NEW DIRECTIONS IN DENTISTRY

REED'S INTERNATIONAL LETTER

JANUARY 1987

Dear Friends

I find it best not to interrupt flow, so if some of the pithier aphorisms remain inscrutable, such as "life is the mother of intuitive coincidence", "less is more", "suction is more powerful than pressure", "time wounds all heels", and "you can't push a rope", imagine how muddy this lengthier monthly pronouncement is going to be.

The dental business is a lot like physics. The reason being that physics is the study of the obvious. We've been trained to be interested, primarily, in what's obvious. "This is this, that is that, true or false, multiple choice", but the power and secret of life is in the UNobvious. A lot of people fail in the dental business because they're looking for the obvious, when the UNobvious is the answer.

From the trenches of the "dental game". . .

WHAT YOU SHOW IS HOW YOU WIN. . .

or, STRATEGIC PLANNING APPLIED (An Overview)

The obvious advantage of being labeled "dentistry's bad boy" encourages the non-conformist in me (hopefully, with a distinctive marketing flair). The "truth in labeling" frankness I have about informational transfer creates an energy in my critics that would have them be pleased were I to "dry up and blow away."

The plain nouns of our vocation can be applied to the behavioral patterns of success, as I see them, in dentistry. It doesn't take a folk hero to smell the osmotic pressure of joyful people in service to others in this game we play. I travel over a 150,000 miles a year and break bread with winners and losers in this game and I find that rarely does the losing have to do with other than the theme of this letter.

I like being around innovative, creative, entrepreneurial, thinking, energetic people who have the affluence, both spiritually and economically, to do something about what they think and believe.

Bernard Baruch, once a year, would "go to cash." He would cash in all of his stocks and bonds and get out of the market completely. Then he would re-allocate his entire life's resources. This included his philosophic time and personal inventory as well. This was back in the 20's and 30's. This man was doing a zero-base budget with his life as well as carefully looking at the world around him.

Rarely did he put the energy or the money back into the same stocks or projects at the re-initiation. He would go to a hotel room, spend a week

with the door locked, slide the instruction slips for re-investment of stocks out from under the door, and have room service bring his food. He cloistered himself during the decision-making and really lived zero-based budgeting.

Change. . . the only constant.

This forced him to take an extremely hard look at the entire environment of the world in which he lived. As a result, he missed the "crash" in 1929 and survived to become a very wealthy man during the 30's. He credits his positive results to this habit of zero-base budgeting.

He would put all his money into his four best ideas. He used intense diversification and his investments, by his own standard, were rarely justifiable. Since this is not a dress rehearsal, but the last half of the second act . . . life is moving along in reality . . . the object for us is to re-set our goals and objectives and to zero-base budget our energies and our life resources so as to force ourselves to take a better look at the environment and to future-focus the preferred future rather than letting the probable one continue due to our marriage, to events, resources, people, places, things, professions or whatever.

Team? . . . or staff? What's the difference?

Baruch reported that he had a renewed appreciation for those things that remained the same . . . family, friends, philosophy and things spiritual.

Losers let it happen. Winners make it happen.

A recent all-day team meeting pointed my interest in the personal power I felt during the meeting.

Strategic Planning Applied Overview From the Trenches . . . A Philosophy

We are currently engaged in the activity of increasing our ability to succeed in the future. This process has been called "Applied Strategic Planning". This overview will explain our applicaton, at Valley Dental Group, of the ideas as we feel them in the wet-finger application.

Bob Mager's thought processes are liberally applied in the verbage and diagramatically able to show best the track we follow. The world changes constantly. It is unrealistic to assume that economics, pathology, delivery systems or the expectations of the marketplace will be the same five years from now. We must apply the process by which we envision the future and develop the procedures and operations necessary to achieve that desired outcome, and to accelerate the pleasure of the journey "from here to there."

Singer's "future focus" is alive.

The process differs from long-range planning and forecasting in that it anticipates a future and prepares accordingly for that future. Strategic planning creates the preferred future for the group, then travels back from the future to the present to generate the plan.

STEP ONE. You plan to plan. It is clear that it must be determined who will be involved, how long will the process take, who will research and develop the required data, and who will benefit. Are you a team? or are you a staff? The ongoing considerations include the values revealed by auditing the individuals involved and the group as it relates to the other similar groups in societal structure.

Incongruous values from individuals or from the organization must be noted and as considerations arise in the planning process, these values must be recognized prior to implementation of the idea systems. The key people in our group are ALL the people in our group. The team functions as "solo stunt pilots" as well as harmonious "Blue Angels". There are not key

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people decision-making for the entire group, but ALL are key decision-makers at the level of the action.

I believe that in the process the group should never exceed seven dialogical members. The team must be free to devote the necessary time and energy to the task, the planning session must be conducted away from the daily work. An overview may be an idea package sketched out by a benevolent "solo pilot" who provides the skeleton for the group's discussion.

It's obvious to me that the individual values of the people, the values of the organization as we understand it, the philosophy of our operation, and the culture from which we abstract our meaning will be expressed in how we receive our people, the rites and rituals of our examination, diagnosis interview, and what these particular functions do to portray us to our public.

Being front deskless, we are remarkably unique as are 12-15 other practices in the nation. This particular paradigm releases tremendous energies, communicatively, in the hearts and minds of those we choose to serve.

One of the things we've also gained insight into is the "stake-holder" position of the team person. S/he is not only a psychological owner, but is an equipment owner and invested heavily in the business decision-making and the result is freedom at the interface of service.

After philosophy is clearly understood, STEP TWO, or "mission statement" is essential. If we know where we're going, only one road will be most effective and efficient. It's certainly safe to say that if we don't know where we're going, any road will do. We must determine, carefully, three things.

1. What are we, as an organization, going to do? What is our performance going to be?
2. For whom will this performance be?
3. How are we going to do it?

The "what" is easily answered in the word "servant". We expect that we'll be providing services and material repairs in the attitude of servitude and our mission statement on the wall of the office so spells that out.

("We are a private care, health centered dental group. We welcome the personal referral of your family and friends.")

For "whom" we're doing this has been discussed by each of us and we see the people we serve NOT as patients or clients but as friends, guests, neighbors and visitors.

We have also seen them coming from a marketplace that is segmented demographically, geographically and psychographically. We've learned that we can't serve everyone. We can serve any one we'd like, we can't serve everyone we'd like and therefore we're becoming intensely more selective by profile. The computer has been invaluable in helping us with this.

How do we do this? By having the individual people and the teams that they comprise have a feeling, at the conscious level, of overt freedom. They can decide how they will achieve their mission and how they will be involved in the marketing strategy, how they will be assisting us as low-cost producers and technological leaders as they function at the interface with the person we serve.

The mission statement has been developed with a great deal of difficulty over a great period of time, but we believe it to be relatively complete in the hearts and minds of each of us. There is a clear mission outlined for each person and

F. Scott Fitzgerald: "I never blame failure--there are too many complicated situations in life--but am absolutely merciless toward lack of effort."

Worry is a misuse of the imagination.

Mistakes are stepping stones to growth. Therefore, anything worth doing is worth doing poorly--at least for a little while.

each team so that a unitization of this mission is clear to us at the level of the application.

STEP THREE is the actual budget/schedule model. Without question the prioritiz- ation of the things we spend. . . self, time and money . . . must be sequential and in the order of priority. Money is the easiest to earn, self and time are invaluable. The budget is clearly outlined and is a useful tangibilitator of our needs to serve. The profitability that we expect, the overhead control we insist on, and the honesty with which we can discuss this economic profile with the people we serve as they co-develop fees with us is unique.

Pressure is neither good nor bad. Pressure can be converted into positive, productive, energetic tension. . . or negative, destructive, limiting tension. The choice is yours.

STEP FOUR. Cost/benefit analysis is a reality. It's our responsibility to determine what we're willing to spend out of the three above categories in order to achieve each point of increased market share. Our profiling will ultimately include a level of growth that the organization can afford to strive for in the coming five one-year periods. Mager's goal analysis, task analysis, performance analysis, critical incident analysis and target market analysis is absolutely invaluable. We have those analyses as "audits." They tell us the difference between what we've planned to do and what we're doing, to help us "manage by exception." Self-management is the ultimate application of the term "management" and it seldom overlaps into managing others in this collateralized environment. Without question, however, the life cycle of inventory, team members and time is the economy on which we operate.

"Restlessness is discontent -- and discontent is the first necessity of progress. Show me a thoroughly satisfied man, and I will show you a failure."

STEP FIVE. Time and timing. The most effective applicaton of strategic planning that we've seen over the years is the three-day brainstorming session in the benevolent environment of others doing the same project. The NAPILI 3 (model-building) since 1963 has vigorously demonstrated the "cross-country solo pilot" overview done by the dentist and his/her spouse and simultaneously, the NAPILI 2 (for doctor, spouse and team) has brought into fruition the team function of the application.

I believe that a dental team, in our time, no longer takes three to five years to form a functional model for behavior and for mission results, but that in six weeks to three months of carefully scheduled time with a measured space between the meetings, the various team persons can research, compile and catalog the information necessary for this process.

The strategic plan will also model the organization's budget for the following year and will schedule the result so that the intangible can be tangibilitated; i.e., the peace of mind, the happiness, the success, the wealth and the strength (which we all desire) can be objectivized and measured, monetarily. As the process refines, budgeting and scheduling will become more obvious and automatic as the tangibilitators of this process.

STEP SIX. Profiling the arena in which the game will be played. I believe there are four overlapping environments that it will be essential to recognize.

1. The MACRO environment. Social patterns, the technology, the economic trends, the interest rates, the political factors, the governmental factors, the pivotal period transitions that we're experiencing outside the walls, and even the outside picture (what's happening in China, Russia, South Africa) implement a great deal of necessary information for our thinking.

2. The structure of our own industry. How dentistry is financed. The degree of governance from outside the products that we're using, the materials and techniques as they

change, the marketing strategies must be understood.

3. The general profile of the delivery system, market segmentation, the patterns of delivery, research and development going into the ongoing process, and what competes for the energy we need for our success; i.e., the discretionary dollar in the marketplace.

I'm not saying that I feel my fellow dental teams are competitive with us, or we with them. I am saying, however, that the entire market is inundated with a shift in pathology, delivery system, and the like . . . and the confusion and competition for the discretionary dollar is at a peak.

4. The internal organizational environment of our own team. Its history, its strengths and weaknesses, its people, the longevity of employment and the physical environment itself. This is particularly important for us, at Valley Dental Group, as bridge-burners and paradigm busters as we will be leaving our environment within the year to redevelop the physical space within which we perform the model we strategically plan.

Each of the above areas must be surveyed in depth and understood by the individual participants to better gain an understanding of the arena in which the profiling and prioritizing is done.

STEP SEVEN. This is the "What If/Contingency Planning" stage. We want to, outside of our model, consider what may happen and what we will do in the face of it. This is particularly true in selecting a new office site, design, model of behavior. We place contingency planning outside the other phases of our model-building because the model itself is based on a high probability assumption pattern. We also have key points that we use as indicators and these are derived from the "budget" of time, self and money. When things aren't going right often enough, or at all, we are triggered by our monitoring process to do a critical incident analysis that helps us solve the problem. Identifying that there is a problem is 90% of the solution/strength. If information can flow in relationship to the game, the deficit contingency can be observed and without question the reason for its occurring can be understood and an analysis of how to resolve immediately begins to take place.

Problems become teachers and opportunities, almost sought after as friends.

STEP EIGHT. In a typical organization such as ours, there is a clear-cut time table, a financial expression of the end result, a marketing plan, the application of human resources, an office floor plan/equipment plant, a chain of supply to provide the industrial needs of serving others. This is all considered in the overall budget and is a decision that is organizationally made in team meetings.

There's never yet been a statue erected to someone who left well enough alone.

The team meeting ends with an action item, typed "minutes of the meeting" report, distributed to all persons, so function and procedure are immediately clear following the decision made by those who meet. As most of you are aware, organizationally, teams of four or five persons meet monthly to clarify against the plan and their word is gospel until the next meeting. As we check action against plan, we find revealed a constant need for clarification of values, mission, strategic business model and the overall objectives and assumptions constantly change.

It requires the eye of faith to see the undeveloped butterfly in the caterpillar.

Mager's cycle . . . objective, plan, action, monitor, modify . . . has been invaluable. We need to understand the competition for resources since resources are not indefatigible.

The more you borrow from your bank account of positive thoughts, the more abundantly it grows.

The wonderful thing about the game of life is that winning and losing are only temporary . . . unless you quit.

(Even though I married a wealthy woman.) Each team person's plan must compete for the overall availability of strength, energy and money and this is difficult because these are not limitless commodities. We may find simultaneous requirement for people, places, things or money. Priorites or compromise must be made in the process of putting it all together.

The actual integration and budgeting of people, places, things and time find implementation at all stages or steps of our discussion. It isn't as if we park off in the wilderness and come back to an environment with a perfect plan. Even Moses had to make two trips to the mountain for his tablets of stone, so the initial plan doesn't have to be perfect. It can be perfected as we grow, go and learn. The major points of our surviving and thriving are, however, clearly defined. And our function and management is personal and team in regard to our service to others.

