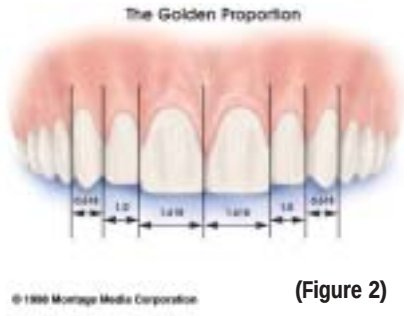
Proportions of the Central Incisors:

The cornerstone of aesthetic smile design is the central incisors. It is imperative that they are properly proportioned (figure 1). The length of the central incisors should be divided into the width to obtain the proper length to width ratio. The ideal width being 77.5% of the length: however, 75-80% is acceptable. If teeth are too square or elongated, they appear out of proportion. Optimum aesthetic would mean this ratio should be as close to 77.5% as possible. This ratio is based on the Golden Proportion of both maxillary central incisors.

(Figure 1)

Golden Proportions:

The Golden Proportion of the maxillary anterior teeth is one of the most important aspects of smile design. If something is off with the Golden Proportions, your eye is drawn to notice this problem. You may not be able to tell what the discrepancy is, you just know it is off. The common denominators in achieving "golden proportions" are the lateral incisors (figure 2). The measurements for the lateral incisors are divided into the measurements of the central incisors as obtained from the visual proportions of a photograph, and they represent a goal which is not always achievable. It is important to understand that these are the visible measurements obtained from viewing straight-on to the smile, not the true measurements of each tooth. Ideally, if we give the lateral the value of 1, the cuspid should be 0.618 of the lateral, and the central should be 1.618 of the lateral.



(Figure 2)

Midline and Arch Alignment:

The midline represents the axis running down the center of the face and may not always align with the nose. The midline of the teeth should be centered, straight, and not canted. The arch alignment should be perpendicular to the midline (figure 3).

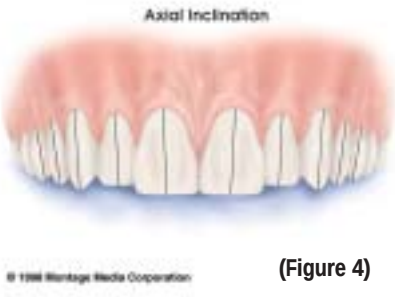
(Figure 3)

A symmetry bite is a great tool to check for proper arch alignment in the diagnostic stage.

Patient with symmetry bite in place.

Axial Inclination:

A slight mesial inclination of the vertical axis should be present in the aesthetic smile. This mesial inclination of the vertical axis is a line drawn from the gingival apex toward the center of the incisal edge, or to the incisal apex with the canines (Figure 4).



(Figure 4)

Incisal Edge vs. Lip Line:

In a natural smile, the incisal edges of the maxillary teeth follow the contour of the lower lip without necessarily touching it (Figure 5). The distance between the lip line and the dentition should be the same posteriorly to the canines. If the dentition is in contact with the lower lip, all anterior dentition should be in contact with the lower lip. An example of an unaesthetic smile would be a reverse smile. A reverse smile is when the incisal edge contour mirrors the lower lip line, and the space between the lip and the central incisors is wider than the space between the lip and the canines. A reverse smile gives the patient an aged appearance.

(Figure 5)

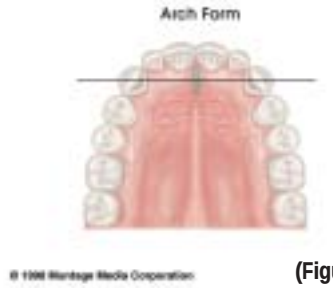
Contact Points:

The interproximal contact points of the central incisors should be in close proximity to the incisal edge. There should be a gingival progression of the contact points between the central and laterals, and again between the laterals and canines (Figure 6). This gingival progression of contact points will also open up the incisal embrasures in these perspective areas.

(Figure 6)

Arch Form:

We utilize the CPC (canine, incisive papilla, canine) line to visualize proportional arch form. A line is drawn between the tip of the canines and this should bisect the incisive papilla (Figure 7). A deviation, which may indicate malpositioned teeth, can be corrected with proper tooth preparations. For example, if the CPC line is behind the incisive papilla, this would indicate a narrow, perhaps vaulted arch. If we were to prepare these teeth to widen the arch, we would be more conservative on the buccal aspect of our preparations (because we are adding more porcelain there) and less conservative on the lingual aspect of our preparations.



(Figure 7)

Gradation:

From the anterior to the posterior, the teeth should exhibit geometrical symmetry, visually appearing shorter from the canines to the molars

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(Figure 8). Think of it as standing in the middle of the sidewalk in a big metropolitan city filled with tall buildings. As you look down the

(Figure 8)

street at the tall buildings, they appear to get smaller. The same thing applies here with the dentition. If you have gradation issues and a tooth appears too small, you may consider some gingival recontouring with a laser. However, keep in mind that you do not want to violate the biologic width.

Gingival Contours and Gingival Symmetry:

The gingival apex of the lateral incisors should be 1-2mm lower than that of the canines or central incisors (Figure 9). Many times gingival con-

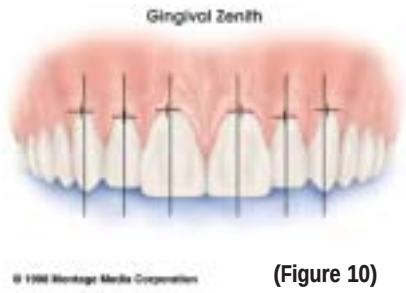
(Figure 9)

tours on each side are correct, yet the sides are not symmetrical. In this case you will have to determine which side is the most aesthetic and treatment plan to see if you can achieve that "mirror image".

The gingival height of the corresponding teeth should be symmetrical on each side, particularly if the gingival tissue is exposed during a broad smile (Figure 9). Simply said, one side should be a mirror image of the other. Obtaining this symmetry is more critical closer to the midline. If the lips hide the gingival level of the teeth, then the gingival symmetry is of no aesthetic consequence. Remember, patients do not walk around with cheek retractors!

Gingival Zenith:

The gingival zenith of the lateral incisors is generally lower than that of the canines or central incisors Looking at a line drawn down the long axis of each tooth, the zenith of the centrals and cuspids is slightly distal of this line, where the lateral is right on this line (Figure 10). This is



(Figure 10)

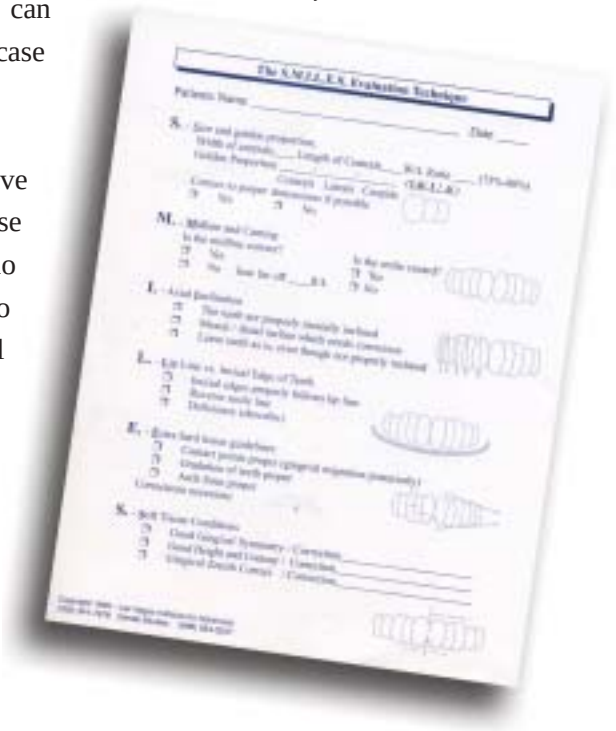
a small nuance that can help to make your case exceptional.

Now that we have gone through all these guidelines, how do you transfer this to the lab? Relating all of these various components is important in the fabrication of these aesthetic restorations. You need to communicate SMILES to your laboratory technician… that is:

- **Size**
- **Midline**
- **Inclination**
- **Lipline/Incisal edge**
- **Extra-hard tissue guides**
- **Soft tissue guides**

At the Las Vegas Institute for Advanced Dental Studies, we have developed a SMILES evaluation sheet to facilitate this communication with your laboratory (see SMILES evaluation form).

In conclusion, by adhering to the outlined smile design principles, dental professionals will achieve aesthetic results that function within the parameters of the natural dentition. These "golden rules" will help you to achieve the aesthetics that your patients are now educated enough to demand. By utilizing these guidelines you will be able to give your patients the Fantasy Smiles that they Dream of.



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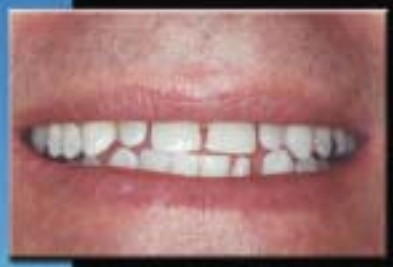

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RONALD D. JACKSON, DDS, FAGD, FAACD

Esthetic INLAYS & ONLAYS

Quality, Proven Restorations

There are many prominent teaching clinicians who feel that inlays and onlays are a grossly underutilized restoration and that crowns are an overutilized restoration.[1,2] I think it is worthwhile to examine some of the possible reasons for this unfortunate situation (for our patients) and see if the reasons for dentists' reluctance to incorporate these restorations into their routine services are really valid today.

Reasons 1: **Large amalgam fillings are easier and more affordable than inlays and onlays.**

Both terms (easier, affordable) are relative. Whether something is easy or not in dentistry depends on your training and how often you've done it. Our first amalgam filling or crown in dental school wasn't easy either. As for affordable, isn't that for the patient to decide? People generally buy what they want or what they perceive is in their best interest.

Reason 2: **It's just easier to do a crown than an onlay.**

Same response as above. However, I will agree that when doing a crown, the clinician isn't faced with the decision of which cusps to keep and which to remove – you just unthinkingly remove them all. But as doctors, we have to ask, are we deserving of the patients' trust and their money, by only recommending that which we perceive (possibly because of lack of training or practice) as expedient?

Reason 3: **Inlays and Onlays are expensive.**

Not any more than crowns or root canals! We have no trouble recommending these services when they are indicated. Maybe it would be easier for dentists to accept these restorations if an onlay (gold or tooth colored) was referred to, and thought of, as a partial crown and carried the same fee as a crown.

Reason 4: **Crowns last longer and are more predictable.**

Although longevity is important and ingrained in the dental psyche, it is not the only criteria of value. In the age of adhesive dentistry, respecting remaining tooth structure and esthetics have become components of value as well. Keeping in mind that patients are living longer and want and expect to keep their teeth for a lifetime (something we tell them can be done) means, in most instances, it is best to recommend a crown only when it's truly indicated. The name of the game in dentistry today is "bank the tooth structure". Regarding durability, esthetic inlays and onlays are not new anymore. They have a track record, and it is good. [3,4] With today's materials, longevity is mainly a matter of diagnosis and execution of technique. *(Figures 1A&B – 3)*

Although not esthetic, well-done gold inlays and onlays are considered to have a proven durability and longevity similar to crowns. If esthetics is not an issue, gold is still the standard and what I always recommend for second molars. However, it's interesting the number of people, and the types of people, who still desire tooth colored even in these teeth. *(Figure 4)*

Figure 1A Patient requested amalgams be electively replaced with natural looking tooth colored restorations.

Figure 1B Quadrant restored with Esthetic Inlays and Onlays at 14 years

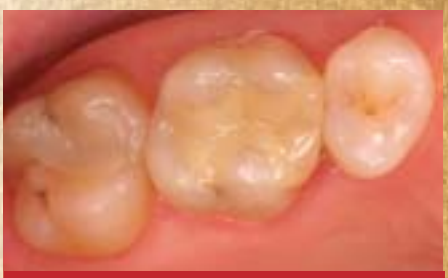

Figure 2 Indirect resin restoration at 17 years post-op. Note ideal contact achieved and maintained. There is no perceptible wear.

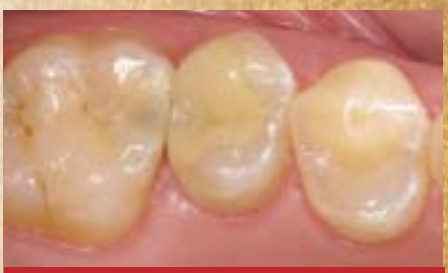

Figure 3
Indirect resin onlay at 19 years post-op.

Figure 4 First molar with indirect resin onlay at 15 years. Second molar with indirect resin inlay at 7 years.

Figure 5A Amalgam fillings requiring replacement. Note that the distolingual cusp of the first molar was cracked. Additionally a broad mesial marginal ridge with heavy contact exists on the second molar.

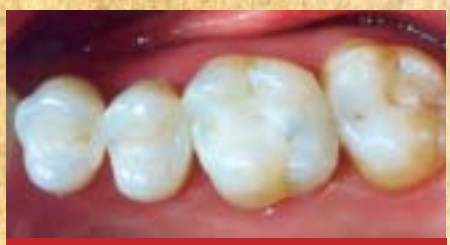

Figure 5B Direct resin restorations were placed in the premolars and indirect resin restorations were placed in the molars. The distolingual cusp of the first molar was overlayed.

Figure 6A Large failing amalgam fillings in first and second molars.

Figure 6B Partial crowns (onlays) replace diseased and/or weakened tooth structure but without removing that which is healthy and intact.