The references I'd like to have you review are Mager's work on the subjects of Preparing Instructional Objectives, Measuring Instructional Results, Analyzing Performance Problems, Goal Analysis, Developing Attitude Toward Learning, Developing Vocational Instruction, and Trouble-shooting the Trouble-shooting. Also valuable to you will be Sisson's work covering in the NAPILI 3 (Model-Building as a Business Technique) and the applied strategic planning work of Goodstein and Pfeifer, A New Model for Organizational Growth and Mortality, the 1985 work on developing human resources from San Diego, California University Associates. Also, by the same authors, a text, Applied Strategic Planning,

As I finish this, I will now say that, in speaking with my friend, Dick Oliver, I'm re-enforced on that which we discovered in our practice four years ago . . . in a ten-year study in the Boston area it was determined that 88% of the restorative dentistry was done on previously restored teeth. "Defective restorations" were defined as restorations that were defective to the point that any dentist would say "you've got to replace it." These determinations, by definition, include fractured restorations, open margins, missing pieces, overhangs, open contacts, and/or other major malocclusal factors that would indicate new restorations are needed.

Sixty-five percent of these "re-do 's " were not related to caries, but to physical failure or the entropic nature of man's feeble effort to compete with nature. This ten-year study that determined that 88% of the restorative dentistry was done on previously restored teeth is not surprising to most of us. Even the ADA is now talking about the recycling resource that exists in the marketplace as being one of the "hopes for the future."

Also, an interesting study was done over a three-year period of time on a control group of people. It was determined that the dentists treating that group of people at the end of the third year had restored only 50% of the dentistry annotated as defective by the terms listed above, so the group of people included in the study, at the beginning of the study, were screened and their examination showed the amount of dentistry that was necessary in the group. At the end of the three-year period, 50% of the annotated dentistry had not been restored, but the restorations that had been accomplished were three times the number of restorations that had been noted as necessary in the original base-line study. At once this seems to be an overtreatment situation (so willingly are we accused of this by the general public), when in truth the definition of what needed to be replaced in the original study was the faulting factor. Many restorations not noted as being

necessary were actualy toothaches or lost fillings, prior to the end of the third year period, and had to be replaced and they weren't listed in the original base.

There's very little standardization or agreement as to what dentistry needs to be replaced and what does not need to be replaced, so it is imperative that we have a commonness that would have at least 80% of the dentists saying "you've got to replace it."

Using the above-listed categories of entropic or iatrogenic factors as they relate to the dental restorative procedure, the incidence of disease is the question. What happens over a period of time with a sampling of people has not been significantly studied in the United States. It's one of the things Dick Oliver is presently working on with the National Institutes of Health in Washington, D.C.

How about perio? How much is there out there? What is the nature of what's out there? What are the percentages of the various types of perio as we find them in the public? How frequently is a person once involved and treated for perio a re-treatment potential as a result of the etiology continuing to produce the signs and symptoms of the disease even after, at one point, the person is diagnosed as having been healed.

What is the repeat business in perio now that we're beginning to look at it in operative and crown and bridge?

As a benediction, this special note: During the last six months, 16 of Phoenix's top physicians, orthopods, ob-gyn's, surgeons, hemotologists have indicated their desire, need and inclination to retire immediately. They are in their forties and fifties. . . in the prime of life . . . have the strength, both in an ethical and a moral sense, to be categorized as top people in their professions.

They are leaving the practice because they are displeased with the way the practice is going, finding "it isn't fun anymore." They've discovered that their insurance preimiums are higher than their taxable incomes. They are the ones who are bright enough to know what's going on and are economically independent enough, as a result of their success, to discontinue their practice and survive well.

I'm concerned that, if this continues for the next five years, serious deficiencies will happen to the profession as we see these major strengths and leaders leaving our community and our environment.

Take note of the addenda article from the dentist who's going into real estate. Interesting, isn't it?

My friend and colleague, Master Architect, Jack Peterson, made a succinct statement:

"Experience combined with knowledge produces wisdom . . . a natural resource . . . which is becoming more and more a rare commodity as executives and professionals leave their fields of endeavor, brought about by insurance extortion, a carnivorous legal system, suffocating governmental regulations, and a society which will not be responsible for its own acts. The result, of course, will become a national tragedy."

Think about it.

Setting a goal is like establishing a needle in your compass. From then on, the compass knows only one point -- its ideal. And it will guide you there through the darkest nights and the most fearsome storms.

Be an action person. Do first things first and one thing at a time-- and follow them through to a logical conclusion.

Napili News

Joseph Marshall Wade said: "If I wanted to become a tramp, I would seek information and advice from the most successful tramp I could find. If I wanted to become a failure, I would seek men who have never succeeded. If I wanted to succeed in all things, I would look around me for those who are succeeding and do as they have done."

Those comments are pertinent, I believe, to what NAPILI is all about. . . NONE OF US IS AS SMART AS ALL OF US. We are pleased and impressed with the quality of person attending NAPILI workshops.

The January sessions with Sy Ogulnick, Ed Zinman (14-17 January) and Beau Van Deren (Aruba, 25-31 January) are clear examples of successful persons from whom we can all learn. We're looking forward eagerly to these opportunities for change, growth and learning.

FUTURE FOCUS:

January 25-17, Aruba, NAPILI 3
Model-Building/A Business Technique
January 29-31, Aruba, NAPILI 4
The Economic Core of Model-Building

February 3-6, Phoenix
People Without Perio Program

March 4-7, Phoenix, NAPILI 1
The People Game - Dentistry

V.I.P.s for December: David Weiss, Beau Van Deren, Melinda/Rick Coker, Dan Grubb, Bill Lawrence.

Best wishes for the New Year!

Marci Reed

President
Napili Seminars

NAPILI PARTICIPATION

AN EXPERIENCE IN ACCELERATED PRACTICE

This note was received from a Florida dentist in regard to the NAPILI 8 (Accelerated Practice) workshop, November '86:

"You have succeeded in getting a non-writer to write. Congratulations. I appreciated this totally different experience. My wife and I were overwhelmed. Thank you so very much.

"I must tell you of two events that occurred on my return (to my practice.) I've been struggling with the co-development of the fee that you've mentioned over the last several years, and it has finally clicked and come into focus for me.

"A person came to me for treatment; he'd lost his orange trees and his banker had refused to loan him money to re-start his orange grove, in fear of another freeze. I told him my fee for his care would be $8,000.

"He became expressionless. Usually this is what I do. . . when in doubt of the fee, I go up. I didn't know what to do at that time, so I said to him, 'I can also put my artistic talent into this case and make it exceptional. In this case you will be the one to decide what the fee is going to be. I'll leave it up to you to coordinate after we've completed treatment. How does that sound to you?'

"He accepted my challenge and at the end of the case answered my question by saying, 'We'll just triple it.' (Three times eight is twenty-four!)

"The second situation, a lady came to me and said her dentist wanted $7,500 to do her case, and she didn't like it. Her daughter told her to come to me. I told her, after diagnosis and treatment planning in my consultation, that my fee would be $16,000. She said, 'I'll bring $5,000 when I come to begin, and $10,000 when we're halfway through, and the balance when we finish,' and then continued to say 'This is the way we do business with our clients, is that okay with you?'

"She told me that her husband built swimming pools and 'my mouth is worth at least as much as a swimming pool.'

"I wonder if I should have asked her to help me co-develop the fee.

"We plan to see you early next year. I'm interested in your wet-finger NAPILI and NOT in seeing your front deskless office!"

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Dental Hygienists Seek to Start Practices On Their Own—Raising the Ire of Dentists

By RHONDA L. RUNDLE
Staff Reporter of THE WALL STREET JOURNAL

Judy Boothby, a dental hygienist in Sacramento, Calif., invested $10,000 in a van and portable equipment so she could make house calls as part of an experimental state project begun earlier this year.

But the van is now parked and locked. By raising questions about the legality of the service, she says, some local dentists are scaring away her clients, many of which are nursing homes.

Mrs. Boothby's venture is mired in a struggle over the proper role of hygienists in dental care. Besides cleaning teeth, hygienists often take X-rays and give fluoride treatments. They usually work for dentists, but some of them—like Mrs. Boothby—want to go into business for themselves. The idea has dentists gnashing their teeth.

"Hygienists aren't trained to supervise the dental health of the public," says Joseph A. Devine, president of the American Dental Association.

Recutting the Pie

Hygienists, too, are casting their arguments in terms of the patient's welfare. But also at stake is a good chunk of the estimated $32 billion that Americans will spend on dental care this year. Because more people are bringing home "no cavity" report cards, less of the dental-care dollar is going toward drilling and fillings and more is going for cleanings and other prophylactic services typically provided by hygienists. Some dentists fear that hygienists want to supplant them as the primary care provider.

The issue of whether hygienists need dentists' supervision, which has surfaced occasionally over the past decade, has been heating up since last July, when Colorado became the first state to let hygienists set up private practices. The ADA is currently appealing a recent court decision upholding the law.

Several Colorado hygienists have already hung out their shingles. One immediate problem: Insurers won't reimburse their patients. "I haven't been granted provider status by any insurance company," complains Deborah McFall, a Denver hygienist who treats nursing-home patients.

Insurers say their legal staffs are studying the issue. But one of the state's largest employers, Adolph Coors Co., says its employee dental plan won't cover hygienists' services unless the patient was referred by a dentist. "It's part of our philosophy to provide the best possible dental care," says a Coors spokesman.

Activist hygienists in California and Washington state, so far unsuccessfully, are seeking legal changes similar to Colorado's. And in seven other states, including Missouri and Ohio, bills are pending that would liberalize current supervision rules. (Taking the opposite tack, Illinois toughened its rules in 1985, and Georgia did the same earlier this month.)

In California, Mrs. Boothby is one of 15 hygienists who went independent under the state-authorized experiment. Her colleagues, for the most part, have set up office practices.

While the project was intended to run for three years, the California Dental Association is challenging its legality in court. "We don't want human beings unknowingly used as guinea pigs to prove a research point," says Dale F. Redig, the group's executive director. Outside the project, California law requires that hygienists work with a supervising dentist.

> **WITH MORE** people getting "no cavity" report cards, more of the dental-care dollar is going for services typically provided by hygienists.

Dentists once supported legal changes to liberalize the rules governing supervision of hygienists, because such changes would give them more flexibility in setting their own hours. Roughly half of the states currently allow for "general" rather than "direct" supervision. General supervision usually means that the dentist doesn't have to be in the office when the hygienist is cleaning teeth.

As hygienists have gained wider latitude in the dentist's office, many have begun to ask why they shouldn't also enjoy the potential financial, tax and professional advantages of owning a business. In a recent poll conducted by the California Dental Hygienists Association, about 25% of respondents said they would be interested in setting up practices if allowed.

Hygienists gripe that the job as it stands now is a dead end, with no security or advancement potential, and rarely with such benefits as health insurance or profit sharing. (Hygienists usually work on a contract basis, and often only part-time.) Moreover, hygienists complain, compensation hasn't kept pace with dental fees.

For example, when Mrs. Boothby started working 15 years ago, the fee for cleaning teeth was around $12. She kept about 70% of that, so on a normal day with 10 patients she had income from cleanings of about $84. But since then the cost of cleaning has nearly tripled, to about $35. When Mrs. Boothby was recently offered a job paying $125 a day, she figured her share at around 36%—roughly half of what it was when she entered the field.

"There's no future in this" as a hired hand, she says.

Some hygienists say they could make more money while charging patients the same as, or slightly less than, dentists. And as independent practitioners, they say, they could attract some of the 50% of Americans who don't regularly see a dentist. They claim that dentalphobes may feel more at ease in a hygienist's chair—especially if it's conveniently located in nontraditional places such as shopping malls. Hygienists also claim they are more willing than dentists to visit the bedsides of elderly or disabled patients.

Questions About Training

Dentists argue that separate practices would eventually increase patient fees because of the duplication of office, equipment and other overhead costs. Citing colleagues who volunteer their time to treat needy patients, they bristle at the implication that they are unconcerned about the plight of homebound people. And most emphatically, dentists assert that hygienists need them to handle medical emergencies and to diagnose such conditions as oral cancer and gum disease.

"Hygienists do a great job," says Mark Harris, a Eureka, Calif., dentist. "But certain things are beyond their expertise."

Dental hygienists must complete a two-year program after high school; some enter the program after college, where they may have taken science courses. Dentists, on the other hand, must undergo four years of graduate-level training.

Many dentists who are former hygienists—the vast majority of them women—agree that the two-year program doesn't qualify hygienists to treat patients on their own. They say hygienists receive only superficial instruction in such subjects as biochemistry and physiology. "My feelings changed as I became a dentist and saw the full responsibilities," says Sheryl Bertrane, vice president of the American Association of Women Dentists.

Having two professions watching each other independently might benefit consumers, suggests John Kushman, a health economist at the University of California at Davis who helped set up the state's project: "Dentists would have incentives to squeal on bad hygienists, and hygienists would redirect patients to good dentists."

FLASH!!!

GORDON MELAND, A DENTIST FROM TROLLHATTAN, SWEDEN CALLED ON 26 MAY WITH THIS NEWS. . .

HEADLINES IN THE SWEDISH NEWSPAPER THAT MORNING STATED THAT SILVER AMALGAM WAS OUTLAWED AS A RESTORATION USABLE IN SWEDEN. . . TO BE PHASED OUT WITH ACCEPTABLE POSTERIOR RESTORATION MATERIALS.

WOW!

REED'S INTERNATIONAL LETTER

Dear Friends

In today's competitive world, quality and productivity are survival issues, linked directly to our practice strategies. There was a time, not long ago, when quality was something to be controlled. We focused on defects in our procedures, or our front desk relationships, and the related costs. In dentistry, oftentimes, the dentist was focused in on the technology with the "Mother Superior" worrying about the people game and the pyramidal experience of the industrial model segmented itself to care for itself without much effectiveness.

Therefore, our concern about the accelerated practice. . .

MEETING THE QUALITY/PRODUCTIVITY CHALLENGE

(or. . . Humanizing the Workplace)

The near collapse of the American automobile industry due to higher quality and lower cost competition from Japan and Europe caused the U.S. manufacturer to change to quality and productivity to a scale unprecedented in American industry.

In the past five years, hundreds of industrial and service companies have launched ambitious new plans to produce better products, better services, eliminate waste, unlock the creativity potential in the people on the team and meet the challenge of international competition.

Question: Does dentistry, in the private care stance, remain a sacro-sanct cottage industry with no conscious significant relationship between quality and productivity? In the past, our concerns dealt with the relationship between resource, application and PRODUCTION. Therefore, production had an "output" orientation. It occurs to many of us that doing something efficiently that was unnecessary in the first place was really not productive. A new word took on the concept being expressed . . "effectiveness." Unlike the output orientation of efficiency, effectiveness was concerned with "outcome," or performance in terms of the END USER.

QUALITY, by the way, has the same basic components. . . efficiency and effectiveness. Traditional quality-assurance activities such as error prevention, detection and correction relate directly to efficiency. Through a quality specification against which conformity is measured, product or service quality

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is related to performance and ultimately the needs of the end user. Thus, quality also becomes concerned with outcome and effectiveness.

In other words, productivity is the "little brother" of quality; an increase in quality means an increase in productivity.

No matter what it's called, one thing is clear. The quality issue has become a matter of survival. The quest for quality and the search for excellence in American society is a headliner. "Remakes" consume fifteen to thirty cents of every sales dollar in most American manufacturing companies and about thirty-five cents of every dollar in the typical service organization. Comparable Japanese figures for producing roughly the same quality of service or product are between five and ten cents of the dollar.

Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives.

The data from the National Institutes of Health is rather exciting in that reports show the restorations placed by recent graduates serving two years in the military, from certain dental schools in the United States, have a 60% replacement necessity after two years of leaving the service. This means that once the work has been in the mouth two years, 60% of it needs to be replaced; frightening statistic.

A Boston study of over ten years' duration shows 88% of restorative dentistry is done on previously restored teeth, 65% of which was not related to caries, but to physical function. These physical functions are listed as defective restorations in the U.S. military terms. This defective restoration must pass the standard that most dentists in the study agreed "you've got to replace it." The reasons listed for defective restorations are:

1. fracture
2. missing altogether
3. overhang
4. open margin
5. fractured tooth
6. open contact

All of these six items contribute to gingivitis. In a controled population, three-year study, 59% of their restorations listed as needing to be replaced were not replaced, but three times the number of restorations listed needing to be done were actually done. This "three times being done" of the listed "to be done" is not an overtreatment, but arose in addition to the originally agreed upon restorations because of the top six factors coming to a terminus in unlisted restorations during the three-year period.

With the iatrogenic factor and entropic failure in the restorations that the dentist can provide and restorations screwed up by physical injury, disease or neglect, who among us can supercede God/nature in providing for people things that will not succumb to entropy. I think there's little guilt attached with these discoveries, merely that for the first time, human data in the United States is coming to fruition. How many of us know how epidemiological data converts to treatment need?

Who among us knows what the "repeat business" in the healed perio person is, across the board? The data is unavailable.

In today's competition for the discretionary dollar, quality and productivity have departed from the manufacturing floor and have become key components of successful

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strategies in all professions and businesses.

I believe this subject is so important that we must look at the vital aspects of quality, productivity revolutionarily. At the inlay seminar, wet-finger, in Phoenix, under NAPILI's banner, we talk the philosophy, pricing, quality control, productivity per unit time, fixed and variable cost and discover rare and unusual opportunity. As a paradigm buster, I can assure you that. . . WhEN pATteRns ArE brOkEN. . . new worlds emerge, staggering bits of information emerge. You can do a quadrant of inlays instead of a quadrant of amalgams at the amalgam fee plus the laboratory fee and double your net, if you're properly scheduled and your procedures and team function are in place.

I invite the "quality" critics in my life to join us, no tuition, to "come and see" the quality of restoration here, after 30 years in the profession, at Valley Dental Group. Call me, personally, and be my guest "in-house","wet finger", for a day of "over the shoulder". I'll arrange it anonymously. The 90-second crown prep, the "seat by primary intent" inlay is achieved comfortably, with style, flair and quality you will enjoy. SEE and KNOW, then TALK! If your beliefs are molded by local political stories or "the grapevine", recognize it is so for you. Why not "walk a mile in his moccasins" and then let your perception of reality mold your words and behavior. (A NAPILI principle, by the way!)

In the people game, administrative process allows us to collateralize and get the best out of the brilliance of people and, then at the level of the action, the best in strategic function of each person.

Achieving quality excellence means moving beyond just making formal commitment, issuing policy or making a speech to the "troops." It takes on a whole new role in making things happen, getting involved, staying involved, and having quality improve. There are no cookbook solutions to the challenges we face in this business. No magic recipe that will work for every one in every instance.

The use of feedback and communication is critically important to the quality improvement which must continue as a top level priority for all of us. Without question, CAD/CAM, robotics, computers, office automation will continue to make substantial contributions to our quality improvement and service to others. But a robot has not yet been invented that can take the place of a creative human who's enthusiastic, motivated, and attitudinally concerned with service to the person coming for care.

These attributes provide a quantum improvement in productivity and quality. Too often, when we talk about launching people programs, we make the mistake of aiming them only at the lowest folks on the totem pole, the most needy on our team. They must be included, of course, but we need to focus on active participation all the way throughout the team.

Model-building and goal analysis must be included as functional tools in this game. The entire team must create an environment in which quality and excellence is a virtue in everything we do. It must be an objective to make the quality we care about a recognized fact, not just an unspoken assumption.

We've not succeeded in answering all the questions. . . we're as confused as ever, but . . . are now confused on a higher level, about more important things.

The great thing in the world is not so much where we stand as in what direction we're moving.

It's ironic that, at the ultimate low point, we need the ultimate vision.

Excellence has to start inside each person. The quality attitude is a shining light in the organization but each person must "spark" that light. Paul, in his Epistle, wrote "The good I would, I do not. That which I would not do, I do." How appropriate. No matter how big the decision or how successful the big case, a few big events don't really carry the same weight as all the signals that go out every day from ALL the events.

It is apparent that quality must be our number one priority or a day will come when the function we presently understand will not exist. Oftentimes the dentist begins to believe that he's not competing with his fellow dentist and feels that he's the only act in town. There's a tempting energy for one to lose touch with one's people. . . those coming for care, and to become a little complacent in one's marketplace. If one succumbs to that temptation, one will quickly learn that s/he's not the only game in town. It is very frustrating for some to understand that a service can be provided very uniquely in one office, at a profit, for the fixed and variable cost of producing that same service in another office.

The ability to produce a very fine service at a very fine profit at an extremely competitive figure makes one singularly unique. Combining this with a person's willingness to co-develop a fee with you gives margins of profit that allows continual investment in quality services.

If a person is with a team where the work environment and the discipline allows each person to become what s/he is able to be, to achieve a maximum potential; and if indeed the attitude and work ethic of the team assumes a personal responsibility for the continuous quality improvement, an unparalleled dedication to meet the needs and values of the people we serve, to be sensitive to their problems and the solutions to those problems, we will find that the increased quality consciousness we enjoy will be responsible for the inevitable improvement in our product and service superiority, our market leadership and our financial results.

What are we calling for? It may sound like the reading of a Communist manifesto to some, but I hardly think of anything being more freedom-generated and individualistically American than a call for major reduction in employee supervision in favor of self-administration to erase the traditional narrow definition of piece-work duty in favor of a team approach, rotating responsibility and a call for supplemental wage systems, individual contracting, including the sharing of the business profit through controlling its cost and annual renewable contracts.

A few short years ago, these thoughts were unique, but now they have been rattling around in dentistry for at least ten years with some effect. The NAPILI 2 workshop has been a major promulgator of these concepts with fantastic and positive feedback.

The business organizations and professional practices that are succeeding in this changing environment are the ones that are competing on an equal footing with HMOs, PPOs, etc. but have revamped their administrative systems. The collateralized American teams described by the terms "quality of life", "quality of work life", "participative management", "quality circles", "work teams", are gaining share in productivity improvement. No matter what the

label, this is the new wave in people relationships.

In the last decade, the quality of life, employee-oriented productivity programs have more than tripled. When people are allowed to stop the mundane in order to improve quality, when they are switching tasks among themselves to alleviate boredom, in many cases where robots and/or software/hardware combinations are doing the tedious chores while humans direct the work of the machines rather than the other way around, we find an improved environment for the emergence of quality.

Industry once taught that jobs should be fragmented and that mental functions, like planning, should be separated from physical work. It's taken us six decades to unravel that "logic". Front desklessness has emerged in dentistry and over a dozen and a half offices are now functioning that way with the ultimate in freedom and creativity being applied to the dental transaction. This produces a reduction of the time in-office up to 30% for the person coming for care and fashions a new production system that's not only more efficient, but much more humane.

We find that this is enhanced by having the team person have actual ownership in the business, not just psychological ownership. This means equipment, or some business phase of actual ownership. They feel a fair measure of job security, they are involved with life-long training and learning programs; they feel the benefits of this environment being tailored to their individual needs through individual contract and they participate in decision-making. They are free to express how they feel and what they think or what they hear and they become what the company is. We as a team are not only what we say, but what we do and that ultimately makes a difference between an organization that's effective and one that's ineffective.

We treat each other as true "stake holders"; we have a true success-oriented interest and commitment to the overall objectives we mutually design. We find that these new procedures are fully utilized in the workplace, where the function really occurs, not just in the seminar/workshop. I recognize how difficult it is for us to devise a system in which employees can legitimately feel they have a say in the administrative process of the office.

Team meetings are essential, where the dentist is absent and the people feel that they are the executive committee of the board, (two-thirds of which is absent) and that they have and do exercise the power to act. After all, the person working on the team will behaviorally reflect the treatment that s/he receives. Each person needs and expects decisions to be rational in an administrative way and the team person's effectiveness is dependent on how aware that person is of the expected performance level.

None of us
can go it alone.
Create your team.

Mager's task and performance analysis is invaluable in this regard. This whole philosophical bag breaks down the adversarial relationship that is so customary between management and work force and provides a relationship of mutual commitment. Only when we have trust and commitment among ourselves will this work.

Perhaps the doctor should quit and be re-hired, or indeed replaced, in order to functionally achieve this entire philosophy.

Action, the antidote for fear, is also the best teacher.

I HAVE MET THE ENEMY AND IT IS ME!

As a comment, I believe that there are many paths to short-term success, but history has shown that a practice's "eminence" comes only from persistent dedication of the highest kinds of principle. Survival of the practice over a long period of time in the same place with the same people is a prime example of high ideas breeding long-term success. You have to be in the same place with the same people for at least five years to find out whether what you do works or not. Perhaps some significance to this International Letter rests in its origin being in the bowels of such a behavioral laboratory. (See the Thanksgiving Letter enclosed, it expresses this basic philosophy. . .that we function under a program based on mutual respect over a long period of time.) Eminence may be a new term to dentistry, but practice eminence, I feel, is an appropriate conceptual tag.

At Valley Dental Group, this has been achieved by team people understanding, having freedom to know, sharing in the growth and profit and/or loss of the practice. If there is no profit, then the plateaus or reductions are obvious. People on the team are enjoying participating in flexible work hours and task provisions. I believe that, over the years, this program and philosophy has bonded administrative process and the people on the team together in a most unique way.

Why not give teamwork a try? Put two people with a common objective together and, suddenly, one plus one is more than two.

Our data shows that we have not only outperformed our so-called "competitors" (if indeed they exist at all), but most of the U.S. industry against which we can compare ourselves. Ours has been a system of mutual return to us as a team. . .of prestige, respect and economic strength. . . and has provided, we believe, especially for those who come to us for care, excellent service.

In a supply and demand way, the most important part of everyone's compensation hinges on company performance. When the company goes up, the pay goes up. We are currently well above the supply and demand dollar value. When the profits are down, it's imperative that the people on the team share not only in the growth and strength of the company but also in effect equally sharing in its shrinkage. Outstanding performance is rewarded. . . by the paycheck. . . compared to supply and demand in the neighborhood. If you have to work an extra day to receive 30% less than you're being paid, by the best job offer you get when you search the marketplace, you know you're on top, not by bonuses, but by annually being free to renegotiate on the basis of fixed and variable cost and profit of the organization in our own marketplace. This is a supply and demand free enterprise game. The market must tolerate what the traffic will bear; we must function as an American free enterprise capitalistic system to grow and serve others appropriately.