Reason 5: **Posterior direct resin restorations are less costly to the patient and can be done in one appointment.**

It is a fact that more and more patients today are selecting tooth colored restorations for their posterior teeth.[5,6] and there is no question that well placed Class I and Class II direct resin restorations are proving to be viable alternatives to amalgam.[7] However, the indications for these restorations do have limits. Generally, when the cavity is large or the tooth is under excessive functional demand (heavy bruxer or clencher), indirect restorations (resin or ceramic) are indicated. Certainly when a cusp is missing, the standard of care is best satisfied by an indirect restoration. After all, there is no question that a laboratory technician working with mounted models at the bench is going to provide a more accurate occlusal morphology and overall contour than we can by grinding all the blue spots in the mouth. It's also very difficult to achieve quality contacts in large restorations with poor tooth alignment or spacing. No matter how good the direct resin materials get, the above situations will usually be better served by indirect restorations in the same way that gold inlays/onlays are superior to large amalgams that replace cusps. *(Figures 5 A&B – 6 A&B)*

Reason 6: **Many third party payment plans don't pay benefits for esthetic inlays and onlays but most pay a benefit towards PFM crowns.**

In a health-care profession, it shouldn't be necessary to even respond to such a statement, but I will. If a properly informed patient would rather sacrifice their healthy tooth structure to save a few dollars or for a perceived greater longevity – well – that's their choice. It may be what the patient feels is best for them at that time. The operative words however, are *properly informed* (pros and cons) and *their choice.* We shouldn't make the choice for them based on an assumption.

For many dental practices, offering only low cost (at least initially) large fillings or expedient crowns, where they may not be the best our profession has to offer, is questionable and short-sighted. The bottom line dentistry today, as it always has been , is to recommend treatment, which according to the clinician's professional judgment, is in the patients' best interest, which is usually what the clinician would select if he/she were the patient. The patient may not always want that particular service and decline to have it done, but they always deserve the choice.

The trend in dentistry is clearly toward more esthetic and less invasive. Indirect resin and ceramic inlays and onlays are not only compatible with this trend but fulfill very nicely the restorative void between fillings and crowns.

RONALD D. JACKSON, DDS, FAGD,

Dr. Ron Jackson has been a featured instructor at the Las Vegas Institute since its inception and is the director of the Advanced Posterior Aesthetics and Anterior Direct Resin programs. He is a Fellow in the American Academy of Cosmetic Dentistry. Dr. Jackson maintains a private practice in Middleburg, Virginia.

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3 Donly KJ, Jensen M, Triolo PT, et. al., A Clinical Comparison of Resin Composite Inlay and Onlay Posterior Restorations and cast-gold restorations at 7 years, Quint. Int;l, 1999; 30: 163-168

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HEY, DOCTOR! I'VE GOT A SURPRISE FOR YOU.

You're the least trusted person in the office by patients!
So, why the heck are you presenting care?

Nate Booth, DDS

In their fantastic Las Vegas Institute team program, *Achieving Extreme Success*, Drs. Matt Bynum, Art Mowery and Kevin Winters effectively make the point that, when it comes to presenting dental care, the doctor is the least trusted person in the office. Most patients perceive that the doctor will receive a direct financial benefit from them agreeing to do treatment. In reality, they're right, of course. I believe that the vast majority of dentists only recommend treatment that is in the best interest of their patients. But that patient perception of impartiality is always going to be there, especially with the big cases. Patients may think that you want to do their cases so you can get closer to buying that new BMW. Luckily, they consider your team members to be more impartial.

So how do you overcome this perception? By having your team members present care in most situations. In addition to the impartiality effect, there are two other reasons why your team members should present the care:

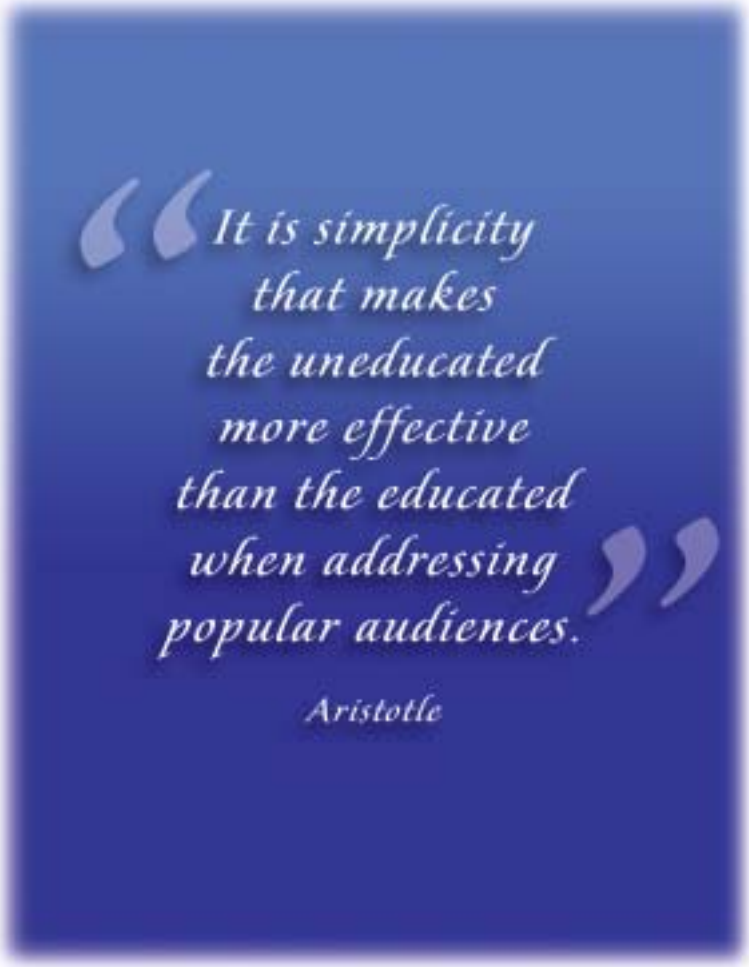
1. In most offices, for most cases, they can do a better job than you.

I'll be blunt here. You probably talk too much and say the wrong things when you talk to patients about care. I did the same thing when I was practicing. We're too darn logical. We're too technical. In plain, non-technical language, most patients just want these questions answered:

- "What are my problems and what might/will happen if I don't take action?"
- "Have you listened to what I want functionally and cosmetically for my mouth?"
- "Have you presented me two or three options of how I can solve my problems and achieve my desires?"

That's it! Anything more is too much in most cases.

At LVI, we've created an in-office, DVD team meeting series called, Success Leaves Clues. Each of the twelve monthly programs is designed to give your entire team they need to provide superior service to your patients or to make it easy for patients to say "Yes" to your treatment plans. Call 888-584-3237 for more information.



2. Having your team present the cases gives you more time to treat patients.

Let's say you spend 40 minutes a day presenting care to patients. If you work 200 days a year, that's 133 hours a year, or more than four 32-hour work weeks. How much dentistry could you produce in four 32 hour work weeks?

One highly effective way to get yourself out of the case presentation mode is to have one or more of your team members be Patient Care Coordinators. In some offices I coach, the Patient Care Coordinator is one person. In other offices, the doctor's clinical assistants do the job. In a few offices, hygienists fill the role.

With new patients, the Patient Care Coordinator is the lead person in all interactions occurring before care begins. She:

- Greets the new patients at the door on the first visit.
- Offers them something to eat and drink.
- Sits down with them in a private room and gets to know them on a personal level.
- Goes over the medical and dental history forms.
- Has a conversation with them to discover their concerns, fears and desires.
- Takes them on a tour of the office, pointing out key features that reinforce

the office as the one that can serve them best.

• Charts existing restorations and records the notes of the hygienist's and doctor's exams.

• Assists or takes the patients' photos, radiographs and impressions.

For simple cases in the $3000 or less range, she:

• Listens to the doctor's treatment plans.

• Prepares the case for presentation while the patient is with the hygienist or is watching an educational DVD.

• Presents different treatment options to the patients at the first visit.

• Makes the financial arrangements.

• Appoints the patients for their clinical visits.

• Follows up with patients who don't make decisions to proceed that day.

For more comprehensive cases, she:

• Makes appointments for the people to return for treatment conferences.

• Prepares the case presentations after receiving the doctor's treatment plans.

• Presents different treatment options to the patients at the treatment conference visit. The doctor may or may not be at the treatment conference. It's nice if the doctor sticks her head in the room and "blesses" the treatment plan.

• Makes the financial arrangements.

• Appoints the patients for their clinical visits.

• Follows up with patients who don't make decisions to proceed that day.

As you can see, the Patient Care Coordinator is the lead person in the entire new patient experience. If the patients don't accept comprehensive care, she makes sure they come back to have something done. She keeps the completion of care moving along. Sometimes this takes weeks. Sometimes this takes months. Sometimes this takes years. It's vital that one or two people in your office are responsible for making sure patient care gets completed. If you don't have these people in place, a lot of patient care will "fall through the cracks."

So who should you select to be your Patient Care Coordinator? The Patient Care Coordinator should be someone who:

1. has natural communication talent. Some team members are just naturally good at communicating with others. They want them to have the best dentistry possible and aren't afraid to talk about that kind of care.

2. has a great personality. They don't have to be raving extroverts, but they should be empathetic and warm.

3. is enthusiastic about the care you provide. It's best if they've been with you for at least a few months and have seen the high quality of your care.

4. knows a fair amount about dentistry. The best Patient Care Coordinators I know have been in dentistry for at least two years. Doctor, you know too much. That's why you over-talk the technical aspects of dentistry, confuse people and lose the case.

5. has the time to spend with patients. This one is vital. In most offices, the new patient gets handed from person to person. Important patient information falls through the cracks. The patient doesn't have time to bond with any one team member. Team members have other pressing duties so they don't give the patient enough time or focus.

6. is willing to learn a few, simple communication skills. There are many places where team members can learn these skills.

In addition to your Patient Care Coordinator(s), you need to make sure that everyone in your office has your approval to talk to patients about proceeding with care. Hygienists, clinical assistants and front office people should all be part of the case acceptance process. I say case acceptance process for a specific reason. Case acceptance is a process that can take years. Your patients will go through seven stages before they say "Yes" to your comprehensive care treatment plans. Some of them go through the seven stages quickly, some go through slowly. Your team and you will be there for people in the right ways through all seven stages of their decision-making process.

Stage One – Selection. The patient thinks, "My perception of this dental

practice matches my values." When do you think the case acceptance process begins? At the first visit? On the first phone call? Actually, it's even before the first phone call because who's calling you on the phone and what they've heard about you can be the most important part of the case acceptance process.

As an example, let's say that your practice has the reputation as an office that provides extremely high quality care and is more expensive than other offices in your area. Who would call you on the phone? Someone who wants the best dentistry and is willing to pay for it. Some people value convenience and are attracted to dental practices close to their work places or homes, or offices that are open evenings and weekends. Some people want low-cost dentistry and are attracted to offices that advertise their new patient exams and x-rays for $29.95. The $64,000 Question is, "What kind of person is attracted to your office?" If it's not the kind of person you want, you need to change how your practice is perceived in your area.

Stage Two – Connection. The patient thinks, "I have an excellent relationship with the entire team. I like and trust them." Doing bread & butter dentistry for patients requires that you only have low levels of connection with them. If you want to do more comprehensive dentistry, you will need to increase your level of connection.

Stage Three – Understanding. The patient thinks, "The entire team understands me – my fears and desires." Like Stage Two, doing more comprehensive dentistry requires that you have higher levels of patient understanding. In addition, if you want your patients to understand what you have to offer, they must feel that you understand them first. That's just the way life works.

Stage Four – Urgency. The patient thinks, "I have concerns/problems/desires that need attention now." People don't take action unless they feel some pressure to do so. The pressure can't come from you. It needs to be generated internally by the patient. There are many ways you can fan the flames of patient desires. I'll discuss these in future articles.

Stage Five – Solutions. The patient thinks, "I know the solutions to my concerns/problems/desires." The key word in the previous sentence is solutions. The vast majority of the time, there is more than one way the patient's case can be treated. You will want to give the patient different options from which to choose. One option is the best dentistry that has to offer. One option is the lowest level of care that meets your standards. There may be an option or two in between.

Stage Six – Decision. The patient thinks, "I choose the best solution." If the patient chooses the best that dentistry has to offer, that's fantastic! If they can't or don't want to choose the best, that's okay too; and you take great care of them until they can.

Stage Seven – Loyalty. The patient thinks, "My expectations were exceeded. I return for care and refer my family and friends." Patient satisfaction is not enough to create a high-end practice that does lots of comprehensive dentistry. You need loyal patients.

One of the biggest mistakes I see dental offices make is they believe case acceptance takes place at the treatment conference. This is a mistake for two reasons:

1. It assumes that case acceptance takes place a one point in time. As you've discovered above, case acceptance is a series of events that begins before the first phone call and never ends.
2. It assumes that case acceptance is the responsibility of one person – the case presenter. In reality, case acceptance is the entire team's responsibility. Your entire team needs to be there for the patients in the right way during each of the seven stages of decision making as outlined above.

In the vast majority of the dental offices I coach, the doctors turn the execution of the case acceptance process over to their teams. They do it for one reason. It works! Join their ranks and reap the benefits of the team approach to case acceptance.

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.

A Contemporary Approach to Bread and Butter Posterior Restorations: A CASE STUDY

BY TIMOTHY C. ADAMS, DDS, LVIM

Aesthetic, Cosmetic, Smile Rejuvenation, Adhesive Dentistry, Smile Makeovers – they are the emphasis and catch phrases in dental practices in North America today.

Due to an increase in awareness brought on by marketing, a more educated public and an increase in post-graduate dental training, these catch phrases have driven the focus of dentistry in North America today. The influx of a vast array of excellent materials, an increased knowledge and improvements in technology have raised the bar of expectations associated with what we deliver to our patients in the anterior region of the mouth. What is missing to a degree, in this author's opinion, is the notion that we can fabricate and deliver the same beautiful and functional aesthetic restorations in the posterior region of the mouth that we do in the anterior region of the mouth. Posterior restorations are the bread and butter of real life practices and to be able to consistently deliver excellent fitting, func-

tional and aesthetic restorations can and should be very rewarding. It is essential that for the aesthetic posterior restoration to come to fruition, an open communication with your lab is critical. Without the proper communication with your lab concerning the proper case selection from an occlusion standpoint, proper materials, shade selection and color mapping and photography, the end result will be very average at best. The following is a case study of a quadrant of Empress restorations emphasizing the importance of lab communication.

Case Study

A patient presented herself with the desire to replace her existing alloys in teeth numbers 2,3 and 4 with the strongest, most conservative aesthetic restorations that were clinically possible. The patient was experiencing no sensitivity and her oral hygiene was impeccable. After discussing the options with her, it was mutually agreed upon that we would plan on utilizing Empress inlay/onlays to restore these three teeth close to, if not equal to their original strength. The advantages of adhesive dentistry in the posterior have been well documented in the literature for years. There have been some experts that have felt that bonded adhesive porcelain restorations rival gold in their longevity (Roulet: Minimally Invasive Restorations With Bonding, Quintessence Books, 1997, page 21).

With this in mind and upon the patients approval, pre-operative photographs were taken of teeth numbers 2,3 and 4 (Figure 1). Shades were also taken at this time and again at the final prep. This allows for comparison of the shade of the tooth structure with and without the alloys, which can cause a graying effect on the actual tooth structure. A rubber dam was placed (Figure 2) and the alloys were conservatively removed using copious water and high speed suction. Once the alloys were removed, the existing recurrent decay that existed in all three teeth was carefully removed. A slight pin hole exposure was noted on the mesial buccal pulp horn of tooth number 3 (Figure 3). The exposure was disinfected with Consepsis (Ultradent), rinsed with water and acid etched with phosphoric acid (Ultradent), rinsed again and lightly dried. The exposure was then saturated with Super Seal (Phoenix Dental) and the excess rewetting agent was blotted off by a microbrush (Kerr). Two layers of Optibond Solo Plus (Kerr) were then carefully applied and with the use of a multibrush, being careful not to get excess over the remaining exposed dentin. After removing the excess primer with a multibrush, the

What is missing to a degree, in this author's opinion, is the notion that we can fabricate and deliver the same beautiful and functional aesthetic restorations in the posterior region of the mouth that we do in the anterior region of the mouth.

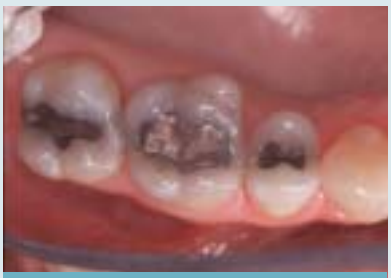
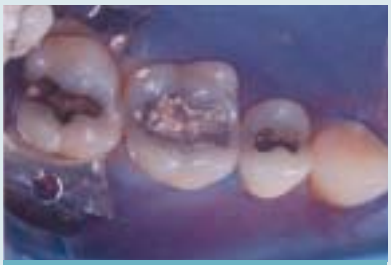


Figure 1



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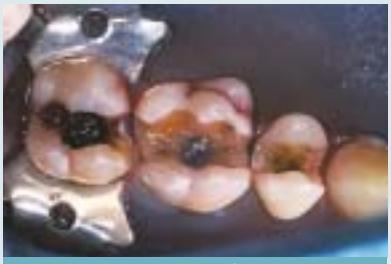

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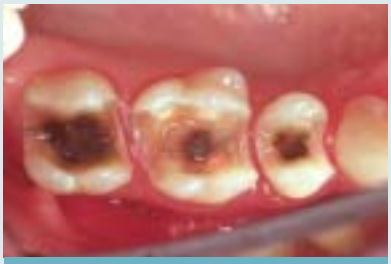

Figure 4

Figure 5

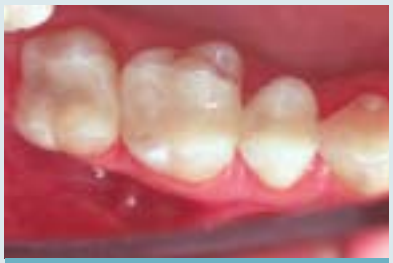

Figure 6

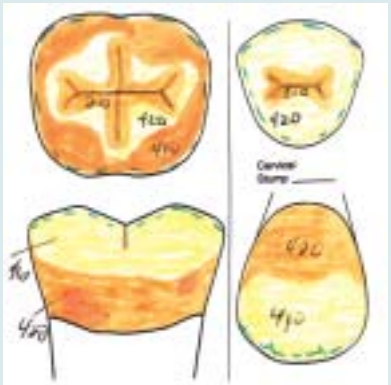

Figure 7

primer was lightly air thinned to dissipate any excess monomer left on the tooth surface. A thin layer of flowable resin (A-1 Revolution, Kerr) was then applied and both primer and flowable resin were light cured for 20 seconds. At this time, the rubber dam was removed and careful examination of the existing tooth structure and occlusion revealed enough solid tooth structure to consider inlays/onlays versus full coverage crowns on all three teeth (Figure 4).

A polyvinyl Siloxane impression (Kerr Take One) was then taken with a full arch tray. Good detail with no bubbles, blood, saliva or distortion was evident (Figure 5). A pre-operative Polyvinyl Siloxane impression (Kerr, Monophase) was then used to fabricate the temporaries. To eliminate the possibility of the temporary material adhering to the pulp cap, a thin layer of Deox (Ultradent) was placed over the pulp cap after the teeth were saturated with a desensitizing agent Super Seal (Phoenix Dental), dried and saturated with an antibacterial agent, Consepsis (Ultradent) and dried again. This prevents the temporary material from bonding to the pulp cap. The temporary material (Integrity A-1, Kerr) was placed into the pre-operative monophase impression and placed over the prepared teeth for two and one-half minutes, then carefully removed. Due to the fact that we used a Polyvinyl Siloxane impression for accuracy, there was little excess of temporary material that needed to be cleaned up. An Enhance cup (Dentsply Caulk) was then used with water spray to lightly clean up any excess. The occlusion was checked and the patient was dismissed with the proper post-operative instructions, especially

The color mapping step along with photographs is critical to send to the lab to ensure that the lab has all of the tools needed to produce an exact duplication of the natural teeth. It has been my experience that this step has been the missing piece of the puzzle that keeps clinicians from delivering posterior restorations that rival their anterior restorations aesthetically.

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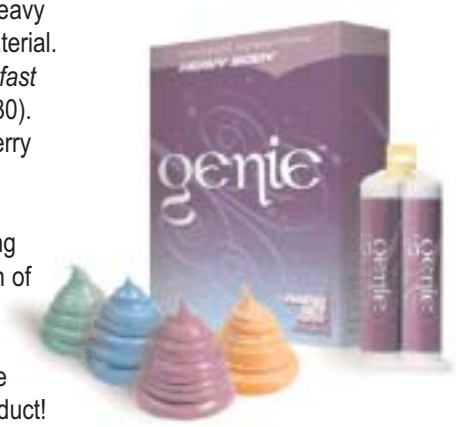

1- Study available upon request.
2- Survey available upon request.

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with the inherent concerns that the pulp cap might develop into an endodontic situation (Figure 6). Color mapping was then performed using the LVI color mapping tablets (LVI) (Figure 7).

The color mapping step along with photographs is critical to send to the lab to ensure that the lab has all of the tools needed to produce an exact duplication of the natural teeth. It has been my experience that this step has been the missing piece of the puzzle that keeps clinicians from delivering posterior restorations that rival their anterior restorations aesthetically. I used both the Mosaic and Chromoscope Shade guides to communicate to the lab the shades, opacity, hypocalcification and translucency desired to replicate the existing natural tooth structure. Please note that it is highly unusual to have a tooth that is just one shade with no opacity, hypocalcification and translucency. These have to be built into the teeth and if this is not communicated to the lab, then your end result will not look natural nor will it blend into the remaining tooth structure.

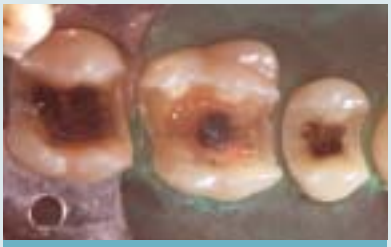

Figure 8

Figure 9

Two weeks later, the patient returned for the delivery of her three Empress (Ivoclar) restorations. She experienced no discomfort in her temporaries and was excited to get her three new restorations. The patient was properly anesthetized and the temporaries were removed (Figure 8). The prepped teeth were cleaned with hydrogen peroxide (Ultradent) and disinfected with Consepsis (Ultradent). Upon examination, the restorations (Figures 9,10) were an exact match of the color mapping that was provided to the lab along with the pictures that were sent along with the case (Figures 1,2,3,4,5). The restorations were tried in and it was determined that the fit, margins, contour and contacts were excellent. A light yellow try in paste (VarioLink II, Ivoclar) was selected to give the restorations a good blend and warmth. The restorations were removed from the teeth and rinsed with water and dried. Phosphoric acid (Ultradent) was then applied on the internal aspect of the restorations to acidify the surface and rinsed with water and dried. A coating of Kerr Silane Primer (Kerr) was then applied to the internal aspect of the restorations and allowed to air dry. A shiny surface should be noted on the internal aspect of the restorations (Figure 11). Kerr Silane Primer Plus allows you to silanate and coat the restoration with an unfilled resin all in one application.

Figure 10

Figure 11

With the restorations ready to be bonded into place, a rubber dam was placed and the teeth were disinfected again with Consepsis (Ultradent) and rinsed and lightly dried. The teeth were then etched – the enamel first for 15 seconds and then the dentin for

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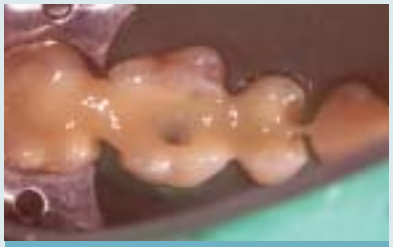

FIGURE 12

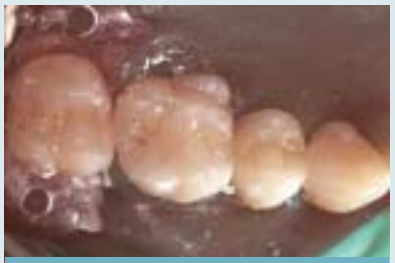

FIGURE 13

FIGURE 14

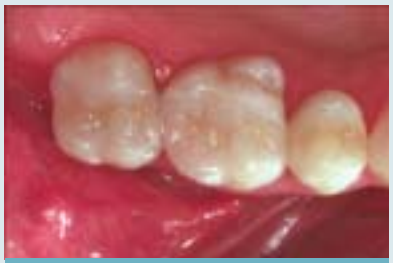

FIGURE 15

10 seconds and rinsed with a copious supply of water and lightly air dried. The teeth were then saturated with Super Seal (Phoenix Dental) for a minimum of 30 seconds to allow for proper rewetting of the dentinal tubules. The excess was blotted off with a Microbrush (Kerr) giving the teeth a glistening surface that is now ready to be primed. Two coats of Optibond Solo Plus (Kerr) was then applied generously and lightly air thinned. Before the primer is cured, care should be taken to make sure there is no pooling of the primer that would create too thick of a layer of primer. This could possibly impede the seating of the final restorations. After air thinning the primer, the author uses a Microbrush to remove any pooled primer. The primer is then light cured and the teeth are ready for the insertion of the final restorations. The prepped teeth are then filled with the resin cement (Variolink, Ivoclar, Light Yellow, base light cured only) (Figure 12) and the three restorations are then placed into the corresponding prepped teeth making sure not to place too much seating pressure. If firm pressure is used at this point before you are ready to spot tack the restorations into place, they could possibly drift up due to hydraulic pressure causing a suck back affect and consequently microleakage could occur. Once the restorations are ready to be spot tacked and the excess resin cement is cleaned up with a multibrush and a rubber tip (Butler), firm pressure can be placed and the restorations can now be spot tacked into place for 3 seconds on both the buccal and lingual surfaces. The restorations are then flossed and immediately final cured for 20 seconds on the buccal, lingual and occlusal surfaces. Excess resin cement is then removed using a scaler and the rubber dam is ready to be removed (Figure 13). The occlusion is checked and adjusted with a fine diamond and then a carbide bur, being careful not to remove centric stops. The final clean-up and polish is performed using porcelain polishing cups and points and diamond polishing paste (Brasseler). The before and final Empress restorations reveal an excellent fit and color match. (Figure 14, 15).

Before the primer is cured, care should be taken to make sure there is no pooling of the primer that would create too thick of a layer of primer. This could possibly impede the seating of the final restorations.

The desire to consistently deliver fantastic looking and fitting restorations in the posterior portion of the mouth is certainly in the realm of possibility. If we, as clinicians, spend the time to color map, photograph and communicate beautiful looking anterior restorations to our lab, why is it not possible to deliver the same beautiful restorations in the posterior portion of the mouth? Just because our patients might not see them as well doesn't mean that we don't see them on those 6-month recalls. There is nothing more rewarding than to see these restorations come back every 6 months and your hygienist exclaims, "I can't even tell which ones they are". Without the proper tools for communication with your lab these restorations just won't happen.

The desire to consistently deliver fantastic looking and fitting restorations in the posterior portion of the mouth is certainly in the realm of possibility.

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.

INTERVIEW WITH DR. OMER REED

What makes Omer Reed tick?

The indomitable energy that comes from the freedom to choose. As paradigms shift, to be free to choose is a tremendous "high." (reference the work of Dr. Viktor Frankl… wow!) When one looks back at dentistry over the past five decades, one of the choices is to see the wondrous gifts we've received… what a trip! What makes Omer Reed tick? The tactical answer is the positive power of attitude, the intentional use of fear as a driver (see Manhattan Project and the moon shot).

Outside of dentistry, what do you do in your spare time?

My spare time is invested with my wife and family as we interrelate and the blessing directly relating to powerful, personal mentors who have achieved far more than I ever will, and who are willing to stoop to share their power with me. Hobbies… traveling, soaring, power flying and the joy that comes from the power of nature… rafting the Canyon with friends… and, of course, the Harley-Davidson.