We have reward and we have appropriate future focus, too. The question is, what do we see in '87, '88, '89, '90 and '91? Will we be working? Will we be on target in our planning cycle? Will we have a stronger, narrower marketing effort? Will we have a stronger narrower recall effort? Will we reduce our lapse rate? Will we project our gross per recall and cost control expense analyze our practice? Will we reprice our services to market tolerances? Will we educate the people we serve? Will we assist them in co-developing a fair fee against

their own values? Will we continue to encourage leadership to emerge, situationally, at the level of the action? Will we continue to understand and believe that we can't add weak things to strong things and make strong things stronger? Will we learn by the wage cuts that have been exhibited in companies that redefine themselves and experience hefty wage increases in their new growth cycles? Will we understand the battle cry on both sides. . . that in service and that in the work life?

One of the NAPILI 8 practices we were recently able to review reduced its production costs by 31%. . .actual production costs! . . . cut administrative duties for the top people by going front deskless and this administrative duty cut reflected 20% of the gross of the practice. Staggering statistics! This means that the practice is basically down to a fixed and variable cost base of 51% against their previous cost factors. They boosted efficiency in the recall/hygiene/pre-perio group by some 60% by altering their recall, by using the computer. . . and cut remakes over a 12-month period by 20% by specifically targeting the time spent in preventing errors.

I don't call this "chipping away" at a problem, but as a huge step forward into the future of profitability. Profit is not a four-letter word, loss is. If we're going to be around to serve those we care for, we must be profitable. And if we're going to ensure our survival, in closing, I must review. . .

The practices I see that are really cutting the mustard, in the trenches, are moving toward productive teams that have built problem-solving mentality into the freedom at the level of the action with the individual person. I believe that offices built on the old classic "top down" paradigm are facing a totally new system today, one with a far greater competition and more educated work force that will replace the old industrial paradigm. If you want to be a paradigm buster, fire everyone and re-hire them with the agreement to restructure the entire practice. Be revolutionary. Don't let it evolve.

I believe this transition will be made or there will be a lot of practices going out of business. That is certainly exhibiting itself in Phoenix with nine bankruptcies in the last 12 months and 26 practices for sale here in this magnificent city where we provided more new jobs in 1985 in Maricopa County than in all of free Europe. We are the bright and shining buckle of the Sun Belt, and yet the data shows that change is the name of the game.

The old view of manager/employee as master/servant must be replaced with a personal respect and consideration for individual strengths, not a paternalistic but an individual worth and individual rights attitude where the new team person consciousness flourishes.

THOSE WHO DON'T WILL
FIND THEMSELVES WORKING
FOR THOSE WHO DO.

It is better to undertake a large task and get it half done than to undertake nothing and complete it.

Napili News

Enclosed is a copy of comments about South Africa from Mark Skousen's monthly newsletter. (FORECASTS & STRATEGIES, Phillips Publishing, 7811 Montrose Road, Potomac, MD 20854)

Omer and I are very interested in South Africa, it's one of our favorite spots. Having been there several times, we're not spooked by the media "hype."

We will go to Pretoria for the South African Dental Congress 2-7 November. (The 1987 NAPILI 6 experience.) We will be arranging a group rate for those who would enjoy traveling with us, to see firsthand the progress that is occurring. (I agree with Mark that South Africa is beautiful. . . I've never felt that it was dangerous.)

Let me hear from you if you're intrigued with the idea of traveling safely with us and our South African dentist hosts; we'll probably leave in late October and return shortly after the Congress. We usually plan 16-day Napili 6 opportunities.

Attention People Without Perio Alums: Herman Corn, an internationally known and respected periodontist, is one of the major speakers at the South African Dental Congress. He'll be worth hearing!

COME, JOIN US!

Marci Reed

President
Napili Seminars

NAPILI PARTICIPATION

THE TIP

Being with FDDS teams across the country, becoming intimate with the score cards (gross and net), listening to the needs of these practices has, in a segmented way, become its own psychographic study. A strong trend is evident and common to high net practices. Patients seen by those practices seem to be from the same pool of our common population; yet, the effect of treating this pool has a dramatically different effect on different teams.

Recently, two practices in the same state completed an informal practice analysis. Both were solo practitioners, with one full-time hygienist; a four-operatory environment; expressed concerns over the increasing complexities of providing superior dental care. One treated me much as he might a salesman, or servant; the other treated me warmly, special, as if he were my servant. One felt his high-dollar ($285,000) practice was the best he knew and his problems were just "the way it is in dentistry today." The other ($900,000) had the same staff expansion/compatibility/competence problems, and patient pool expansion problems; but had visions of ways to increase his skills and procedures to improve his service to clients. One of his patients glowed as he told of the artwork imbedded on three posterior crowns. . . "no one knows they're there except me and the doctor. . . and I love them!"

The TIP (To Insure Profit) has been around since the Dark Ages. We're accustomed to adding to the fixed cost of dinners, taxis, etc., "tipping" for service. Better service, bigger tip. Many who serve in this way know the secret to obtaining good tips is to give something special. . . an extra dessert or cordial, hanging one's travel bag, adjusting the air conditioner, etc. What if dentists were to work for tips, not fixed fees? Would we then do something special, making the patient feel the warmth, see the concern, taste the caring?

I see the use of the TIP in wonderful ways in high net practices: a flower at each visit, a phone call for each person injected, or just placing a hand on the patient's shoulder, taking a moment to show "I care". It really doesn't seem to matter which extra service is added; the client expresses gratitude by paying for the service. . . To Insure Profit. . . and, a fair exchange of service for dollars involves a feeling by both persons that something special occurred. No clients. . . no producers. Each is a servant to the other, each side TIPs the other.

Joe Portale, D.M.D.

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NEW DIRECTIONS IN DENTISTRY

REED'S
INTERNATIONAL
LETTER

APRIL 1987

Dear Friends

The excitement in which we invest ourselves. . . NAPILI, life, and the dental practice. . . has to do with what people are, how they communicate, and the process through which they apply these two "entities" to serving others. Graphic facilitation of the idea systems that work provides a challenge. If we knew HOW we cerebrate, we could better share with others the meaning of what we feel. And since "who you are is where you were when," the picture becomes complicated.

The International Society for General Semantics (Box 2469, San Francisco 94126, membership encouraged) shows us how the transfer of meaning is facilitated by

ODE, MYTHOLOGY, METAPHOR AND PARABLE

(The Managers of Meaning)

In 1988, we will celebrate the Silver Anniversary (25 years!) of NAPILI's existence with little more in marketing effort than direct mail communication with those who've attended since that first workshop in June, 1963. And, by definition, the central role of this effort has been that of imagery and metaphor in shaping the context of what people perceive as "realistic", "practical", and what they consider to be ultimately acceptable.

The lecture circuit, the treatment consultation in practice, case treatment plan acceptance, team administration, and the ongoing process of family and friends is based on imagery, metaphor and parable.

These resources, along with the work of Doug Edwards (Closing the Sale), have long since been classic. . . the "similar story"-telling close produced by "before and after" slides, waxed up models and all the other gadgetry we employ in dentistry communicates for us. The parables told by Christ to His students, the process of communication He used with His family, His friends, His enemies (remarkably differing one from the other) carefully orchestrated the experiential transfer in group process. Storytelling has been one of the most profound tools for the continuance of human history and the perpetuation of tradition.

Today some of the most exciting results are being achieved by the use of graphic audio-visual tooling for guiding the imagination and the constructive use of thought for the transfer of meaning.

We cannot direct the wind, but we can adjust the sails.

To love what you do and feel that it matters. . . how could anything be more fun?

OMER K. REED, DDS

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We still find that the role metaphor plays in guiding the perception of our individual minds has a parallel in roleplaying and psychodrama, in the seminars as people storytell their life experiences in regard to success and problem-solving, and guide the decision process in the attendees who workshop their way to individual experience and the application of their insights at the group level when they get home.

What is imagery? and metaphor?

Imagery is a word used to include all the patterns and combinations we weave from our various modes of perception. (It's almost impossible not to use a metaphor, the word "weave.") In Jung's terms, these include our intuition, our feelings, our thoughts, our sensations. When we form imagery through these modes, they constellate as "visions", "emotions", "concepts" and "routines".

An image can be a line of poetry, a bar of music, an object, a personal relationship. When a pattern of imagery connects with an important life experience the sounds, sights, smells and feelings connected with the image achieve a symbolic power to trigger memories of the original experience. Much of our behavior at the unconscious level seems to be guided by these trigger reactions. We seem to seek repeats of our "successes" and avoid contact with the "failures". This occurs on a complex level when one appreciates that the associated symbols and integrated images are in fact only what we perceive. . . even "new" experiences may not be genuinely new experiences. When our base images "transform", we, too, experience remarkable changes in behavior, attitude and perception. REALITY and TRUTH are truly inter-cranial experiences. . . perceptions.

Metaphors are those classes of images that are used to represent something other than what they directly suggest but are alike in some "true way". I may say someone is "tightly wound" or "loosely wrapped" and convey an accurate image, even though literally, the people are neither wound or wrapped. What I intend to convey in metaphor usually establishes a context for facts and concepts that are directly associated with the subject at hand.

Certain metaphors, through repetition, take on an important organized role in people's thoughts. Larry Porter and David Sibbet, working with David Cawood and Bob Eskridge, consultants from Canada and Los Angeles, heavily lace their consultative therapy with the Esalen/General Semantics applications discussed here.

The team, collateralized in dentistry, is an organizational aggregation of people. Their modes of perception are bound together by imagery and metaphor. These central metaphors may be called agreements or assumptions and will, in some literature, be referred to as myths because they exist externally not at all, but only within the minds and experience of the people.

Metaphors provide meaning by establishing a basis for integrating and interpreting the complex varieties of behavior possible in any group of people or at the hands of any given artist. Not everyone has the same experience, but people can share a sense of these experiences through their metaphorical comparison. A

tuned ear and eye provides plenty of evidence. Listen to what people say. "This place is a zoo at closing time". "He runs a division like a finely tuned orchestra." "When that practice hires bright new people, it chews them up and spits them back out."

We finally figured out our practice's core business, it's growing high achievers. When images like this become widely appreciated as being "true" they take on both a generative and a stabilizing quality providing an archetypical "glue" to counter the ambiguity and uncertainty of affairs and communication in group.

Reuel Howe's book, MIRACLE OF DIALOGUE, brings into focus what holds it all together. . . how the stories and the dialogue between people can create a meeting of meanings that identifies the transfer of the person to the person. Since all people are inherently good and will good for others, this is an extremely therapeutic and powerfully positive event.

When we tune into the power of central metaphor and capture it, the interaction of our dialogue provides the redundancy needed for clear group communicative process. And we can unlock group, and personal, creativity creativity in a gentle, unthreatening way. This must be done in a "real time" facilitative environment. . . where we can listen to, and feed back, key words and phrases and illustrations that create pictorial images, cerebrally, in sufficient quantity for clear transfer to be made.

We, in our experience with each other, must both free and celebrate the process of finding meaning in what we do and in each other. Being explicit about imagery and metaphor, people have the choice to change communication and themselves. During a recent team meeting where we invested a day with each other, I began to sense the long-range plan, or model, process that we are playing was being facilitated by the key metaphor of "flight plan." We certainly understood the need for the pilot to understand where he was going to be when he ended his flight, BEFORE he took off and we were able to visualize such objective things as budget by seeing the fuel use between radio check points, time in flight, winds aloft and various things that were very typical of the journey we were about to begin.

The greater a person's responsibility on the team, the more likely it is that imagery and metaphor become crucial as a way to appreciate the wholeness of situations, particularly in the face of a flood of analytical data.

Individual contact between the people and the budget on the computer and the chief person facilitating budget meant a lot in transferring this flight plan to a reality to each of us. It played a significant role in establishing individual contracts for 1987.

Does a team have a collective way of consciously seeing a process at work? Can they bridge beyond the specialized ways of seeing resulting from professional training? Does their collective metaphorical base embody any developmental imagery? Does organizational imagery support intuitive modes in non-explicit aspects of human capability? Can we become more creative than we are through seeing ourselves at a future focus position worthy of our commitment?

The quality of a person's life is in direct proportion to his/her commitment to excellence, regardless of his/her chosen field of endeavor.

Host resistance, immune system, calcium metabolism, periodontal disease. . . all are linked.

Plan purposefully. Prepare prayerfully. Proceed positively. Pursue persistently.

Inherent in our learning is the need for emotional maturity of a supernatural kind for each person operating at his/her near-peak experience level. (Maslow)

In watching an old movie (Four Horsemen of the Apocalypse) I felt the strength of the paradigm in dentistry that could be drawn from the French underground. The terrorist tactics of the successful underground operations against the Germans in France and Holland was built on trust, communication, flexibility, and if employed in the dental team environment will show a hard-hitting core system representing a powerful stream of thinking and potential change that in this economical period of time is essential.