Far too many dental professionals are over burdened by their practice. Hey! Life's too short. Among my favorite pastimes is riding astride my Harley-Davison motorcycle, touring the scenic Southwest and Rocky Mountains. It's "freedom for prisoners of the work ethic" - as a great friend of mine once described it. Neat thing is that I've been fortunate enough to couple my passion for dentistry with my passion for motorcycle touring as a guest lecturer for Learning Curves… an organization that combines continuing dental education with Harley-Davidson motorcycle adventures. Founded by my close friends, Roy and Frances Hammond (star dental providers in their own right) Learning Curves has been a great way for me to co-mingle education, stress relief and fun. If a little break is long overdue for you, join me sometime on one of these rides. I'll watch for you in my rear view mirror.

Who do you admire and why?

In dentistry, the names are familiar to the "chronologically maturing" in our game: L.D. Pankey, Harold Wirth, Bob Barkley, Herman Corn, Lennie Abrams, Hamp Burnett, Morty Amsterdam, Nate Freidman, Dutch Woehler, Ralph Phillips, Art Dugoni, Bailant Orban, Dan Laskin, Richard Tucker, Perry Ratcliff, Gordon Christensen, Peter Dawson, Jan Lindhe and Nieman, Rex Ingraham, Siggi Ramfjord, Helmut Zander, Cliff Oschenbein, and, of course, Lattimer. . . and the "latter day saints." Too early, you say? Don't sell short the "new crop" … the seventeen "Institutes" out there. They won't all make it, but they go forward in faith. I won't continue this. It could, and to be complete, should go on so no one is left out. How about Bill Dickerson? Has anyone experienced a metamorphosis as dramatic and complete as Bill? Time will, in my opinion, park Bill among those most responsible for paradigm shifting the game. Mentors all … and to answer "who do I admire?" there you have it, limited to the profession.

What makes you happy in life?

Happiness in life is a choice. I believe one chooses to be happy. It's not wise to wait around to see if it will "happen" to you. Think about it. Where were you, what were you doing and with whom were you the last time you recognized the passion that comes with happiness? Want more? Arrange the time for the people, the place, and the activity and you'll re-achieve your desired happiness.

You have seen dentistry evolve in your career. What do you think the most significant change in dentistry has been and why?

Without question, the wellness movement in dentistry, the wholeness of being well, dentally, is the most significant change in our game. Most do not have their "arms around it" conceptually. Finally the Surgeon General has supported our game, the first such focus. "You cannot have a healthy body without a healthy mouth." Wow! To many this may seem distant, unrelated to the revolution in interactive, diagnostic technology, the many new systems to fix it if it's broken. The doctor of dental wellness will use all of these in synchrony to consciously inter-relate with the co-therapist coming to us for care. If our guest in the dental chair doesn't care, we cannot afford to care. The more complex the rehab, the more likely it is to fail over time. The best dentistry is no dentistry. The best we do cannot compete with what nature provided in the first place, and the guest in our chair has allowed and contributed to its destruction. So, nutrition, hydration, all known etiologies removed, daily, by the person who chooses to stay well instead of repeatedly "getting well"… physical exercise, proper breathing, tobacco cessation… it goes on! Here lies the passion for our profession for the future. And people will pay well to stay well. We must restore these people to "look good, chew good, be stronger and be more cleansable," then, the interceptive energy that converts the sinner to the saint is where I find the fun.

You have been a huge proponent of front-desklessness and the single-chair schedule. Why and what inspired you to do this?

The study accomplished the Kellogg Education Foundation in 1978-80 in Washington State. Wow! Published by the ADA in the mid-80s, it profoundly and irreversibly affected my point of view. Net-tracking the behavior of the doctor and team with industrial-type stopwatch studies shows the easiest and most personable, fun way achieve economic independence (having enough money working for you as hard as you've worked for it so you don't have to work at all… ever!) is by serving others in a personal, private care setting where fee = cost + profit, not fee - cost = profit. It's simple. It's obvious. But it is being ignored. Dickerson got the message over 17 years ago and… wow!

If every dentist could understand 1 basic principle, what would it be?

Love your neighbor (the person coming to you for care) as you love yourself. If you don't love yourself, your neighbor doesn't have a chance. It seems to me that the LVI energy proves this equation well. What do I want for me? That's what my "neighbor" is given.

What has been your most rewarding experience in dentistry?

The power of the personal relationship with each and every team person and the person coming for care is the most rewarding experience in dentistry for me. The acceptance and gratitude that comes from servitude is addictive. Yes, indeed, extremely rewarding.

What sort of legacy would you like to leave behind?

Legacy? That I cared, that I shared and that I loved my fellow man. On the tombstone, "… and this is the only stone he left unturned."

Why did you join LVI?

Not wanting to be down on something I wasn't up on, I attended the occlusion course at LVI to personally experience what I chose to be "up" on. I found the experience, the philosophy and energy at LVI to be contagious. What they are teaching at LVI was applicable in the treatment room and has proven to be effective to the people coming to me for care.

Bill extended a warm invitation for me to "re-ignite" the energy and passion that I had been teaching in the past to the current LVI dentists – he felt it was extremely important for these dentists to experience the message. So I decided to teach the Omer series of courses and the Million Dollar Roundtable at LVI. LVI has a great delivery system and has become a distribution center to further spread the message.

What do you think the future of dentistry looks like?

The future is more than a projection of the past. As dentistry moves away from the co-payment systems, the values of the people coming for care will be expressed, personally, by their choices. The media generically helps the person buy what s/he wants, whether or not s/he needs it. We must help these folks buy what they need whether or not they want it. We are not well aware of the pro-

jections of the dental work force and the disease rates and our able-ness in production per unit time. As these combine, so will be our future. There are a lot of naturally well people among the "boomers" and the "X-ers." I'm very positive about our future. A caring, listening, personally concerned, well-trained dentist will have the world's attention and will succeed beyond all imagination in the teens, twenties and thirties of this century.

You have impacted the lives of dentists from around the world. What inspires you to continue spreading the word?

No behavioral pattern in our lives continues without a "payoff." Reward is a part of the game. To teach is to learn twice… and I'm going to die learning. Gratitude is a big paycheck when a "stolen" tidbit solves a painful problem for a fellow man. There's little new under the sun. The philosophy, vision, mission, and strategy of the master mentors combined with the challenge of change never ceases to provide fun, happiness and WOW! What a pay off! Ask Bill Dickerson, he knows.

To teach is to learn twice… and I'm going to die learning.

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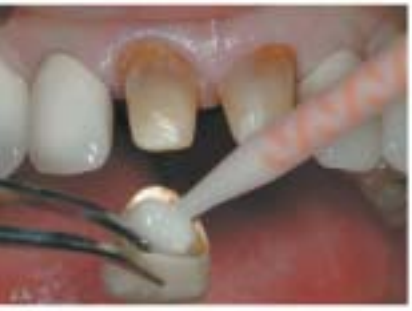

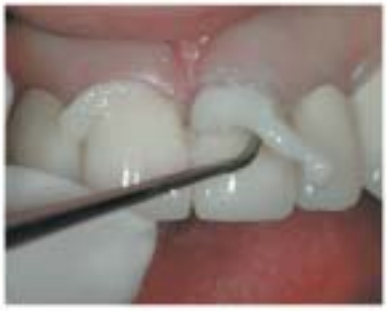

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Ask Heidi

Clinical Questions and Answers

Dr. Heidi S. Dickerson is a Clinical Director at LVI. 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

Q

Dear Heidi,

I use a great PVS impression material but am having some issues when the restorations come back from the lab. When I try to seat them, they are too tight on the teeth; however, they fit the die perfectly. Is there anything the lab or I am doing wrong that is causing this problem?

Thanks, Dr. L.L.
Virginia

A

Dear L.L.,

It is so disheartening when you get a case back from the lab, anesthetize the patient, try them in…and they do not fit!! ZOIKS!!! We have ALL been there. It is easy for us to grumble and moan and initially blame the lab…but, the truth is, it is a doctor issue. The problem here is the impression. If the heavy body starts to set up before we can get it in the mouth and we get "spring back" from the "memory" that the material has developed.…the wash covers over the hard body so the impression looks good, but the dies will be smaller than the teeth actually are. This is generally the result of the assistant putting the heavy body in too soon while you are placing the wash in the patient's mouth. My best advice is to revisit your impression set times and technique with your assistant. It may be possible that the hard body is being loaded too soon. As for the lab, they have escaped blame on this one!

Heidi

Q A

Dear Heidi,

My bonded, all ceramic crowns have fractured in the past and now I am scared to do them. I absolutely love the aesthetics but must admit, I do not recommend them to my patients because I do not want to redo any work. What materials do you recommend?

Signed an "Apprehensive Bonder",
Dr. B.C., California

Dear B.C.,

What a fantastic question! I am sure this same thing troubles many dentists across the country. There are so many materials to choose from: Empress, Finesse, Sinfony, Belleglass, Cristobal+, Cercon, and P2Z …to name a few! Which one should you use? Well, all of these restorations have pros and cons to them and it would take a magazine in itself to describe them all. But, I think there is an underlying issue here that we need to solve before you choose the material in which to fabricate your restorations. The issue is that of addressing the stability of the occlusion. How are you adjusting your restorations? Are the forces directed down the long axis of the tooth? I routinely place 28-32 units of all ceramic restorations in my FM patients without fracture problems. For me, holding to the principles of Neuromuscular Occlusion has proven to be successful. On those rare occasions when I have a fracture, I investigate to see the cause. A majority of the time it is an incline interference that is causing a lateral force on the tooth instead of down the long axis. You need to determine what occlusal philosophies to restore by and go from there. I know one thing, the key to your success is a stable occlusion. If the occlusion is stable, then any aesthetic restoration you choose will be a winner!

Heidi

Q A

Dear Heidi,

My porcelain margins do not fit like my gold margins. Should I be concerned? Thanks in advance for your advice.

Dr. A.C., Virginia

Dear A.C.,

Take a deep breath…everything is fine! I realize that when you place gold restorations, you burnish down the margins and there is virtually no space in between the margin and the tooth. When you begin doing bonded porcelain work, it is easy to be nervous at the margin because you are used to your other restorations. The difference is you are bonding these restorations in with a permanent restorative material. It's like there is no margin as it goes from tooth to restorative material (composite) to porcelain. The luting cement is not any different than doing a composite on the facial of number 20. You would not hesitate to restore the facial surface with a composite, would you? Of course not. This is the same thing. You are filling in any discrepancies between your margin and the tooth with a permanent restorative material. Unlike gold restorations that we "cement" with Durelon, zinc phosphate etc., these bonded restorations are strong, stable, and will not come off if the patient chews some Salt Water Taffy! One last thing, if I have not convinced you, do a few of these restorations and then take post-op bitewings. You will see how beautiful the margins look! I hope I have eased any concerns.

Heidi

Michael Miyasaki DDS, LVIM

Dr. Michael Miyasaki is a 1987 graduate of USC School of Dentistry. Mike developed a highly successful reconstruction practice in Sacramento, CA. Following his passion to teach and mentor other dentists, Mike moved to Las Vegas to become the Executive Director of Programs at LVI and practices in the LVI Faculty Practice. Mike lectures and publishes articles on the latest aesthetics, occlusion and materials available.

PRODUCT REVIEWS

High-tech Equipment I Couldn't Live Without

In this issue, I'm going to concentrate on two pieces of operatory equipment that I could not practice comprehensive aesthetic dentistry without. On the diagnostic side, I'm speaking about digital radiography and on the treatment side, I'm speaking about the diode laser.

Let's begin with the diagnostic piece of equipment first. You get a call on a weekend, an emergency toothache patient. You meet them at the office and they need an x-ray. Luckily you have the Dexis™ Digital Radiography unit. No waiting while the developer warms up before taking that periapical radiograph. Instead, in less than a minute you've got your digital image which is displayed on a large computer screen ready to manipulate or enhance to make the diagnosis, treatment is under way, and you're weekend is back on track.

I bought my first digital radiography unit 10 years ago. The drawbacks I found were that the resolution wasn't as high as I needed to diagnose and once I printed it, it got even worse. I couldn't e-mail the images because no one had e-mail access to share images. But today things are different - the sensor and software are better, our displays provide a higher diagnostic resolution, printers are so much better and affordable, and just about everyone has e-mail access so these old problems no longer exist.

The Dexis system is easy to use and cost-effective. There are no chemicals, no chemical disposal fees, no developer, no developer maintanence meaning less wasted staff time. When restoring implants you can get that quick radiograph to be sure everything's together. Or, when taking your regular series of radiographs, you can do so quickly (probably in a third of the time), and have it available to incorporate into any word processed documents or to e-mail to a fellow colleague.

There is almost universal agreement that digital radiography enables patients to better understand and give informed consent to the treatment plans recommended because they can see so clearly exactly the conditions the dentists can see.

Dexis's fully customizable software allows each dentist to configure radiographic image capture and presentation to his or her own preferences. If you have a specific order in which you prefer to capture the images, Dexis enables you to specify that order. From then on, with a single mouse click even for a full-mouth series, you'll automatically capture the radiographic images in the order you prefer.

It's the same with mounting. The Dexis system digitally mounts the images exactly as you want them mounted. It does this automatically to your specifications, so you and your team don't need to manipulate each image manually in order to see them as you'd like to. It's literally a "set it and forget it" application.

Dexis continues to do extensive testing with dental patients. Among the innovations to emerge out of this testing is the PerfectSize™ sensor. It's a single sensor designed to maximize the area of exposure while minimizing patient discomfort during the radiographic procedure. It features rounded corners that minimize the discomfort patients typically experience due to the sharp corners of radiographic film packs and other digital sensors.