Can you imagine a team using these tactics to lower the break-even point in a budget? Even when not previously learned experientially, it's vitally important to initiate this new situation by challenging the old assumptions. I choose to listen in an atmosphere of personal trust and credibility. I can choose to trust and to see credibility in behavior even if it's unearned in new people or in those who have previously provided experiential distrust and lack of credibility. This is a matter of personal perception and decision.

Truly interactive, generative metaphors have the power to create a new cluster of meaning as opposed to merely attaching knowledge into existing frameworks. I can choose to change the framework in which I see you and/or your behavior and as a result of this power, often, instead of threatening and experiencing the resulting dissonance with old organizational ideas or old experience with current team people which is stressful, I may metaphorically choose to shut down one engine and with the other one on full power have a quality of truly being interactive because I decide to. Oftentimes I find the end result of this very satisfying experience is that I misunderstood the behavior and the message-sending in the first place and in struggling to make sense through a process of active involvement, new insights appear and grow, eventually leading to a change in behavior, both in me and in others.

So often we disagree (and are disagreeable) before we understand.

In a truly trusting environment, this shift can be experienced as having all the excitement of a land-based exploration during the historical age of discovery.
When the term "Camelot" is used, it is often able to precipitate medieval imagery. . . Sir Lancelot and Prince Valiant rally. . . Napili is so diversified in its format the structural language that is otherwise unavailable in many business frameworks is implemented by referring to the interface as a Camelot experience.

YOU are NAPILI. . . you don't belong to it, or join it as a result of fees and tuitions, but as a result of "networking" (or "not working"), you generatively contribute the energy and spark that has perpetuated this loose framework of fellowship. You are the knights of the round table!!

Napili is not a heavily traveled route. Little of our life is shaped by our own efforts, but usually brought about by a "brother" who cares and shares . . . and others who lead us as the fellowship of a family.

The model-building (Napili 3) and team-building (Napili 2) experiences can literally become the containers and boundaries for people's thinking into which ideas are poured and molded. Many of these ideas can be translated into systems graphics and are used in new forms of note-taking, projection programs, graphic idea boards and various facilitative mechanical systems that delineate and cross-stimulate thinking.

Recent exposure, again, to Carl Hammerschlag shows the power and centrality of imagery and metaphor being so increasingly fundamental that it's almost his private technology. (See Napili 8 video tapes [4], November '86, 16 hours, $425/set.) His strength and ability to hear and mirror the healthy center or the true key of informational transfer that allows wellness and healing to orient and align itself with the individual is so profound that once it is in the open the group with whom he is participating can use its power. His transforming image and metaphor use works in many ways, but its common power is its ability to add immense meaning to previous experience. Artists and poets strive to capture the sense of encounter and each of us can probably remember transformational experiences.

Carl says, "Recollection is more fun than the experience. . . as the occasion usually comes and goes too fast to savor." In the words of T. S. Elliot, "It seems, as one becomes older, that the past has another pattern . . . we had the experience but missed the meaning and approach to the meaning restores the experience in a different form beyond any meaning we can assign to happiness."

Carl's recent work with Napili 8 (Accelerated Practices) on the behavioral paradigm, or the mini-manuscript of life, involving drivers, stoppers and depression was so classic that requests for the tape of the workshop are flooding in.

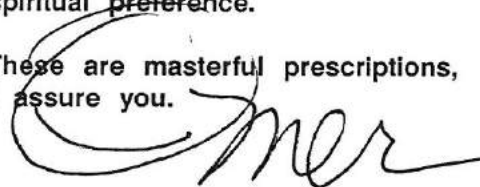
"You can't sell from an empty wagon" so if you have nothing to say, or no meaning to transfer, all the odes, myths, metaphors and parables in the world will not make a silk purse out of your sow's ear.

I have two prescriptions that I believe will sharply enhance your team leadership, treatment consultations, case acceptance, retention of people in the practice, accelerate recalls, double new person referral, ease your transfer to the non-piecework fee schedule, the cash practice, the front deskless office, the effective use of time scheduling, the reality of a paperless computerized office.

The first prescription is for a membership and close attention to the literature of the American Society for General Semantics (out of which I "bore" Semantodontics in the mid-sixties).

The second prescription is for the purchase of a "red letter" edition of the Bible, to study Christ's use of odes, myths, metaphors, and parables in His interface with His students, His friends, His family and His opposition. . . a marvelous study irrespective of your personal spiritual preference.

These are masterful prescriptions, I assure you.



Ability without ambition is like a car without a motor.

Napili News

These words were sent by Dr. Dick Oliver. . "For the work we are enabled to do, and the truth we are permitted to discover. . . for the desire and power to help others; for every opportunity of serving our generation in ways large or small. . . . we give thanks."

These sentiments are appropriate at any time of year, and certainly Omer and I feel that they are applicable not only to what we're enjoying (Napili, et al), but to what dentistry is all about.

We'll be exploring this idea in depth in Hawaii at the Model-Building (August 9-11) and the Economic Core of Model-Building (August 13-15) workshops at the Sheraton Princeville on Kauai. (Note: One of MANY changes in our lives this year. . . we're changing Islands after 15 years! . . .)

Evolutionary, Revolutionary, Pivotal, Transitional . . . you've heard all the buzz words and you're aware of dentistry's involvement. These two workshops are more important, to each of us, than ever before. Invent your future with a time/design framework that will help you assemble a personal and professional lifestyle.

Reminder: Two spaces remaining . . . Colorado River Raft Experience, July 23-31.

May 13: One-day Inlay Rehab Course.
May 13-16: Closed Circuit Video Case Presentation workshop begins Wednesday evening, 6:30 p.m. Limited Attendance Due to Limited Space.

Come, join us.

Marci Reed

President
Napili Seminars

NAPILI PARTICIPATION

IT'S MY PLEASURE TO LET YOU KNOW. . .

Dear Omer:

I have really appreciated the things I learned at NAPILI 3 and 4. Thanks!

As you know, I carefully sought to be included in those two workshops because I wanted to learn. I do not know exactly why I sought the experience. Maybe it was a notion or an intuition.

It may have something to do with what is explained in an article I read recently about metaphors:

". . . fundamental to adult learning processes is the need for emotional arousal. This feeling state can be stimulated through the careful use of anomaly and ambiguity as people struggle to fit metaphors into existing mental contexts."

It is possible that your approach (Model-Building [N3] and Economic Core of Model-Building [N4]) to helping people plan is the best available anywhere, for any price.

I intend to give you whatever feedback I can to reassure you of the quality of these two programs, not only for dentists, but even for professional planners.

After I thought about your program and discussed it with others in our client base, I realized that your concepts of

(1) the ten-year model,
(2) the computation of retirement funds and seed money and,
(3) the review of actual results by previous participants, are powerful and give great hope to individuals.

Most individuals have no idea that the vast majority of people "net out to zero" (assets equal liabilities, or worse). In addition, most do not realize the actual dollar amounts which can work for most of us in the United States to provide economic freedom.

How do you get couples to spend several days doing the unpleasant task of calculating and computing? . . . you do it! And I'm amazed.

Jim Norman, CPA

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NEW DIRECTIONS IN DENTISTRY

REED'S
INTERNATIONAL
LETTER

Dear Friends

At a time when change, growth and learning . . . societally and professionally . . . has accelerated beyond the monitorable stage, and at a time when only the laws of gravity and things recognized as spiritual have, by agreement, apparently remained constant, I am challenged and encouraged by Harry Frankfurt, Chairman of the Department of Philosophy at Yale, to deal with things objective and subjective, as I see them, under the remarkable and somewhat questionable, and somewhat daring title, of this edition.

REFLECTIONS ON BULLSHIT

No man is an island. . . and I use that term generically with no sexist intent. . . although those female-type persons who are reading this will certainly agree from either point of view.

Human communication, when defined as the transfer of meaning, or the meeting of meanings, exclusive of agreement or disagreement, most assuredly only takes place when there's human dialogue, and then heavily dependent upon metaphor. Who can tell who hears. . . who understands. . . who cares? . . . or how?

Bob Mager, in his work, GOAL ANALYSIS, makes clear the difference between subjective and objective and our traditional misuse in our human communication. To the person, those of you reading this are well aware of my activities, the activities of Valley Dental Group, the activities of NAPILI seminars, the lecture series, the international travel and communication, the Maverick efforts, the privilege of living in Phoenix, Arizona (a hotbed of more than one kind) and the other variables that have promulgated this gibberish.

Many of us consider things objective as things that are true, or fact, simply because they can be measured and through attribution they become part of the matrix we consider to be reality. Reality, however, is an agglutination, an aggregation, or perhaps better, a precipitation of those things that we choose to perceive as reality as we combine them for our world, "as we see it."

I do not belong to the skeptic camp that denies that we can have any reliable access to an objective reality, nor do I reject the possibility of knowing how things truly are. I, however, recognize the tremendous smear that takes place intercranially as one assembles those objective things one perceives in the order in which one puts them to create the world as one perceives it.

MAY 1987

More people are humbugged into believing too little. . . than are humbugged into believing too much.

This does not create for me a need to retreat from the search for social, technical, professional or spiritual correctness to a world alternative described as sincerity.

I'm reminded of my friend who got on the train at midnight in Phoenix on his way to vacation on the beach in California and as he awakened in the morning, some few hours later, his seat partner stretched and expounded on how great it was going to be to spend the day in El Paso. Adamantly denying the arrival point, my friend said, "But, I got on the train to Los Angeles." His sincerity and belief did not preclude his physical arrival in El Paso.

The word "sincere" was stamped "sine cera" on the huge marble blocks that Michaelangelo received from the quarry to simply identify for him the fact that the block was solid, not cracked and filled with wax, and therefore he could depend on the product from the quarry master.

Sincere then . . . to be without wax. . . simply means to be able to withstand the heat of disclosure in regard to integrity. This is not an argument to set aside sincerity, nor an attempt to convince you to abandon it.

There are, reportedly, more than 1500 "circuit riders" lecturing in dentistry today. It is apparent that everyone feels it is important to make the scene, for his/her own sincere reason. I have no argument with this phenomenon. In fact, I find it interesting and amusing.

Seminars and workshops have proliferated to the point that anyone traditionally exposing self through this means is somewhat smothered if not in an advertising mode. This smothering is at once a blessing as it allows the remarkable phenomenon of exclusivity to emerge through tradition, location, personality and integrity. The identity of persisting individuals, the focus on a small segment of the market that interests the ongoing organization, and the inevitability of showing an operating profit from the endeavor. . . all are essential challenges.

I've watched several of the traditional organizations, which would have included Barkley had he lived, as they enjoy the repeat business of those who highly value fellowship and growth as they perceive great value in investing themselves in the particular brand of congruence and well-integrated uniqueness of the experience.

It is almost inevitable that the personal referral that perpetuates these programs of energy far supersedes the advertising effort of those more newly arrived.

As NAPILI approaches its 25th year as a facilitating coordinating opportunity of fellowship, in a rapidly changing profession and time, an interesting effort is about to be mounted. This effort will simply be a personal inquiry to each person who has participated in NAPILI, requesting a succinct description of what NAPILI is as seen by that person. What is NAPILI?

OMER K. REED, DDS

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Without question, the large red ("B.S.") stamp which was gifted to me by a friend, (which he purportedly uses each year on his IRS return) will be one of the succinct descriptions of that which NAPILI is.

In referring to the article by Frankfurt, on careful study, one must become acquainted, if not comfortable, with the phenomenon and its being compared to the perception of truth, the lie, the bluff, and other processes that we use to "fake" our way through life, death, marriage, childbearing and rearing, and service to others in the health industry.

A good Midwestern manure spreader has been considered as the new NAPILI logo, perhaps appropriately. The collection and spreading of that which fertilizes growth and change is not inappropriate!

Great lucidity with self will be implemented if one reads the new text by Daniel Goleman entitled, "Vital Lies, Simple Truths: The Psychology of Self-Deception", and the book, "If I'm So Successful, Why Do I Feel Like a Fake" (sub-titled The Imposter Phenomenon) by Harvey and Katz.

The book, "Necessary Losses", by Viorst, describes the loves, illusions, dependencies, and impossible expectations that each of us has to give up in order to grow.

Pertinent reading, as well, is the new work by Robert Rivlin and Gravelle, "Deciphering the Senses: The Expanding World of Human Perception." These are readily available through Prentice-Hall, Box 10614, Des Moines, IA 50380-0614.

In the western world, one of the expected realities is for each person to have a response, irrespective of the subject or the experience, and it's quite easily tested.

We attain knowledge about reality. . . by what we tell ourselves about reality.

When asked a question. . . any question. . . any western world person with any degree of social freedom and politeness will have an answer. It's almost an expression of ignorance and impoliteness not to give one's opinion or one's view of reality on the subject and, although this is oftentimes criticized, this phenomenon is a testable reality.

The answers given to these questions may be perceived as faking, lies, recitations of truth, or absolute "bullshit" to the question asker, depending upon his relevance to the material and his awareness of his reality in regard to that question.

My point is clearly a simple one. When one attends a seminar/workshop, or when one finds oneself invested in reading one of the myriad of newsletters that presently exists in the United States, a background question could well be felt at the conscious level, "What is the intent of this energy?" "Why is this event truly taking place?" "Is the apparent end point at all similar to perhaps the true driving force behind the whole equation?"