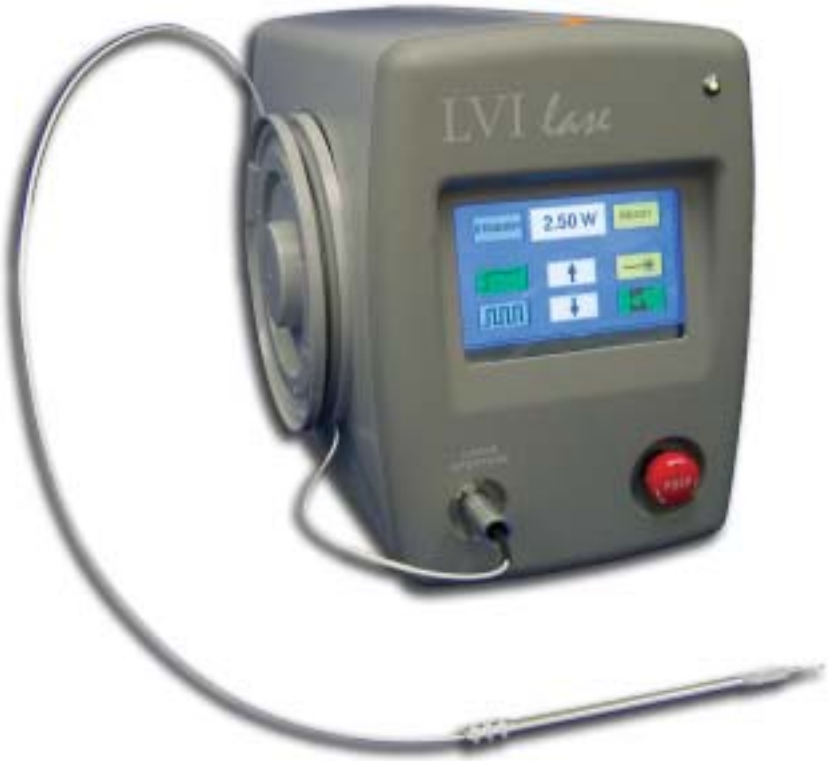
Dexis™, is the manufacturer of top-of-the-line digital radiography systems and has consistently stressed innovation in response to the needs of the dental community and its ability to fully integrate with practice management systems through its customizable software interface. Dexis has developed the most widely compatible digital radiography software in the industry and Dexis' commitment to radiographic excellence and seamless integration means that its customers do not have to compromise the quality of their digital radiography by purchasing a "package deal" from a practice management specialist that adds digital radiography as an afterthought.

If you are looking at digital radiography as a possible addition to your practice "see" what Dexis has to offer.

Introducing The LVIlase

It's finally here… introducing the first soft tissue diode laser manufactured exclusively for the Las Vegas Institute by HOYA ConBio. We chose HOYA ConBio to develop a laser that would be affordable, reliable and suited for all our aesthetic and therapeutic needs. Lasers are here to stay they identify your practice as high-tech and give you the opportunity to take your aesthetic cases to the next level. You may be thinking about a buying a laser, but are hesitant as they seem too expensive, intimidating, or you wonder if you'll find any use for it. Let's see if we can put your concerns to rest.

The LVIlase is priced under $10,000 which makes it quite affordable The first lasers I purchased cost more than twice this amount, but I still felt the return on my investment then was priceless. But remember your laser can be an income producing piece of equipment. Think about what you would charge for a gingivectomy, apthous ulcer treatment, etc. Just like your radiographic equipment it generates income while improving the quality of your service. And, just one or two of these units are sufficient in most offices-I had one for myself and one for my hygienists to use We worked to design a laser that could be moved from room to room without the use of a cart, and with a small foot print to minimize the amount of precious countertop space taken. Transporting from op to op is managed easily and quickly. The laser has a carry handle on the back around which the power and foot pedal cords can be wrapped, and the light weight unit is ready to go.



Intimidated using a 'laser'? Don't be! This laser is easy to use. The touch screen control is easy to read and enhanced to allow viewing from any angle and in any lighting. The icons on the screen are self explanatory. Power settings are displayed and 'arrowed up' to increase power and 'arrowed down' to decrease. Discussing power this laser has 2.5 watts of power, which is more then sufficient to accommodate any soft tissue procedure (rarely would one go above 1.2 watts). The most dramatic improvement is with the management of the fiber. The fiber is manually spooled on a cassette which protects the fiber, improves fiber management and offers the ability to sterilize the fiber. The laser will be available with all the necessary accessories (safety glasses, two fibers, hand pieces and disposable tips) as well as a one year warranty. Still worried? The included manual will give you power settings and technique tips to get you going.

Okay, now you're thinking, "The laser is priced right, I'll get everything I need to get started, but what am I going to use it for?" Here's are a few examples-gingivectomies to improve aesthetics, sulcular troughing and hemostasis to eliminate the need to pack cord (always the highlight of my day), and apthous ulcer treatment to relieve the pain many of our patients suffer from having an open sore just to name three everyday uses. The laser also saves you time. Here's an example, if you're using it to sculpt the gingival tissue for an aesthetic case, it's not the

"wait and see" that you might have experienced with an electrosurge or scalpel. You can perform the gingivectomy, prepare the teeth and take the impressions during the same appointment without worrying if the tissue will recede appreciably after laser treatment. In the past, working on the tissue either surgically or with electrosurge meant that a healing period was needed to allow the tissues to heal to their final position before taking your impressions for the final restorations. Using a laser eliminates the extra visits making your use of time more efficient and profitable-a win-win for you and your patient.

Why a laser? In many instances, using the laser gives us a way to work with the soft tissues by creating a very limited zone of necrosis while at the same time sealing blood vessels and nerve endings. This means that patients have predictable healing with relatively no post-operative swelling or discomfort. Lasers are no harder to use than an electric hand piece in my opinion. You turn it on, don the safety glasses, set the power you need and begin. I'd recommend attending a one-day laser certification class, offered at LVI so that you understand the physics, indications of its use and how to effectively treat your patients. It's that easy!

If you haven't tried a diode soft tissue laser look at the LVIlase as a possible addition to your practice. I think you'll soon be wondering how you lived without it.

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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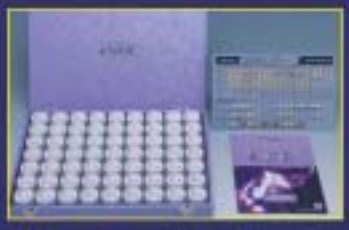

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Meta

When you call LVI, you always hear the uplifting phrase "where lives are changing daily". We are very fortunate to be two of the lives that were changed. We are a husband and wife dental team that have been married for 20 years and have practiced together for over 18 years. We were both in our 3rd year of dental school at Temple University when we got married. We had big dreams and big debt, but we were excited to start our journey.

We graduated from dental school in 1986, and after working for another dentist and having various jobs at the typical dental clinics, we realized we wanted our own office. We opened a brand new "start up" practice in 1988 in Yardley, PA (just outside of Philadelphia). Starting with zero patients and choosing an area where we didn't know anybody, we thought the best way to get patients was to sign up for insurance plans. We eventually became providers for Blue Shield, Delta Dental, and a few PPOs. In a little over 10 years, we grew the business into a very successful general and family practice. We were always trying to find ways to squeeze one more patient into our extremely busy day. We did all phases of dentistry and worked at least 60-70 hours a week.

Randy Bryson and Toni Margio

Every CE course we would attend was to help us to work faster, so we could see more patients in a day. We thought that the only way to make money was to be as busy as possible. We also thought having a very big staff and a wall full of charts was the sign of success. The practice that we built with our hearts was a small 4-chair office that had a very modern and high tech appeal. We felt that we were reluctantly going to have to move to a bigger space after putting so much of our personality into this office. We began to look for ways to not only increase the size of our staff, but expand the size of the office. Needless to say, the more patients we added and the larger the staff, the more headaches we seemed to bring on.

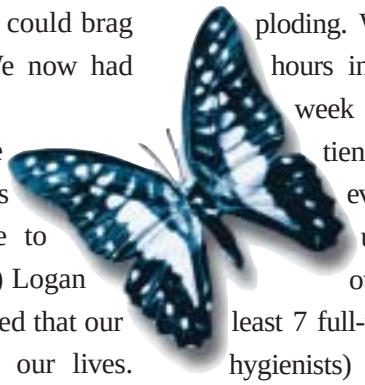
At the same time, we had the typical business skills of most dentists…NONE. We rarely collected any money or collected just a co-payment from our patients at the time of

morphosis

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

service. We trained our patients to say "just bill me". We would then send out hundreds of statements a month and hope for the best. At the time, we thought that one good thing had developed, a six-figure AR. We were so envious of the bigger, more established practices that could brag about their huge AR. We now had our very own!

Even though we were both working 60-70 hours a week, we found time to have our only child, (son) Logan in 1996. We slowly realized that our practice had taken over our lives. After our son was born, Toni only felt comfortable staying away from the office for 4 weeks and worked up to the day before she delivered. We worked so many hours during the day that we usually left for the office before our son woke up and we normally returned home from the office after he had already gone to sleep. Even if Logan was awake, we were normally too exhausted to enjoy his company. Our son was almost 2 years old when we realized we were missing him growing up.



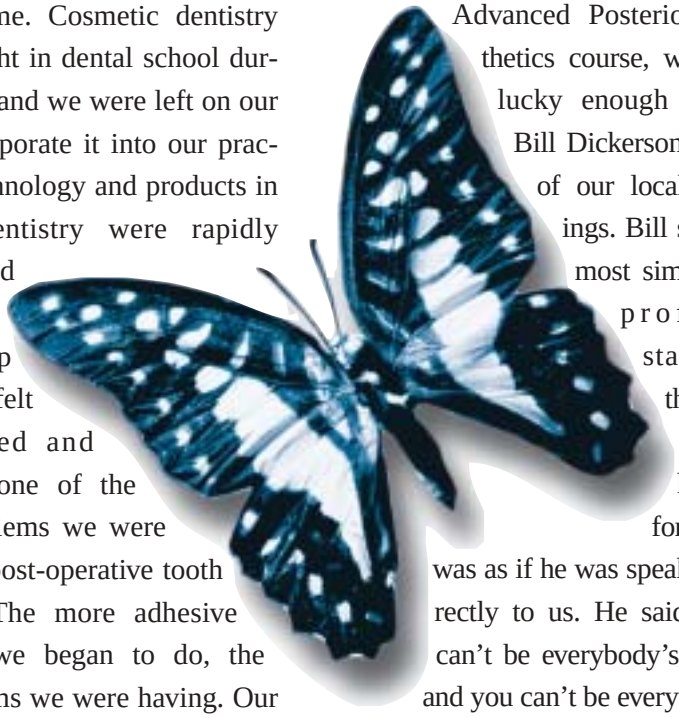
Financially we were doing very well and the growth of our practice was exploding. We never had enough hours in a day or days in a week to see all of our patients. We worked most evenings and every Saturday to accommodate our patients. We had at least 7 full-time staff members (2 hygienists) and would have had more if space allowed. We were an insurance-based practice that proudly enrolled most of our patients in the "crown of the year club". We did mostly single tooth procedures and would only treatment plan what their insurance would allow. We would be sure not to go over their annual maximum as this might upset our patients. This is what we thought as dentists we were supposed to do. We trained our patients not to pay, and only do "need-based" dentistry. Surprisingly even though our practice had no real business systems in place, we were still able to make a very comfortable living.

However, we began to dread going into the office each day and were quickly facing "burnout". We began to hate Monday mornings. In early 1999, we visited a well know financial consultant to dentists and drew up a plan to retire in 15 years. We were 39 years old and began to count down the days until we could quit dentistry. We worked so hard to become dentists and build a practice, but couldn't wait to leave it. It was very profitable, but not enjoyable. However two things happened in the summer of 1999 that helped us to get where we are today. First, we enrolled in the Advanced Posterior Aesthetics course at LVI with Dr.

Ron Jackson, and secondly we saw Dr. Bill Dickerson speak at a local meeting. We didn't understand that our professional and personal lives were about to change… forever.

We were always scrambling to find answers by taking local CE courses. We wanted to become cosmetic dentists rather than traditional family dentists, but we weren't sure how to go about it. It seemed like you would listen to one speaker tell you one thing and then you'd read an article that said to do it another way. The reality was that the more courses we would take, the more confused we would become. Cosmetic dentistry was not taught in dental school during our time and we were left on our own to incorporate it into our practice. The technology and products in cosmetic dentistry were rapidly changing, and it was difficult to keep current. We felt overwhelmed and confused - one of the biggest problems we were having was post-operative tooth sensitivity. The more adhesive procedures we began to do, the more problems we were having. Our typical solution to this problem was to just switch to another product, hoping it would go away.

About this time, we saw the LVI courses advertised in one of our dental publications, and felt that this may be what we needed. We never thought that there could be a single place to help dentists. LVI helps to eliminate the confusion and has everything a dentist needs to help change the way they do dentistry. It seemed like a very big step because it was so different than your typical CE courses - the tuition is higher, you need to take patients and team and Las Vegas isn't that close to the east coast. We hemmed and hawed, but fortunately had the guts to sign up. We often look back at that very moment and laugh at how much angst we had. If anybody is reading this article and is just starting their journey, please take it from us…don't hesitate. LVI is the best investment you will make in your practice!



Before traveling out to LVI for the Advanced Posterior Aesthetics course, we were lucky enough to see Bill Dickerson at one of our local meetings. Bill said the most simple but profound statement that day that hit home for us. It was as if he was speaking directly to us. He said, "You can't be everybody's dentist and you can't be everything to everybody if you want to be good at what you do. " Bingo, that is exactly what we were trying to do. We were trying to make all of our patients happy and at the same time making ourselves more and more miserable. This revelation started us on the first really focused direction of becoming the practice we always wanted to be… a high-end cosmetic practice offering 5-star customer service. We finally understood the importance of having a clear vision and direction for your dream practice. Also, he made us "mad as hell" at Delta Dental, which was not too difficult to achieve. We immediately went back to our office and dropped Delta Dental and came up with a plan to drop all remaining insurances.

We felt we were one of the best offices on the insurance lists, so we were getting most of our patients from that source. The hectic pace we kept didn't allow time to pamper our fee-for-service patients that wanted the type of dentistry we wanted to provide. Our practice was filled with insurance driven patients that consumed most of our efforts. We can remember spending half of our patient time talking about insurance issues. Also, we were delivering the best dentistry we could offer, but at a reduced fee, which is not the way to make a profit when you are in business. Therefore, we decided to become the type of dentists we wanted to be and treat the type of patients that wanted and valued our services.