We are awash in a sea of information.

There may be a comfortable warm insulating layer of "bullshit" between those two forces that for the sake of one's own use best be left alone. . . best be left

functionally insulating one from the driving forces that produce the event.

A now-famous group of dental students, loosely referred to as the "Wise Men From the East" (Or the Jersey Mafia), are more than able to express opinionated feelings about the origins to which I refer when asked, quickly even, in the public setting about the key people currently on the dental scene today. This frankness is refreshing.

Respond, flex, cope, change, be responsive, be available, be open.

One finds it easily understood and one finds it quite simple, then, to agree or disagree as one processes it against one's own perception of reality. When taken in the context of the entire environment in which we live, I find that force and energy happiness producing and joyfully constructive to the never-ending process of continuing education in dentistry.

The word responsibility is overworked and under understood, perhaps by intent. If we changed it to response-ableness, or one's ability to respond, to flex, to move, to cope, to change, to be responsive, to be available, to be open in the face of one's obvious vulnerability, it would perhaps again become a useful word.

There is a "no sameness" about the word responsible as we see it individually.

I'm comfortable with the fact that you who are reading this are applying these thoughts to your practice, your family, to those significant around you and to your role of servitude in this world.

As things roar along in this transitional pivotal period, I'm convinced that history does not repeat itself. At best history will create resemblances and similarities, but the pendulum never swings all the way back to that time or that event.

The milieu in which we find it is so remarkably unique that each and every moment is unique unto itself, allowing the intuitive individual edge of each of us to become quite sharpened.

For us to develop understanding and intuition in regards to how we apply self to the various roles available provides us with a positive challenge that is ever new and never-ending.

Perhaps if you've read Frankfurt's essay a couple of times, by now I can carefully plod into an application that has been around for at least 25 years that I know of (and possibly considerably longer than that) and yet a consideration or concept that has not taken dentistry by storm, to say the least.

I refer to the subjective/objective role of things in life that has conveniently escaped the mentality of dental educators and the tradition of our profession.

It's specifically the concept of the non-piecework fee schedule. This is not simply a mechanism to avoid insurance companies or "bullshit" your way through case presentation. It is truly a philosophically-rooted, values-determined point of seeing the world.

When one considers private care different from private practice, by definition, one certainly is attracted to the readily recognizable niche in the market that is becoming more apparent to dental readers, daily,

I would certainly encourage any of your sons/daughters to go into dentistry and land running with a brilliant knowledge that there will be more people demanding private care than there are dentists providing it, and that with humanness and concern, skill, wellness orientation, and the things that accompany private care. . . the newly-graduated dentist can hardly help but be a smashing success.

S/he must however, embrace those philosophies and have them be real, intercranially, for him/her, such that they are synaptically available to those s/he serves. There will be no shock in his/her not accepting assignment from an insurance company or the federal government and what now appears to be the Delta Dilemma won't even be of historic interest when it's realized that the pieces aren't worth anything, it's what the pieces do as valued by the person wanting them.

It's true that one can be more successfully sued before a jury if one is non-piecework than if one is piecework. If one buys a crown, and the piece is yours, for $400-500 or whatever, it's considerably different than if what was "bought" was "I'm going to look good, chew good, be stronger, more cleansable" because those subjective factors exist in the perception or the intercranial reality of the person being served.

The only thing needed before a jury, in all honesty, is the denial of those perceptions by the new owner of the crown (the "patient") and/or the services intended to be rendered by that crown, for guilt to conclusively be admitted by the practitioner.

Most dentists aren't ready for this, let alone to submit to the evaluation by qualitative rather than quantitative standards in the profession.

When we, over the years, have insisted that dentistry in this arena is not price sensitive, cash sensitive, time sensitive, or piecework sensitive, it's been difficult to transfer the reality of the philosophy and our concept in an understanding environment, let alone to create a sameness in view in sufficient quantity for agreement, or disagreement, to take place.

To listen is not to hear.
To hear is not to understand.
To understand is not to believe.
And to believe is not to do.

This can be stated in a positive sense.

To hear is to listen.
To understand is to hear.
To believe is to understand.
And to do is to believe.

When we say "fee for service," we are not talking about pieces or things, as being a means to an end.

We are talking about the perception of what it does for the person who now uses it. What a difference.

The grandaddy of all judgments. . . the act of accepting (or rejecting) a course of action.

Let us work to develop understanding.

Your mind operates best when it's open. It opens only as wide as the smallest thing that offends it.

I've added up the pros and cons . . . the pros come out ahead.

The subjectivity of the value of that service is related to the values of the person exclusively and it will allow fees to fluctuate on a piecework basis depending upon a number of factors.

This allows the dentist to simply proceed even below his fixed and variable cost per unit time if he chooses to continue to render that service to that person at that time.

To provide services below cost, in a free enterprise, profit-oriented society, may not be wise, but it does happen intentionally on occasion now in those practices who understand the stance rather than having it happen unconsciously without them knowing.

Co-development of the fee is as natural as co-discovery, co-diagnosis, co-treatment planning and in the hands of a mature, sociologically-oriented individual, with or without a dental degree, it's an easy step in human dialogue, since there is a difference between the buyer and the seller in any marketplace that is significant.

The buyer wants the service or the product more than he wants the money by quite a bit, he is not just willing to make the transaction, but he is eager and delighted to make the transaction. . . and so is the seller. . . whether it be a Mercedes, a 3-unit bridge or whatever.

Because the seller in this game much more appreciates the actual remunerative standard, or the money, than retaining the service from that person who would appreciate it so richly.

This surely sounds like a bunch of "bullshit" to some. Yet, since it's my very best, I encourage you to believe with me that it, for you, is either a fake. . . a lie. . . bullshit. . . or my perception of something that's quite real.

(I challenge Bill Berry to write his subjective understanding of the sometimes ill-received 90-second crown prep . . . for publication.)

When standing before audiences recently I have overtly enjoyed the privilege of prescribing that the message they are about to hear won't work for them where they are. . . "only in Phoenix will what I have to share with you work." And not in their hands will it work. . . only in mine. . . and therefore what I'm telling them, as an educational process, is obviously a lie.

The whole concept is humorously exciting in that, without question, the exposure to change in philosophy and belief perception is oftentimes precipitiated in workshop where others have come. . . seeking tactics, strategies, procedures and how to's to apply as tools when they get home.

I don't object, nor do I deny these experiences. I believe they are whole opportunities to alter one's perception and they become the true nidus around which a peak can be built for self.

The impact of this experience will be philosophically destructive in sufficient quantity to convince oneself that

what one has been believing has only in part been true as determined by the functional standard of how it's working.

It is easy then to abandon that which one has been thinking and doing as pure bullshit in a sincere struggle to become a better servant to others, to alter one's form and function in sufficient quantity to "better mousetrap" our feeble replacement of that which Nature originally provided.

I also believe that with the definitive awareness of the ever-present bullshit syndrome we have an opportunity to strengthen our perception of change and continue our growth and learning with perhaps less pain and greater frequency.

Obviously, I continue to advocate that any change one chooses to precipitate should take place well before one understands.

I certainly mean understand in the sense of the idea system itself, its application and/or the outcome of these applied changes. One's ripping out one's front desk over the weekend to create the problems that will be resolved from within as one literally grows one's own tactics can hardly be more vigorously encouraged.

It may be practical to run a non-piecework fee schedule parallel to the piecework fee schedule so one can untangle the bullshit in one's philosophical belief system; however, in this age of revolution, evolution may not be so popular and one may choose to totally abandon the piecework fee schedule, go to a fixed and variable cost per unit function after carefully measuring one's performance.

The initial revolution to approaching those we serve on a co-develoment of fee (from their values not ours basis) will help us find that there's nothing irreverent or non-evangelical about bullshit.

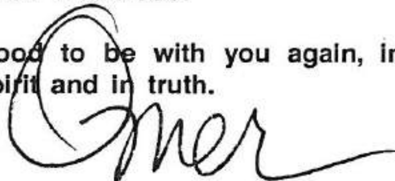
I find that it's a part of the Pauline theology to recognize the phenomenon and for those of you who do not share this perception, please quietly leave me with mine for the moment. With time, I'll perhaps grow and mature in those areas where you have exceeded my growth in sufficient quantity to come back in tune with you as you see yourself.

In the meantime, please adopt with me the humor of the situation as you look about the field of clinicians and seminars and at their probable root causes as we enjoy together the "process". (That is the word of the day, isn't it?. . . process.)

Have you read the book, When All You've Ever Wanted Isn't Enough, by Harold Kushner? It's a Summit book by Simon and Schuster and is certainly appropriate to the entire game that I've been sharing with you today. Don't miss it!

In closing, let me recommend that those who have become readers enjoy, as I have many times, the simple text that relates to historical study found in the book, The Humor of Christ, by Elton Trueblood.

Good to be with you again, in spirit and in truth.



Process: A specific, continuous action operation or series of changes.

I've been sitting at the terminal for the longest time trying to decide where to start in the litany of activities occurring at NAPILI.

First things first. . .
perhaps that's the best way.

Closed Circuit Video/Case Presentation workshop is in process this week. It's a delightful experience to watch/listen to doctors and spouses "role-play", learning to be better able to have a meeting of meanings with the person coming for care in regard to his/her wanting that which s/he needs.

The new NAPILI Turtle workshop will premiere on the 20th of May, featuring Carl Hammerschlag, John Koriath, and Omer. More on that, post-workshop.

June 24-27: Workshop for doctor and team has available space for two or three more groups.

August 9-11, 12-15, Model-building and the Economic Core of Model-building, two workshops being presented at the Sheraton Princeville/Kauaii.

The South African experience is confirmed: October 26 through November 12. Call or write for more information.

Then, COME, JOIN US!

Marci Reed

President
Napili Seminars

TRIBUTE TO DR. F. HAROLD WIRTH
1907–1987

Dear Sybil:

We cannot begin to tell you of the joyful anticipation we had for the evening of April 9th. . . the evening that the members of the New Jersey Dental Research Group were planning a surprise party for you and Harold.

He knew we loved him, and didn't need this fanfare to prove it . . . but we needed it. We wanted to thank him for a few of his many wonderful attributes that may have "rubbed off" on us. . . his honesty, his guidance, his inspiration, had been somewhat taken for granted, but now we were going to have a chance to have him all to ourselves. . . to hug him, and thank him, and hug him again.

We were going to let him know, first hand, what he has meant to us all these years.

We are heartbroken that our dear Lord decided against this. He simply could not wait any longer to have Harold with Him.

The sorrow, the anguish, and the sadness we are left with, is entirely overshadowed by the blissful delight of our Father now that Harold is His.

Though our tears betray us, we accept His decision with joy.

Sybil, dear, we're all praying for you. You were an integral part of the love we felt for Harold. He never spoke with us that he did not mention you, and always with endearment in his voice, and adoration in his eyes.

We thank God that your marriage was blessed with wonderful children and countless friends to share your grief. With all our hearts, we share it, too, and will never forget Dr. and Mrs. F. Harold Wirth.

The New Jersey Dental Research Group

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[Essay]

REFLECTIONS ON BULLSHIT

From "On Bullshit," by Harry Frankfurt, in the Fall 1986 Raritan. *Frankfurt is chairman of the department of philosophy at Yale.*

One of the most salient features of our culture is that there is so much bullshit. Everyone knows this. Each of us contributes his share. But we tend to take the situation for granted. Most people are rather confident of their ability to recognize bullshit and to avoid being taken in by it. So the phenomenon has not aroused much deliberate concern, nor attracted much sustained inquiry.

In consequence, we have no clear understanding of what bullshit is, why there is so much of it, or what functions it serves. And we lack a conscientiously developed appreciation of what it means to us. In other words, we have no theory. I propose to begin the development of a theoretical understanding of bullshit, mainly by providing some tentative and exploratory philosophical analysis. I shall not consider the rhetorical uses and misuses of bullshit. My aim is simply to give a rough account of what bullshit is and how it differs from what it is not.

Bullshitting involves a kind of bluff. It is closer to bluffing, surely, than to telling a lie. But what is implied concerning its nature by the fact that it is more like the former than it is like the latter? Just what is the relevant difference between a bluff and a lie?

Lying and bluffing are both modes of misrepresentation or deception. Now, the concept most central to the distinctive nature of a lie is that of falsity: the liar is essentially someone who deliberately promulgates a falsehood. Bluffing too is typically devoted to conveying something false. Unlike plain lying, however, it is more especially a matter not of falsity but of fakery. This is what accounts for its nearness to bullshit. For the essence of bullshit is not that it is *false* but that it is *phony*. In order to appreciate this distinction, one must recognize that a fake or a phony need not be in any respect (apart from authenticity itself) inferior to the real thing. What is not genuine need not also be defective in some other way. It may be, after all, an exact copy. What is wrong with a counterfeit is not what it is like, but how it was made. This points to a similar and fundamental aspect of the essential nature of bullshit: although it is produced without concern for the truth, it need not be false. The bullshitter is faking things. But this does not mean that he necessarily gets them wrong.