Now that we had a vision for our practice, the one thing we knew that was needed was better clinical skills. Dr. Ron Jackson's Advanced Posterior Aesthetics course and the LVI Advanced Functional Aesthetics course were the much needed stepping stones in the right direction. After the Advanced Posterior course, we immediately began to treatment plan more comprehensively. We no longer had the problems with post-operative tooth sensitivity and we felt confident for the first time that we knew exactly what we were doing. We

were now able to understand and choose the best product and restorative material to use for our patients. We began to restore the teeth to their natural form and function. Also, this course established the foundation of our practice. Patients readily accept and understand the benefits of comprehensive, conservative posterior dentistry. Dr. Ron Jackson was the first instructor we had ever had that was so knowledgeable and giving of himself. Our first mentor in dentistry had been established and we will be forever grateful to him. I don't think we do an adhesive procedure without him sitting on our shoulders.

Now that we had a vision for our practice, the one thing we knew that was needed was better clinical skills.

The next course we took was the Advanced Functional Aesthetics course. This course is amazing and meeting Dr. Bill Dickerson for the first time was even better. Bill is such an inspiration and his great passion for dentistry is contagious. If you are not fired up about dentistry after meeting him and taking this course, you need to find another profession. Talk about a confidence builder and a energy booster course. Finally, we were beginning to feel like true cosmetic dentists. We wanted to take on the world and give everyone beautiful smiles. We learned amazing temporary techniques, systematic approaches, predictable results through smile design and diagnostic wax-ups, and finally were introduced to labs that could produce expected results. This course also shows you that in order to have this type of practice, it involves much more than great clinical skills. You need to develop and improve the clinical, business and customer service areas in your office. Talk about a metamorphosis - this is the course that takes you from a caterpillar to a butterfly. It also humbles you into realizing that "you don't know, what you don't know" as Bill would say.

Bill Dickerson is an amazing force in changing the face of dentistry and we knew that we had found yet another magnificent mentor. We knew our growth had just begun and we had found a home at LVI, not to mention many friends and the most sharing colleagues in the world. This was nothing like dental school or your local dental meeting. We were also introduced to occlusion philosophies that finally made sense to us and the restorative results we would be able to perform. We caught the "LVI bug" and took course after course, and plan to continue as long as they keep adding them. We have embraced the Neuromuscular Occlusion concepts taught at LVI and incorporate the use of the K-7 into our treatment.

As you can already tell from our earlier years in practice, we also knew we needed to improve our business skills. We had Bob Maccario and Gwen Hoffenberger from Dental Concierge come to our office several times. They finally pounded some business sense into us, kind of like fitting a square peg into a round hole. We are proud to say that we are totally insurance free (almost 4 years), have a negative AR, give our team bonuses routinely, and have solid systems in place. We consistently have record-breaking months and had our best month in August 2004, which was $176,000. We keep raising the bar and are on track to reach a goal of $1.6 million this year. Not too bad for one dentist working 32 hours, one working 18 hours, and only one full-time hygienist. We went from working over 225 days a year to less than 170 days. We also are able to keep a low overhead with a small office and team. What is most important is that we finally have the practice of our dreams. We are doing dentistry that we never thought possible and getting paid for it. We now decide how many days we want to work and who we want to treat. We decide the best treatment options for our patients, not what the insurance company tells us. We now can say we LOVE dentistry.

Our practice significantly changed, as did our lives. As our skills and confidence grew, we were doing more and more cosmetic procedures.

We went from treatment planning quadrants, to upper arches, to the entire mouth as our awareness developed. Suddenly, it wasn't how many patients we had, but what type of patients were they. Did they want comprehensive dentistry? We also made a huge transition from having a "staff" to developing a "team". This transition was as important as any we made. Our team has been a huge help in developing and growing our practice. You can't do it alone. We now look forward to going to the office every day to have fun with our team. Our team is also more satisfied because we can afford to offer them better compensation and they earn bonuses with our continual success. We are able to spend quality time with our guests and do "world-class" dentistry. We also aren't dead tired at the end of the day. We almost feel like we are cheating because we get paid very well to have all this fun.

The most important transition in our practice has been that Toni was able to cut back her schedule to 3 days and is home when our son Logan gets off the bus. She is able to volunteer once a week in his school. She has more administrative time for the practice and is not spending her weekend catching up on work not completed during the week. I can coach my son's soccer and basketball team and spend quality time with my family. I also have had the honor and time to be a clinical instructor at LVI. We enjoy dentistry and can't think of anything we'd rather do.

Personally, we are very grateful that we found LVI. We cannot imagine what our lives would be like if we hadn't started on this journey five years ago. We hope our story can have some meaning for others. We believe that LVI has allowed us to decide what type of practice we want to have - we can decide the type of dentistry that we want to do, and whom we want to do it with. We think the only limitations are the ones that we place on ourselves. The important thing that you need to do is to develop a business plan and acquire the skills to implement that plan. LVI has all the programs that will help you develop your own vision for the type of practice you wish to have. No other place can provide what LVI has to offer.

The important thing that you need to do is to develop a business plan and acquire the skills to implement that plan.

Before 1999, we never thought much about having a mentor in the field of dentistry - we weren't enjoying dentistry that much to even care. We now would like to thank 2 amazing dentists that we consider our mentors, Dr. Ron Jackson and Dr. Bill Dickerson. They are so very different types of personalities, but they share many things in common. One is their passion for dentistry and how they make you proud to be a dentist. To say very inspiring, doesn't do their lectures justice. Also, they both share an intense commitment to see LVI grads become very successful. Bill and Ron inspire you to go out and do what they have done. Every course at LVI enables you to go back to your office on Monday and implement what you have learned.

Personally, we need to thank Bill Dickerson. We are so grateful that he had the vision, courage and strength to lead LVI to where it is today. He had amazing insight to bring the neuromuscular dentistry to the forefront. His example of standing up for what you believe in, even if it is unpopular, has had an effect on us. We don't take nearly as many arrows in our backs as he has, but we do stand up for what we believe in. We will, forever, be strong supporters and a voice for what Bill is accomplishing at LVI. He has not only made us much better dentists, but has also improved our personal lives. Our family will always have a special place in our hearts for Bill and LVI. We could never thank LVI and Bill enough for "changing our lives".

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WHY ARE MORE GENERAL DENTISTS BECOMING INVOLVED WITH IMPLANTS?

By Leo J. Malin, DDS

Dental implants are now considered a standard of care. Recent surveys taken by the American Dental Association (ADA) have shown that not only are more general dentists placing implants, but the number of implants each dentist is placing is also growing. For those general dentists who placed implants, the number of implants placed per year grew from 28 implants in 1995 to 31 implants in 1999 and the numbers continue to grow. The percentage of general dentists who place implants has grown from 4% in 1995 to 6% in 1999, to over 9% in 2003. According to representatives from a dental implant manufacturer, that number stands at 12% in 2004. Why is the market expanding?

Reasons include:

- The development of advances in technology
- Radiology
- Implant design
- Better protocols used in implant placement.

It has been stated in the Dental Practice Report that traditional crown and bridges as a solution to missing teeth will give way to implants because implants are almost always a better clinical solution. Along with technological advancements, patient demand has been a driving force. Patients are beginning to understand both the aesthetic and clinical advantages of implants over alternatives and are demanding the best aesthetic and clinical solution to their dental problem. All of these factors lead to the inescapable conclusion that more implants are going to be placed by more general dentists in the future.

General dentists also need to take better control of all their implant cases, self-placed or not. Most often, control means controlling the implant placement. Exact placement of the implant controls the occlusion and the aesthetics of the restoration. Every general dentist can become part of this growing market at a time when technology has made the treatment planning, radiology component and surgical aspect of placing implants the easiest and most predictable it has ever been.

Many institutions have implant courses available to the general practitioner. The training received at LVI from the Implant One & Two classes will allow general dentists to place approximately 75% to 80% of the implant cases presented to them. General dentists can be more actively involved in implants by actively controlling the implant placement by others or by surgically placing implants themselves. Of course, in some more advanced implant clinical situations, specialists are required. These cases may have more advanced complications like bone grafting or other disease factors that may bar the general dentist from placing the implant without more extensive training.

Why would general dentists want to get more involved with implants? Control: Gaining control extends from the treatment plan through surgery to the final restoration.

Treatment Plan

General dentists are often seen as the gatekeepers for their patients. Almost all referrals to dental specialists go through the general dentist's offices. Many patients do not want the implant process split between two professionals. Since the general dentist provides the initial implant treatment plan and provide for patient acceptance of that plan, the patient may feel more comfortable with their general dentist performing the planned procedure. An implant treatment plan (not including extraction and immediate implant placement) that does not have a tomographic or CT component is more likely called a treatment guess. A treatment plan that starts with the occlusion is more likely to succeed because that plan is based on Neuromuscular Principles. In my opinion, an implant placed in a properly loaded occlusal bite, is the number one factor in implant success. I personally would not want anyone performing implant surgery on me without the third dimension that tomography or a CT scan provides, along with a complete treatment plan.

Dental implants are now considered a standard of care.

As is the mantra of LVI, "Diagnose as if it were your own mouth, don't do something on someone else that you wouldn't do on you." In a recent Implant Two class at LVI, doctors who had very limited implant placement experience, placed 23 implants in nearly sequential surgeries in less than 7 hours. How was this possible? By utilizing complete treatment planning! This included tomography and the NIS protocol being applied to each of the patients. The Neuromuscular Implant System® protocol I have developed has simplified and enhanced the predictability of the placement aspect of implants. In this NIS system, a surgical stent is prepared with an adjustable guide placed in the stent exactly where the restorative dentist wants the final restoration to be placed. The drill guide is then adjusted to align with the available bone by utilizing a CT or tomographic unit to create a straight line from restoration to bone. During surgery, by placing the implant along this line, subsequent lateral forces placed upon the implant are minimized. All occlusal forces are applied vertically along this line. By placing all implants using this protocol, angled abutments are never needed and all occlusal forces will be balanced.

Surgical Placement

The implants, abutments, surgical kits, motors and restoration components have all seen advances in technology in the last years. The materials and design of the implants and abutments have been enhanced to support better oseointegration and aesthetics. Using the NIS protocol in simple implant cases, only a small tissue punch is used to create the implant opening, resulting in impressions for the final

restoration being done immediately after the implant is placed. This tissue removal method also results in very little trauma and post-surgical pain to the patient. The tissue is removed using the surgical stent which a drill guide has locked on the alignment generated from the treatment plan. This stent also guides the surgical drills along the pre-selected line into the bone. Using the NIS protocol also reduces the number of office visits from three to two for the patient and cuts down on the chair time for the dentist. All of these factors lead to a higher success rate for implants, better aesthetic results and greater control over the implant case.

Final Restorations

The two most important aspects of the final restoration are aesthetics and occlusion. Both of these characteristics are almost entirely dependent on the exact placement of the implant. If the focus of placing implants is driven by the concept of occlusion down to the bone, then the restoration component of an implant case is no different than a normal crown restoration. In a non-bone grafting implant case, the impression can be taken at the time of placement because the NIS protocol allows for very little tissue trauma. The only tissue removed is replaced with a healing collar. There are no sutures. When the implant site is ready for the restoration, the healing collar is replaced with the abutment and crown. There isn't a requirement for a second surgery to uncover the implant site.

The NIS protocol is the preferred protocol in all implant cases, from single implant sites to full mouth reconstructions, because this protocol controls placement using neuromuscular concepts. As of August 2001, there had been over one million dental implants placed in the United States, with less than a 5% failure rate. Currently there are over 18 million people in the United States with multiple missing teeth. Almost all are candidates for implants! The market for placing implants is now! Currently simple, predictable, reliable implant procedures and products have opened up this area of dental care to the general dentist.

The market for placing implants is now!

Many dentists are taking advantage of this market, like the graduates of the implant courses at LVI. These graduates are providing an implant service to their patients they once thought was not possible. You may chose to surgically place most, few or none of the implant cases presented, but in cases referred to a surgical specialist, you still control the position and angulation of the implant in order to achieve the best cosmetic and functional results. It is that fundamental control of the implant positioning which makes the NIS protocol so unique.

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.

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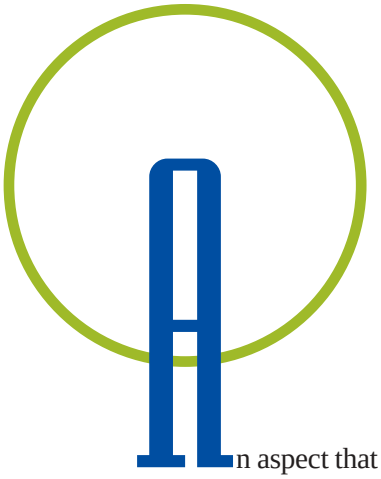
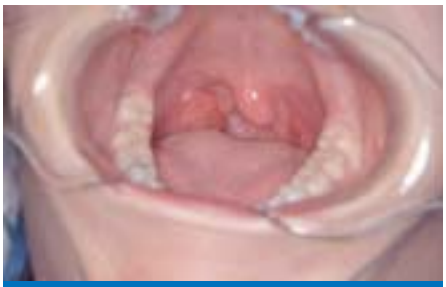
Clayton A. Chan, DDS, LVIM



n aspect that should be considered when treating the stomatognathic system is the study of occlusion that relates the maxillary and mandibular teeth as well as relating the temporomandibular joints together. With further study, it encompasses a relationship that must be determined between the mandible to the cranium.[1] Today in dentistry, there are numerous musculoskeletal occlusal signs and symptoms that can alert the clinician to other related problems that often go unrecognized beyond the occlusal perspective of how teeth articulate and where the centricity of condyle to glenoid fossa relationship exists.