In Eric Ambler's novel *Dirty Story*, a character named Arthur Abdel Simpson recalls advice that he received as a child from his father:

> Although I was only seven when my father was killed, I still remember him very well and some of the things he used to say. . . . One of the first things he taught me was, *"Never tell a lie when you can bullshit your way through."*

This presumes not only that there is an important difference between lying and bullshitting, but that the latter is preferable to the former.

In trying to understand why our attitude toward bullshit might generally be more benign than our attitude toward lying, however, the pertinent comparison is not between telling a lie and producing some particular instance of bullshit. The elder Simpson identifies the alternative to telling a lie as "bullshitting one's way through." This involves not merely producing one instance of bullshit; it involves a *program* of producing bullshit to whatever extent the circumstances require. This is a key, perhaps, to

his preference. Telling a lie is an act with a sharp focus. It is designed to insert a particular falsehood at a specific point in a set or system of beliefs, in order to avoid the consequences of having that point occupied by the truth. This requires a degree of craftsmanship, in which the teller of the lie submits to objective constraints imposed by what he takes to be the truth. The liar is inescapably concerned with truth-values. In order to invent a lie at all, he must think he knows what is true. And in order to invent an effective lie, he must design his falsehood under the guidance of that truth.

A person who undertakes to bullshit his way through has much more freedom. His focus is panoramic rather than particular. He does not limit himself to inserting a particular falsehood at a specific point, and thus he is not constrained by the truths surrounding that point or intersecting it. He is prepared to fake the context as well, so far as need requires. This freedom from the constraints to which the liar must submit does not necessarily mean, of course, that his task is easier than the task of the liar. But the mode of creativity upon which it relies is less analytical and less deliberative than that which is mobilized in lying. It is more expansive and independent, with more spacious opportunities for improvisation, color, and imaginative play. This is less a matter of craft than of art. Hence the notion of the "bullshit artist."

What bullshit misrepresents is neither the state of affairs to which it refers nor the beliefs of the speaker concerning that state of affairs. Those are what lies misrepresent, by virtue of being false. Since bullshit need not be false, it differs from lies in its misrepresentational intent. The bullshitter may not deceive us, or even intend to do so, either about the facts or about what he takes the facts to be. What he does necessarily attempt to deceive us about is his enterprise. His only indispensably distinctive characteristic is that in a certain way he misrepresents what he is up to.

This is the crux of the distinction between the bullshitter and the liar. Both represent themselves falsely as endeavoring to communicate the truth. The success of each depends upon deceiving us about that. But the fact about himself that the liar hides is that he is attempting to lead us away from a correct apprehension of reality; we are not to know that he wants us to believe something he supposes to be false. The fact about himself that the bullshitter hides, on the other hand, is that the truth-values of his statements are of no interest to him; what we are not to understand is that his intention is neither to report the truth nor to conceal it. This does not mean that his speech is anarchically impulsive, but that the motive guiding and controlling it is unconcerned with how the things about which he speaks truly are.

It is impossible for someone to lie unless he thinks he knows the truth. Producing bullshit requires no such conviction. A person who lies is thereby responding to the truth, and he is to that extent respectful of it. For the bullshitter, however, all these bets are off: he is neither on the side of the true nor on the side of the false. His eye is not on the facts at all, except insofar as they may be pertinent to his interest in getting away with what he says.

For this reason, telling lies does not tend to unfit a person for telling the truth in the same way that bullshitting tends to. Through excessive indulgence in the latter activity, which involves making assertions without paying attention to anything except what it suits one to say, a person's normal habit of attending to the ways things are may become attenuated or lost. Someone who lies and someone who tells the truth are playing on opposite sides, so to speak, in the same game. Each responds to the facts as he understands them, although the response of the one is guided by the authority of the truth, while the response of the other defies that authority and refuses to meet its demands. The bullshitter ignores these demands altogether. He does not reject the authority of the truth, as the liar does. He pays no attention to it at all. By virtue of this, bullshit is a greater enemy of the truth than lies are.

One who is concerned to report or to conceal the facts assumes that there are indeed facts that are in some way both determinate and knowable. His interest in telling the truth or in lying presupposes that there is a difference between getting things wrong and getting them right, and that it is at least occasionally possible to tell the difference. Someone who ceases to believe in the possibility of identifying certain statements as true and others as false can have only two alternatives. The first is to desist both from efforts to tell the truth and from efforts to deceive. This would mean refraining from making any assertion whatever about the facts. The second alternative is to continue making assertions that purport to describe the way things are but that cannot be anything except bullshit.

Why is there so much bullshit? Well, bullshit is unavoidable whenever circumstances require someone to talk without knowing what he is talking about. Thus the production of bullshit is stimulated whenever a person's obligations or opportunities to speak about some topic are more extensive than his knowledge of the facts

that are relevant to that topic. This discrepancy is common in public life, where people are frequently impelled—whether by their own propensities or by the demands of others—to speak extensively about matters of which they are to some degree ignorant. Bullshit also arises from the widespread conviction that it is the responsibility of a citizen in a democracy to have opinions about everything, or at least everything that pertains to the conduct of his country's affairs.

The contemporary proliferation of bullshit also has deeper sources, in various forms of skepticism which deny that we can have any reliable access to an objective reality and which therefore reject the possibility of knowing how things truly are. These "anti-realist" doctrines undermine confidence in the value of disinterested efforts to determine what is true and what is false, and even in the intelligibility of the notion of objective inquiry. One response to this loss of confidence has been a retreat from the discipline required by dedication to the ideal of *correctness* to a quite different sort of discipline, which is imposed by pursuit of an alternative ideal of *sincerity*. Rather than seeking primarily to arrive at accurate representations of a common world, the individual turns toward trying to provide honest representations of himself. Convinced that reality has no inherent nature, which he might hope to identify as the truth about things, he devotes himself to being true to his own nature. It is as though he decided that since it makes no sense to try to be true to the facts, he must therefore try instead to be true to himself.

But it is preposterous to imagine that we ourselves are determinate, and hence susceptible both to correct and to incorrect descriptions, while supposing that the ascription of determinacy to anything else has been exposed as a mistake. As conscious beings, we exist only in response to other things, and we cannot know ourselves at all without knowing them. Moreover, there is nothing in theory, and certainly nothing in experience, to support the extraordinary judgment that it is the truth about himself that is the easiest for a person to know. Facts about ourselves are not peculiarly solid and resistant to skeptical dissolution. Our natures are, indeed, elusively insubstantial—notoriously less stable and less inherent than the natures of other things. And insofar as this is the case, sincerity itself is bullshit.

Omer K. Reed, D.D.S.
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RE: May 1987 Newsletter

Dear Omer:

I read your draft of the May Newsletter, "Reflections on Bullshit." I found it to be most interesting.

I believe the interpretation of what one sees, hears and reads is based upon past experiential background. The past experiential background drives one to see things in light of that which is important to us.

Recently, an elementary school teacher told me she was criticized by her peers at a faculty meeting because she wanted to teach values to students. Her complaint was that the students believed that the wrong was not in the immoral or illegal act, but in getting caught.

Translate this into the national setting and one finds it difficult to compromise the diverse views wherein the population in this country finds that it is anathema that South Africa should not be giving votes to the blacks on the grounds that the whites do not want to lose control. However, there is no objection whatsoever to the citizens of Israel denying votes to the Arabs so that the Israelis can keep control. This is another example of selective morality.

Dentists like to do restorative dentistry for the most part rather than periodontics. Therefore, they will be exercised when the patient does not have good restorative health, but will overlook the periodontal needs of that patient. Many people get very upset because they have gone to the same dentist for a number of years only to find that the dentist of tradition was out of town when a periodontal abscess developed. The new dentist said "you have to see a periodontist or have your teeth extracted." Perhaps Dentist One was doing what he felt was right and really was not too different from the elementary school teacher's position where she objected to the selective morality of not what was wrong, but getting caught.

Many of my peers in periodontics are trying to justify laying flaps for access to teeth so that they can remove the calulus. I am reminded that 20 years ago, Irving Glickman used to recommend the "unembellished gingivectomy." This procedure meant that he was cutting away the gingival tissue to expose the calculus so that it can be totally removed. Henry Goldman objected to this, saying that it seemed logical then to do a gingivectomy at every recall procedure. However, the students from Boston University today are laying flaps to have access to the calculus. Does this mean we should lay flaps at every recall?

Beauty is in the eyes of the beholder. So is our perception of truth . . . or bullshit. If we wish, we can block out anything that seems convenient to us provided we have the right kind of experiential background to make this possible. I think it is unfortunate, but that is the human mind. . . .Thanks for listening.

Kindest regards,

(signed) Perry A. Ratliff, D.D.S.

REED'S INTERNATIONAL LETTER

Dear Friends

During the People Without Perio (NAPILI 11, February) we were indeed blessed to have Dr. Perry Ratcliff and Dr. Richard Oliver join us. The following paragraphs are from my understanding of that remarkable experience, attended by 30 other dental teams. (The experience will be repeated in December, 1987; Napili/Update Foundation will offer a clinical/didactic three-week workshop in 1988, University affiliated.)

In this land of the free and home of the brave, private care, much as leadership, emerges situationally . . . . thence cometh the title of this blurb:

FAREWELL TO WELFARE

Dick Oliver comes from a background of study at USC, Loma Linda, the deanships at USC and the University of Minnesota, and his long-time experience with Perry Ratcliff. . . nearly 30 years of perio inter-relationship. . . that's 3/5th of (or 60%) of Perry's 50-year experience. . . these two gave to us from a total of 80 years of perio experience!

Dick reported to us from his current experience with the National Institute of Dental Research.

We're seeing a shift from the individual medical doctor to large corporation "providers". Paul Elwood, father of the HMO, predicts that we will see 20 megacorporations practicing medicine in the 90's. Toffler and Drucker both refer to these trends. Single-issue people in the "politics of life" will be "hunkering down" (believing it will go away) rather than model-building for change and growth to deal with the internal and external that can be to our advantage.

Only a third of our societal structure, according to Yankelovich, consciously believes in accommodating change and recognizing the transitional shifts that are taking place in this pivotal period.

The 1983 American Dental Association Report on the Future of Dentistry, which Dick Oliver chaired, reviews and reports relative facts from the many data bases. The two growing population segments are the 25-44 age group which is going to grow 35% in the next few years, and the over-65 age group, which will grow 20% in the next few years. The age 65 and over had little dentistry in the 20's and 30's. . . under 20% of them saw a dentist. They grew

up when total infection theories led to extensive removals resulting in edentulism and this leaves them with the pre-fluoride era type of crown and bridge rehabilitation needs.

In a Florida study of 1,034 people with a median age of 75. . . . in 1960, 50% were edentulous; in 1985. . . 27% edentulous, 83% had a physician of record, 42% had a dentist.

What are the implications of the epidemiological data?

If 50% of the dental schools were shut down, dentists will still grow in numbers until the year 2000. We've cut them by about 30% now, with 6,300 new students a year being cut to about 4,100 last year, and there's a lot less pathology out there than we think.

There are three major points to consider in the marketplace:

1. Changing disease patterns.
2. Continuing increase in dental manpower.
3. The unmet need existing in the population.

Considering these factors, the Strategic Plan for the Future of Dentistry was developed with five major recommendations:

1. Convert unmet need into demand.
2. Prepare the practitioner to be more patient-/public-oriented.
3. Broaden practitioner clinical skills and the mix of services available.
4. Influence supply (quality and quantity) of manpower.
5. Stimulate research.

Dick Oliver is currently analyzing the epidemiologic data on dental disease from two studies, the Research Triangle Institute Study of 1981 and the NIDR Adult Survey of 1985-86.

Both studies show substantial declines in caries, moderate and advanced periodontal disease, and missing teeth since the NHANES study of 1971-74.

Decision rules are being developed to convert the epidemiologic data into treatment needs. For periodontal disease, the vast majority of treatment needs are for scaling and prophylaxis.

He did point out that all epidemiologic studies represent some underestimate of the amount of disease but noted that even substantial underestimates will not change the trends or treatment implications.

Dick shared some changing concepts about periodontal diseases including:

1. Perio pockets are not progressive, but rather are cyclical in disease activity. (The "burst" theory.)
2. Increasingly, specific bacteria are related to specific diseases that we've diagnosed.
3. Host response and immune system, e.g. systemic

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diseases such as diabetes, are heavy overlays to the disease entity and complicate the care and prognosis.

Risk's assessment is important. The "burst" theory of disease activity is new to some.

In one recent study, Goodson followed 1,100 pockets for a year; 5% got worse. . . and they were most frequently the shallow ones rather than the deep ones, contrary to expectations.

He summarized ten megatrends for perio:

1. There are more older people with more teeth.
2. There are more affluent and educated people in our societal structure.
3. People are more discriminating as they come to us for care.
4. There's more interest in self-help and prevention today than ever before.
5. There's less perio in extent and severity in the people we see.
6. We are in an era of changing treatment plans. There's less surgery today.
7. Cost containment is increasing.
8. Capitation will increase as a form of delivery.
9. Competition for patients will increase.
10. Expert systems will lead to greater standardization of care.

Oliver noted the Ramfjord article, Journal of American Dental Association, January, 1987, in regard to these ten megatrends, specifically the sixth one.