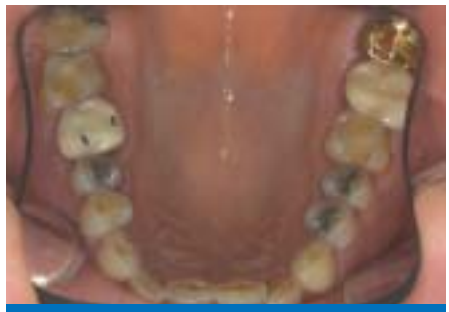
Notice the airway obstruction caused by inflamed tonsils and adenoids

A Bad Bite

Neuromuscular occlusion represents a position in space where the mandibular complex physiologically relates to the maxillary complex via the coming together of the cusps and fossa. A physiologic relationship of the dental arches can be established by electro-neural stimulation of the masticatory muscles. All movements of the mandible naturally seek a balanced end-point in which a stable relationship exists between the teeth, jaw joints and the masticatory muscles. The masticatory muscles including the intra-oral muscles, the extra-oral muscles, the cervical neck and shoulder muscles assist unhindered mandibular movement and positioning within normal boundaries of function and rest. All excursive lateral movement, protrusive, retrusive and bordered movements of the mandible should support an ergonomic functional and aesthetic balanced occlusion without chipping, torquing, and extraneous forces to the periodontium that contribute to excessive gum recession and bone degeneration. Neuromuscular occlusion is an aid to properly support the head and neck as well as maintain a well developed arch form to aid in normal swallowing tongue posture as well as normal chewing cycles. A "bad bite" can result in many other unrecognized medical as well as dental problems that relate to the surrounding muscles, joints and teeth.

Results of Abnormal Mandibular Jaw Closure Patterns

There is increasing evidence that indicates that abnormal mandibular jaw closure patterns contributes to headaches, neckaches, shoulder pain, atypical facial pain or neuralgia, ear congestion, myalgia, tinnitus (ringing in the ears), limited opening of the mouth, dyskinesia of the jaw, hyperactivity of muscles, vertigo



Notice the abnormal wear facets.

(dizziness), paresthesia of hands and fingertips, nervousness or insomnia, dysphagia (difficulty swallowing), thermal sensitivity to hot or cold, and torticollis (abnormal head posture) to name a few.[2] These types of symptoms are signs of temporomandibular joint dysfunction (TMJ) which are a common problem among 10 million people in the USA. Approximately 1 in 27 or 3.68% of all people in USA experience these types of symptoms daily.[11] It is these abnormal jaw closure patterns that contribute to abnormal anterior wear patterns such

Notice the anteriour open bite due to mouth breathing and tongue thrust.

as maxillary lingual faceting, excessive mandibular incisal wear of the lower anterior teeth, bicuspid abfractions and wear facets on bicuspids and canines.

Deep bites may also be indicative of an entrapped mandible that may function more anterior than the existing maximal intercuspal position during speech, swallowing and chewing patterns. Is it possible that as clinicians, we have overlooked the fact that our patients' jaws may be posteriorized and lack adequate posterior occlusal height that can contribute to ear congestion feelings, jaw joint tenderness, clicking and popping joints where the condyles are posterior and superiorly positioned within the joint fossa causing the articular disc to anteriorize. This condition is called hypo-occlusion of the posterior teeth. We clinically observe bicuspid drop-offs, narrow arch forms, crowded lower anterior teeth with incisal wear and a deficient lower one third of the facial height profiles of our patients' faces. Excessive worn dentition, root exposure over time with accompanying gingival recession may develop even though the patient may be under carefully managed oral hygiene care and maintenance.

Primary Environmental Factors

Poor arch development, lack of tongue space, facial aesthetics, tooth long axis discrepancies, anterior crowding, and vertical deficiencies are growth and development outcomes of abnormal tongue habits, airway obstruction (breathing), muscle, postural and facial abnormalities. These are just some of the primary environmental factors that lead to skeletal and neuromuscular problems of any patient with multiple influences.

A comprehensive understanding of the early iatrogenesis of aberrant tongue function is available in the Garry's monographs on "Early iatrogeneic orofacial muscle, skeletal, and TMJ dysfunction". Placement of the tongue to maintain a compensatory airway due to nasal obstruction or placement of the tongue between the teeth for compensatory bracing of the mandible may also lead to unstable occlusion.

Notice the deep overclosed bite.

Science has shown that nasal airway obstruction is caused by hypertrophied tonsils and adenoids, inflamed turbinates, allergic and nonallergic rhinitis, vasomotor rhinitis, deviated septum and posterior choana stenosis. Harvold's experiments demonstrated that the recruitment of orofacial muscles for respiration have a significant effect on muscle development which changes the morphology of the upper lip, the tongue, and orophayrngeal opening. It has been noted that lip and tongue changes are followed by remodeling of the alveolar process and changes in direction of tooth eruption that results in subsequent malocclusion.[10]

Muscle Physiology of the Head and Neck

Neuromuscular Dentistry emphasizes the need to establish an occlusion based upon: 1) optimizing a physiologic jaw position and function of the temporomandibular joints and 2) optimize the resting posture and function of the masticatory muscles at a physiologic rather than a pathologic position.

This approach differs greatly from the common dentistry approach that treats the teeth and assumes the teeth, active muscles, and the jaw joints will accommodate to a habitual/ acquired occlusion. Treating teeth by restorative procedures (crowns, bridges, and fillings) or common orthodontics (straightening teeth) are often overlooked and done without accurately determining a correct jaw posture and a proper vertical dimension!

A Neuromuscular trained dentist can determine a proper resting jaw position that effects the facial, head and neck muscles, the teeth as well as the joints. A physiologic resting

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position and body posture is often overlooked and not even considered as an important part of the whole dental system when performing restorative aesthetic dentistry! Finding a neuromuscular jaw position is paramount before a final restorative/ orthodontic phase of treatment is started to prevent muscular imbalances that would lead to instability of the teeth, supporting bone and compromised posture. A comprehensive analysis and evaluation is highly recommended to assist the doctor in accurately diagnosing and developing a treatment plan that can best meet the patient's needs for long-term optimal dental health and comfort!

Dr. Clayton Chan is the Director of the Neuromuscular Dentistry Curriculum at LVI where he teaches advanced occlusal restorative concepts, TMD and orthodontics to GP's and specialists. He graduated from Loma Linda in 1988 and is a trained gnathologist who practices neuromuscular dentistry. He teaches and \lectures extensively nationally and internationally on the physiology of occlusion, neuromuscular occlusion, and the clinical application of computerized bio-instrumentation. He is a strong advocate for change within our dental profession. Dr. Chan is a Master of the International College of Craniomandibular Orthopedics, a member of the American Academy of Functional Orthodontics and International Association of Orthodontics. Clayton practices in the LVI Faculty practice.

Where Is Your Practice Headed? CONTINUED FROM PAGE 9

the saving grace that will defeat the evil empire of managed care. The reason to incorporate quality, want-based dentistry into your practice is to eliminate the control that insurance companies have on you and your profession. Remind yourself that the one specialist in medicine who has escaped the shackles of managed care is the plastic surgeon.

This article is meant to be a wake-up call. We can't wait till our leaders take the bull by the horns; we have to do it on an individual basis from within. Don't sign up for fee-limiting PPOs. If you are signed up, don't just drop your insurance plans, as it may be very costly. But you can wean yourself off of them, as we teach thousands of dentists to do at LVI. And you can immediately stop letting insurance companies dictate your quality of care and fees. Realize dentistry is a valuable service to humanity, and you should be justly compensated for it.

Dr. Harold Wirth commented: "People have money for what they want, whether they need it or not. It's our job to make them want what they need." Next time patients tell you they can't afford something, look at their kid's feet and notice the $150 sneakers. Listen to them tell someone out in the waiting room about the cruise they are taking this summer. In some extreme cases, listen as they tell your staff that the reason they look different is that they have had breast implants. You see, it's all about priorities. We, as a profession, have to make dentistry a top priority, as it should be.

Do these things in your own practice and watch how your own personal satisfaction in your profession changes. I confess that I used to hate being a dentist. But because of a simple philosophical change, I now love my job. In fact, I can't imagine doing anything else. This philosophical change has created a win/win/win environment for me, my team and, most important, my patients. It has also worked for thousands of other dentists who have taken the same plunge.

My friends, the present holds more possibilities than the past ever did. Dentistry is a great, noble profession — if you take the time to explore what is open to you. The satisfaction you'll receive from creating natural form and function with aesthetic restorations and, in many cases, improving what nature has dealt your patients, as well as eliminating a lifetime of pain for them, is the rejuvenation your practice may need.

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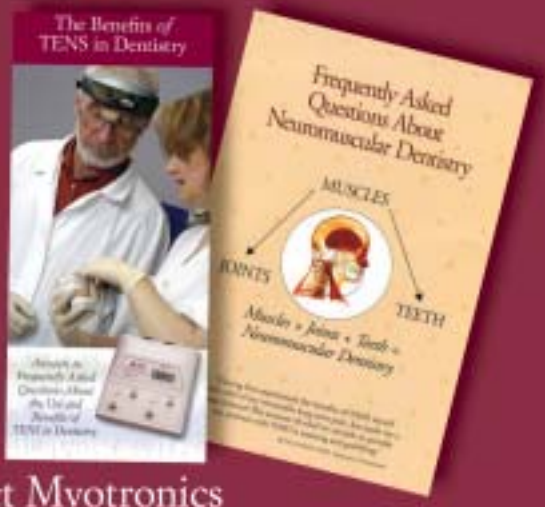

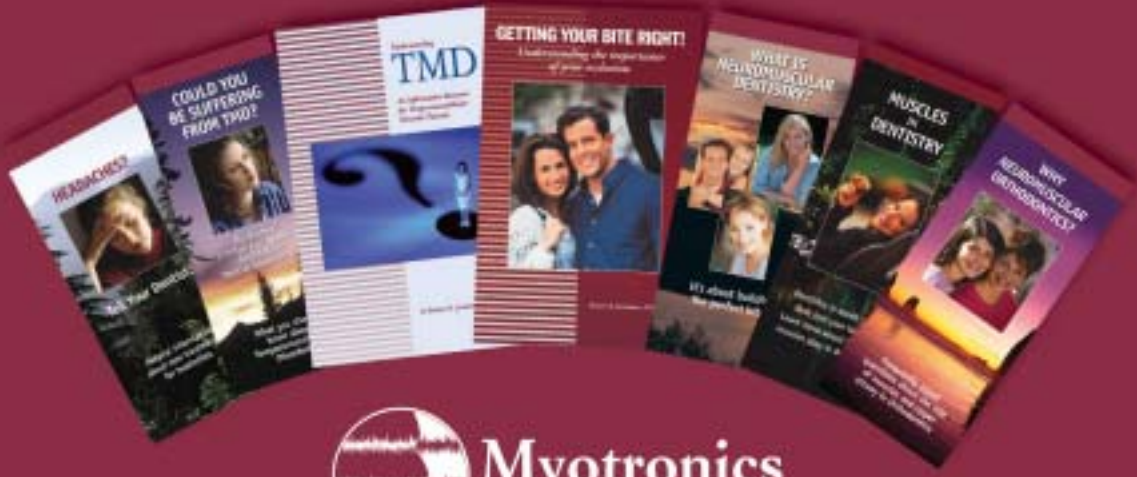

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GETTING YOUR TEAM ON BOARD

Ashley C. Johnson III, JD

Okay, you've taken another course. How many does that make this year? How much of what you were exposed to have you implemented? How much have you mastered? If you are like the majority of dentists out there, you have taken the course but don't really know what to do with the information. You left the course with a new vision and you want to take your practice in a new direction, but you don't know where to start. You realize your team doesn't have a clue what this new

vision is, and to make matters worse you don't understand it well enough to teach them yourself. So what happens? You get back to your practice with the best of intentions but you are overbooked on Monday because you have been gone since last Tuesday afternoon. You really want to share what you learned with your team and watch them get the same light in their eyes that you had last week. Instead, you just get that glazed over look that says, "Oh no, another course. Let's give him a couple of weeks and everything will settle down and we can get back to doing what we've been doing." You make attempts for a few weeks, then everyone's frustration level goes up and you fall right back into the same old habits. Sound familiar?

Then you add in the factor that for years you have been practicing a certain way and you have just spent days learning new ideas, techniques and skills. You're excited about it and you just want to start doing it. Is it even possible at this stage? You're still excited but you are starting to feel the "edges of a headache" coming on. How in the world are you going to start getting prepared for this? If you've just been to LVI, you now know that for years you have been oblivious to all those signs of musculoskeletal occlusal problems. So what do you do? Nothing! You've made no changes in your practice and all that treatment that hasn't been diagnosed is still walking right back out the door. Your frustration just goes up.

If you really want to get your team on board, teach them a lot about dentistry. That's right, dentistry.

When I go into offices to train the doctors and their team, I hear one common problem from the doctors and another from the team. If you listen to doctors discussing these issues, you will hear them say that they want to implement the changes but their team just isn't willing. Of course, when you talk with the team members, they say they would love to try something new, but they have no idea what the doctor wants.

If you really want to get your team on board, teach them a lot about dentistry. That's right, dentistry. When I go into offices I find team members who are very good at their individual jobs, but they know very little about dentistry. You expect them to be able to discuss dental problems, which treatment options are available, which was chosen and why, and then what happens if no treatment is done. How can they do that? How could they have learned that? Osmosis? The fact that they work in a dental office doesn't mean they understand dentistry. Can your front desk team members explain what an abfraction is, what caused it and why a facial composite alone will not repair it? What about your assistants or hygienists? You can bet they get asked.

So make sure they learn as much about dentistry as possible. If you want to see your team get excited about their jobs, then help them understand the how and why of what you do clinically. You want to get their attention? Use their mouths as your examples. Take impressions of

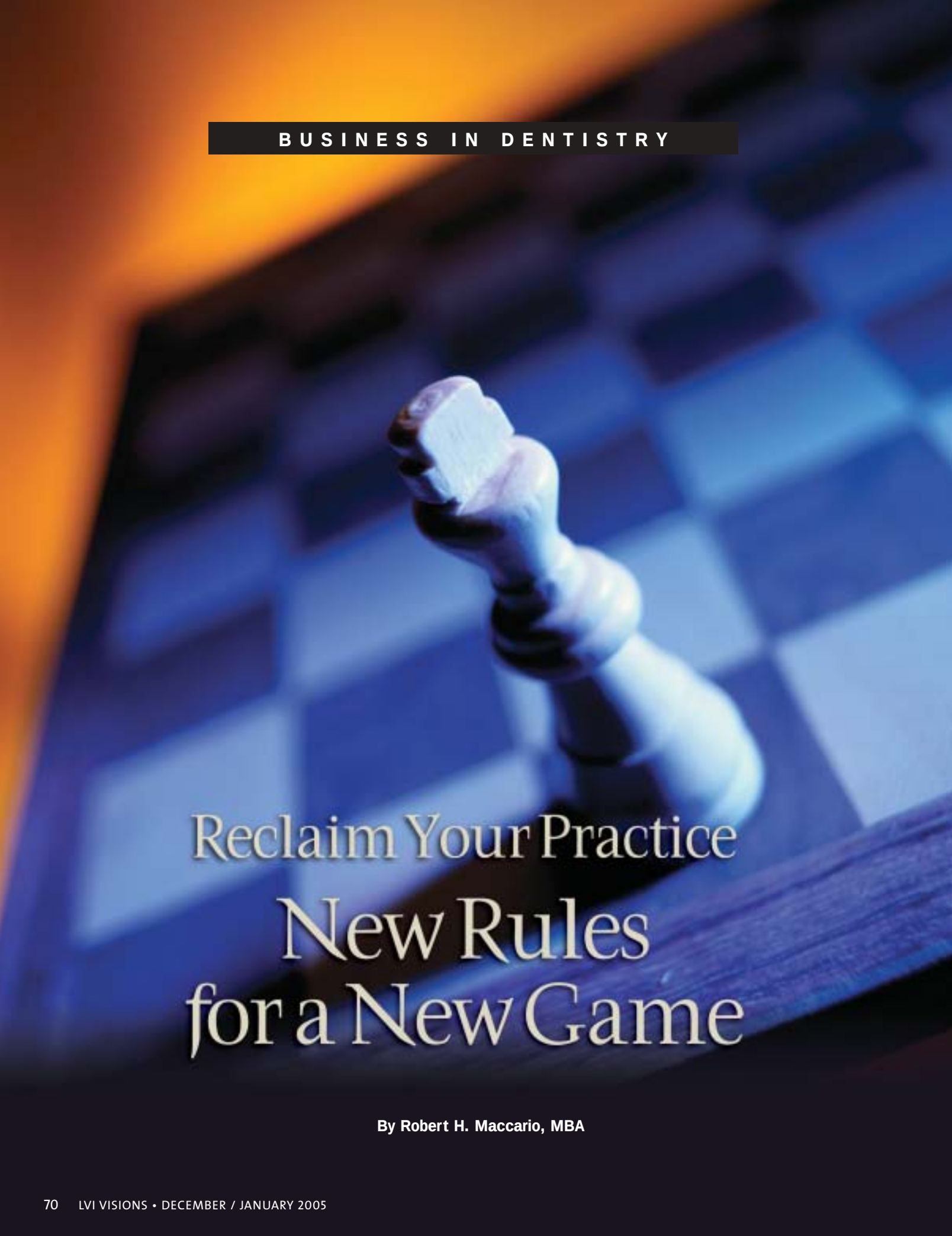
their mouth, better yet have them do it themselves and evaluate their techniques. Have them pour the models, again evaluate their techniques and results, and then go over every problem you find. Believe me, if you do it on your entire team, you will find them all. With all of them present, go over what caused the problem, the seriousness of it, what the best treatment is, why you decided on that one and what will happen if they don't get it taken care of. By doing this as a group, they will pay attention to all you say because it is their mouth or that of a team member. They will want to know all about what you find. The interest level in a proper diagnosis and discussion of dental problems will take on a life of its own. Once they see it on themselves and understand the long-term implications, they will be able to relate it to your patients.

Your practice will start to soar when their dental IQ goes up. They are the ones discussing most of the dental issues with the patients and now they are doing it from a more informed position.

The entire team has to be involved in this training to make this vision work. They are the ones that your patients talk with. A recent survey showed that of the patients surveyed, of those that had accepted treatment, over 70% did so based on something a team member told them and not based on what the doctor had said. Surprised? Dr. Bill Dickerson told me that he would have thought it would be much higher than that. You and your team have to give the same message to your patients from the back of the office to the front desk. When your team understands how important their role in treatment acceptance is, they are much more excited about explaining the choices to the patients. This is when it will all start to come together. They will know that all they can do is make sure the patients understand the problems, the treatments and what happens if not treated. After that, it is up to the patient to make the decisions.

You and your team can do this! Take them to the educational programs with you. If for some reason you can't or they won't go with you, and you have the patience and ability, you can take the time to teach them yourself. Or, you can have someone that is trained to educate the team come in and do it. Either way, get your team on board and fasten your seat belt. The changes are going to come!

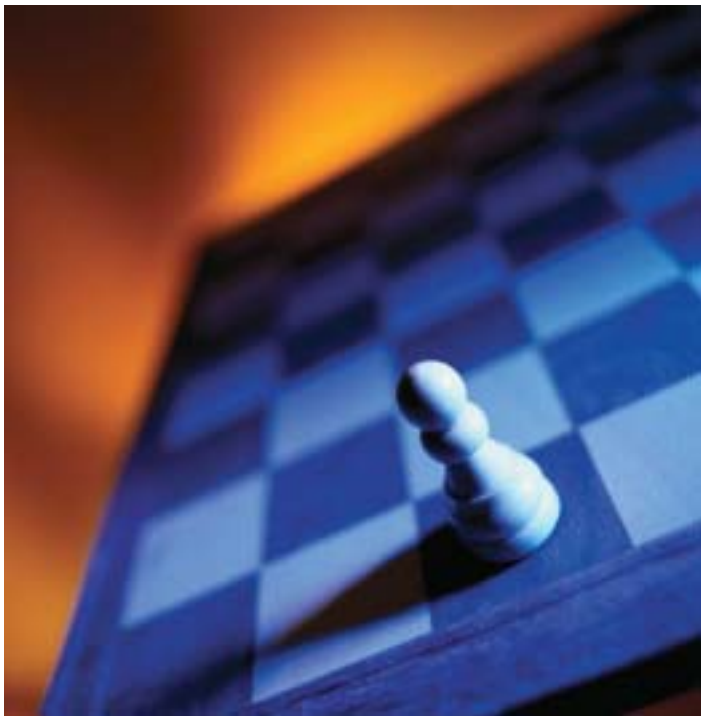
Mr. Ashley C. Johnson III, JD has been involved in dentistry for over thirty years. He has had the privilege of being a faculty member of the Dawson Center for Advanced Dental Study in St Petersburg, FL, and has also enjoyed the experience of serving on Dr. Frank Spear's Board of Advisors. Ashley does Neuromuscular in-office consulting. He believes that if you are to be successful at the NM transition you have to have a well educated team. He spends 2 days in your office teaching you and your team how to implement much of what you have been exposed to at LVI. Including lots of hands on training for dentists and team members on proper impression taking, bites and going through an actual TENS treatment. He helps dental teams learn the difference between CR and the Neuromuscular way of looking at patient's bites.



Reclaim Your Practice
New Rules for a New Game

By Robert H. Maccario, MBA

The discontinuity between what consumers want and what their insurance will cover gives you an exciting chance to reclaim your practice. Today you can refashion your



business in a way that not only gives patients / guests what they want but also puts control of your treatment recommendations, time-efficiency, and profitability back in your own hands. Yet to take advantage of this opportunity, you must look to new practice models.

New Rules Demand New Competencies

The new practice model of an independent business that is no longer dependent on insurance requires that you concentrate on meeting consumer demands. This means making dramatic changes in the values of a traditional dental team, prompting a wider range of skills for everyone involved. It starts with revising the mind-set of everyone involved and understanding a new set of "rules" that govern the dental practice. Below, you can compare the old and new rules and their corresponding competencies.

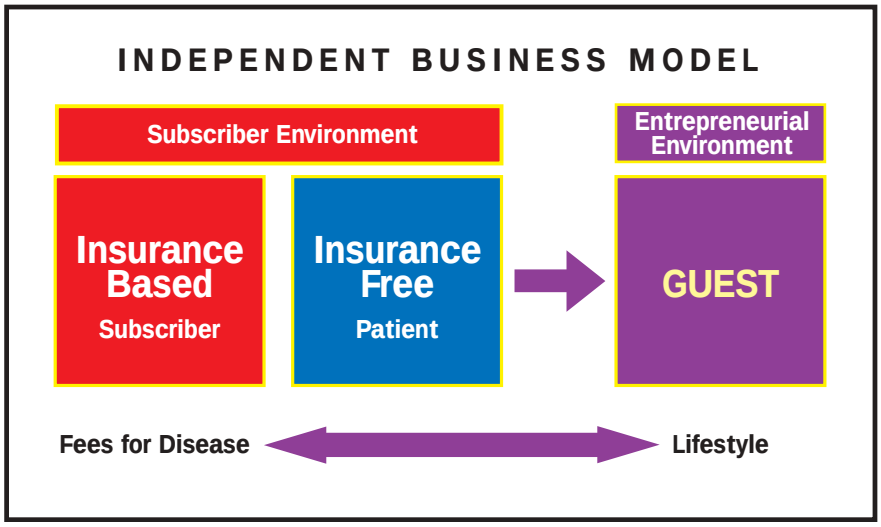


Diagram 1.1 illustrates the evolution of a practice and its customers:

OLD RULE: *Follow the insurance companies' practice-profitability model.* Insurance companies base their profitability on the least expensive, professionally acceptable, ethical treatment — not necessarily what is in the patients' best long-term interest, it is needs based. This does not create an opportunity for your guests to buy discretionary care, such as a beautiful smile. Because your practice is insurance-based, you are willing to accept what they say should be an acceptable return on your effort.

NEW RULE: *Implement the independent business profitability model.* Think and act independently. Set your budgets for your practice based on your real operating costs.

• What does it take to attract skilled professionals?

• How many dollars must you allocate to influence your guest expectations with professionally developed marketing?

• What is the appropriate investment to make in continuing education, new technology and the best materials needed to deliver the quality care?

• What does it cost to utilize an exceptional dental lab or work with a superior supplier?

Set your fees based on the unique value you deliver — not some insurance company's perception that all crowns are the same. In setting budgets and revenue expectations, don't underestimate your value. You should be compensated at three levels in your practice:

1. As a dentist: What would it cost to hire a dentist with your clinical skills and experience? You should not accept anything less for yourself.

2. As the president of a healthcare company: It is your job as the president to allocate your resources, people, time, and money to deliver the highest quality of care. What would an outside business pay you to run a business like yours? When the rest of the team goes home, are you still there figuring out the marketing plan? Are you still there calculating the cost of new equipment? You deserve to be paid for your efforts, just as any other health care firm's president.

3. As a stockholder: You have a significant investment in professional training and your business. Your name is on the line with the bank, so you are at risk, and as a stockholder in your organization, you deserve a fair return on your investment each and every year.

OLD RULE: *Have an office manager.* The office manager comes up from the ranks to contribute to running the business. Many of their skills are garnered from their experience of how other practices become successful, not necessarily solid business skills. Some are simply thrust into a management position without any training. Others are given the title of manager, but in name only: Their duties are still limited to being a glorified receptionist.

NEW RULE: *Have a vice-president of operations.* The title is not as important as acquiring the skills. Many office managers are skilled and respected for their contributions to a

practice's success, but it is time to go to the next level. Integrate their dedication and years of experience with new skills to move your practice into the independent business model. They need to develop hard-core business skills, which will give them a new direction in their career.

Concurrently, it's time to recruit new management professionals into dental practices, injecting new viewpoints and experiences from other real-world independent business models. The well-respected veteran of dentistry with solid business skills, or the experienced management professional from outside the field of dentistry with support from the veterans in the field, should morph into a vice-president of operations (administratively or clinically). When the president (dentist) is in his or her clinical role, focusing on the care of the patient/guest, he or she should feel confident that the business is still on course. This evolving business professional needs the skills and confidence to work with a marketing company, bank, consultant, and accountant, but, most important, he or she must develop the skills of the other personnel.

Consistent with this new rule is the number of staff: The future will be based not on the quantity of staff, but on the quality. Bring into your practice only people who have the capacity to produce. As the president, do not dilute your time working with marginal players: Direct all of your efforts and energy toward people who can take you into the future. Currently, there is a core group in dentistry proving the worth of this position, running businesses and providing guests with services at the same level or higher as a practice's clinical care.

OLD RULE: *Rely on insurance-based referrals.* As long as you have insurance in your practice, insurance companies will consider patients their subscribers. In this model, resolve yourself to listening to the patient say, "I only want to do what insurance covers" and feeling the impact it can have on their care and your practice. The insurance company sets the expectations of "their" subscribers, not your patient/guests. Resolve yourself to sending statements, having an excess accounts receivable and a significantly eroded profitability.

NEW RULE: *Develop your "brand" image.* Move to strongly influence your patients'/guests' expectations of the practice. By raising those expectations, you strongly attract the type of patient who will appreciate the quality of care you provide. Create public awareness that quality of care goes beyond insurance coverage. Develop a well-thought-out marketing program consistent with your budgeting process that highlights your brand — not insurance.

The practice of the future must anticipate the acceleration of competition within the field of dentistry and realize that the place for homegrown marketing has been left far behind. Establish a relationship with a professional marketing company, one that can position your practice consistent with the patient/guest experience you deliver. Your vice-president of operations should have the skills to orchestrate this relationship and be able to guide the process so you earn the best return on your investment.

Evolving into a Successful Business

By adopting the new practice model and leaving the old model behind, you will evolve into an independent business capable of meeting consumer demands that other dental practices cannot. The increasing skills of you and your team will keep you on the cutting edge of all areas — customer service, technology, and materials — which will exceed your customers' expectations, as well as reinforce your brand identity. These positive changes will improve not only your professional stature, but the lives of your team and your patients/guests, while at the same time allowing you to reclaim your practice and recapture your future. What could be better?

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.

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