Dick posed these questions:

1. If we find that most of the periodontal need, 90%, is in the area of prevention and gingivitis, who will best deliver the care? The general dentist, the hygienist, the periodontist?
2. What method of treatment should be considered? (Ramfjord's article)
3. If the implications of the "burst" theory are taken seriously, how do we monitor? Isn't monitoring the most critical thing we do for people?

   Pockets don't change much. Pocket depth, bleeding points and plaque scores are now critical in a continuing manner to uncover the "burst", or episodic nature, of our disease entities on the personal level.
4. What are the regional, geographic and ethnic variations that present themselves in the need for care?

Persons coming for care. . . often convince themselves to delay action in seeking periodontal treatment.

Debilitating conditions can be expected to complicate periodontal disease.

Changes that are taking place in dentistry require alterations of our attitudes.

The need is to recognize the changes . . . and to respond in a positive manner to the opportunities that are present.

WOW!!

Some of the general findings that were reported to us:

1. There is NO evidence in the disease data to imply that periodontal disease is replacing the loss of caries as a treatment entity in general dentistry.

2. Health services data does not show that general dentists are taking on more perio care than they have in the past. (One hour per week increase.)

3. The continuing restorative care, for the pre-fluoride generation, is the primary future prospect in dentistry, replacing existing restorations.

Dick quoted Douglas' definition of the "Iwo Jima", the "Coke", the "Baby Boomers" and the "Atari" generations. . . four groups of people who are different, one from another. . . (the tape done by Morris Massey, "Who You Are Is Where You Were When", in one era and out the other, came to my thinking.)

The Coke generation began to see dentists, had a lot of care; the Baby Boomers had the benefits, in the long range, of preventive information; the Atari generation had the benefit of fluoride.

We know that the Iwo Jima generation rarely saw the dentist, needs crowns, bridges and dentures. . . and is beginning to disappear from our society.

The restorative group (the Coke group, the Baby boomers) will have continual replacements of existing restorations.

There seems to be greater services being provided per person and more sophisticated work being accomplished.

Although the number of incoming students has dropped dramatically to around 4,000 each year, we need about 3,300 graduates per year to maintain the same dentist-to-population ratio until the year 2000, about the same number of graduates as in 1962.

We will still be charged with an over-supply of dentists between now and the end of the century.

Even with the access to evening and weekend office hours, advertising and other such changes available, there is no change in the numbers of people coming to the dentist from the half of our population that doesn't come to see us now.

Collectively, we have not been effective in creating change in the demand for care and there may not have been as much need out there as we projected in the first place.

We have increased the knowledge that the people have about dentistry, we have increased the readiness to buy our services once they get to us, but there is limited evidence that we have significantly increased the percentage of the people coming to us for care.

No matter how each of us sees

his/her situation, the 135,000 dentists who are presently in the market will feel the effect and all of us will be affected by what the large group experiences.

Dick listed four continuing crises for dentistry:

1. Economics.

(A) Most predictions are for reduced consumer spending which will effect dentistry.

(B) High tech versus care of the aged. We can't have both. We can't have huge defense spending and national deficit and still take care of the elderly.

The last few months of life take the largest portion of medical care. Some 10% of the total life care for the person takes place in the last three or four months of his life. This is creating a great deal of challenge.

The Veteran's Administration takes care of three million people now, and in ten years will take care of nine million.

We will be having a growing need in the economy as is faced by our health care.

The U. S. has a problem with salaries that have flattened since the early 70's and yet a growth in per capita spending has increased, primarily because (1) we've had fewer children. (2) We have two-worker families, therefore a bigger consumer dollar available and (3) We've borrowed. We are a nation of borrowers. We've borrowed unbelievably. We cannot borrow any more.

(C) We may have reached the limits of all three so further growth in consumer spending is unlikely.

In addition, deficit reduction and the growing health care needs of a rapidly growing elderly population make additional government expenditures in dentistry unlikely.

And, unfortunately, these are the people with the greatest dental needs. . . and with very little money. . . a high percentage of the people with the pathology are living below the poverty level.

"People without teeth usually don't have money either."

Corporations are also concerned with cost containment to improve their competitive position and an increasing number are considering flexible benefit programs which may put dental insurance at risk.

Corporations are going to self-insure. There will be more cafeteria programs with flexible benefits.

We must learn from change . . . adjust to change, and add to it for a new dental adventure.

The big shift in marketing home dental products has been from denture aids to preventive products.

The dentist's mission is to provide persons coming for care with co-therapy in health, comfort, and function.

By upgrading the quality of education and recall maintenance care, the average dental practice should be capable of preventing gingivitis.

On the high side, people will take programs with medical help, not dental help, and fewer will take dental health programs.

The ones who'll take dental programs are the high risk people that will drive the premiums up and then even fewer people will choose dentistry.

2. Crisis Number Two is personnel. We will continue to have an over-supply of dentists as related to demand, at least until the year 2000.

3. Crisis Number Three is organizational rigidity. Dentists, dental organizations, and the dental delivery and financing systems will find it very difficult to adjust to the many changes that beset us as rapidly as change appears.

4. The Fourth crisis that was cited is the crisis of expectation. . . the entitlement issue. We feel we're entitled to live at a high standard. We are now in an era where there is relative freedom.

   As the number of dentists increases from 135,000 to 150,000, it will be improbable that this group will be able or willing to shift to a different mode at all . . . let alone quickly enough to compensate for the change we feel.

One hundred thirty five thousand dentists, or more likely, 150,000, will see the marketplace as competition.

Ultimately, service and quality of care will distinguish the survivors. (Great argument for a commitment to private care.)

Our inaccurate expectations are a major problem. Dick Oliver sees a light at the end of the tunnel, but the tunnel is a lot longer than he expected a few years ago.

There is a great deal of uncertainty and we must chart the course of adaptation. Uncertainty helps us adapt and is a healthy symptom.

Anxiety, however, creates a paralysis, so the difference between anxiety and uncertainty must be understood.

Yankelovitch made the point in his book, New Rules, that in the time of accelerated change, 34% of the population creatively adapts, 29% do all the bad things in mal-adapting, and all the rest hope it will go away and that things will come back and be as they were.

HMOs continue to grow because of what the public sees as quality of care. The definition of quality may differ sharply from what some of us see.

In our effort to be a part of the adapting few, we must be continually in search for the reality that will assist us in that adaptation.

We must develop a healthy skepticism and become critical

thinkers. We can't accept the answers of others. We must find our own.

How does what I find fit with who I am and what I am doing?

"The future is not created by those who do not believe in it," says John Gardner.

Victor Hugo says, "Will the future arrive? If we continue to look upward, will the light we see be extinguished?"

Dickens quote on "These are the best of times (for some) and the worst of times" is probably more appropriate.

We know that things presently seen will be different. What will be working may not be recognizable today, but will be working tomorrow.

Capitation may be, as we understand it today, incompatible with private care on a fixed and variable cost basis as we know them, but what will work in the future will be different than what we now know.

Dick's presentation was upbeat and energizing . . . much appreciated.

Private care, an option for the future, will be enhanced by an awareness and mastery of three points in practice. . .

. . .the uniqueness of the people serving in the practice;

. . .an awareness of social and personal interdependence;

. . .and an attitude of servitude.

At the conscious level and behavioral level. . . these qualities are almost totally unavailable at the local and national dental meetings, but for those who are committed to these premises, it's "farewell to welfare" as we see it in society.

We must do what is right for the person coming to us for care. . . and what "right" is keeps changing.

Napili News

August 9-11 and 13-15, the Model-Building and Economic Core of Model-Building workshops (N3/4) at the Sheraton Princeville (Kauai) has a fantastic pre-registration. If you're planning to join us, please send your reservation in now. . . not so much because the seminar is full, but because we have a limited number of rooms at Princeville and they will require your reservation by the end of this month.

NAPILI 6 - South Africa. . . WOW! October 26 - November 12. . . the itinerary is exceptional, the persons with whom we'll travel is ultra-exceptional. There is space available for five more. Call!

In an effort to apply skills already learned and used, it's our intent to precipitate model-building in your thinking by suggesting that you put away $500 (plus or minus) per month for a NAPILI 6 experience. That way, when the trip time arrives, the trip is actually totally or partially (depending on timing) pre-paid.

It's a painless process to pre-pay the NAPILI 6 experience (or other such planned experiences), so open a small savings account so you can mechanically see it happen, and play the somewhat childlike game of laying aside some dollars each month, and enjoy the fruits of your labor.

We'll enjoy being with you when you COME, JOIN US.

Marci Reed

President
Napili Seminars

NAPILI PARTICIPATION

Work. . . or Play?

During the 50's, as a student on an extremely limited budget, I was "privileged" to work in the freezers at Swift and Company, South St. Paul, Minnesota.

Students were of interest to the management team; the night shift was a pleasure when compared to the alternative of not having a paycheck!

The regular 8-hour shift was broken with a half-hour "lunch" break. The company provided a locker for us to store our own heavy clothing and lunch bucket . . . the "good old days."

I read an interesting article recently about industrial employment. The article stated that long hours and adverse conditions experienced by people in the frozen food industry, when they're working full time in the freezers, created a need for them to have a ten-minute break every hour.

The company was required to provide all the clothing, including insulated boots and jackets, down gloves, etc. A hot beverage had to be within 25 feet of their working position at all times so that they were free, even during non-break periods, to stop and have a hot beverage to lessen the rigors and vigors of their traumatic environment.

This gave me a chuckle, having recently been in ski country with 64 inches of new snow in four days. I watched with interest while hundreds of persons enjoyed eight to ten hours of rigor, outdoors, providing their own clothing and not being concerned about being 25 feet away from a hot drink and certainly not taking a ten-minute break every hour so as to survive.

I remember the good old days in North Dakota when we'd shoot a big mallard and if it was too far out for retrieval with a wood-cross and a rope and/or a cocker spaniel, we took off all our clothes, broke the ice, and swam out to get the mallard, then put our long johns back on and went on with the hunt.

Isn't life interesting? And aren't we unique in our behavior?. . . depending on whether it's our work or our play.

It's only when it is as play that we inseparably add the enthusiasm for life to the service we render in our work.

The premises for the 90's include free time any time . . .the discretionary use of time . . . and an admixture of work and play that is yet difficult for some to imagine.

One need not wait for the 90's. "If it isn't fun, it shouldn't be done" reflects the joy of servitude, the "knowledge-pleasure" of the power, freedom and economics of niche market mastery.

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REED'S INTERNATIONAL LETTER

Dear Friends

In a time of change. . . a pivotal period when the our society is shifting from the industrial to the information/service-driven economy. . . it is exciting to realize a parallel revolution in the profession of dentistry.

A NEW WAY TO SEE

This paradigm shift is driven by the reduction in disease, across the board, an increase in dental manpower, and a discovery that the "unmet need market,". . . over half our population. . . when surveyed, has less disease in intensity and frequency than those who are coming to see us. We realize and appreciate the revolution that is simultaneously taking place in materials, techniques and philosophy in dentistry.

In a society where "free time," any time is a reality, and the needs of people have risen. . . the Maslow's pyramidal base has become discretionary. . . a parallel revolution has taken place in the felt needs and wants of our market.

J. Paul Getty, one of the world's wealthiest men, said "One can quite simply become wealthy when one finds what it is others want and then helps them to get it. . . humbling oneself to serve another human being is the only way one will become economically independent."

So, it seems that our uniqueness as individuals, our interdependency, and our attitude of servitude will be the primary marketing tools for this new age.

To paraphrase the late Harold Wirth, "A sequence exists when one considers economic independence. It comes only when one has economic strength remaining after costs from collected moneys. . . due to procedures and services that have been properly accomplished by efficient scheduling of financially arranged and presented dentistry. . . that has been preceded by the marketing of one's services. This sequence is inviolable."

The uniqueness that is potential in dentistry today is enhanced by the remarkable phenomenon of front desklessness, appreciated now across this land by the astute few who realize that it is far more than interior decorating. Were it to be only internal architectural change rather than the intense philosophic change

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in serving people that it is, it would be strikingly similar to re-arranging the deck chairs on the Titanic.

In fact, computer humanizing the leadership in the office in place of the "front desk fiasco" provides a uniqueness, an interdependency and an act of servitude that is unparalleled.

The computer is clearly out of the back office closet and into our daily lives.

The computer provides us with the opportunity to environmentally and personally help people to feel understood, rather than educationally forcing them into a state of understanding.

PEOPLE BUY BECAUSE
THEY FEEL UNDERSTOOD,
NOT BECAUSE
THEY UNDERSTAND.

The premise has been that if we educate people to know what we know, they will decide as we would. . . a philosophy that is badly flawed.

The 90's will be front deskless, paperless, plasterless, and remarkably phoneless. The computer also provides a paperless environment in the dental office of today, and electronically ties the people in the practice to the literature in a marketing way that is cost effective and more efficient than ever before.

Innovation makes breakthrough possible.

The uniqueness to the dental office today is approaching a plasterless environment as well with the Duret micro-milling machine and four other emerging systems in the critical mass of this philosophy and procedure are quickly coming to the market.

A person can, without an impression or temporary, have the finest and most accurate veneer, inlay, crown or bridge placed during the first visit, creating a far more profitable win-win game than ever before. . . for both doctor and person coming for care.

This continued revolution in marketing and presenting our services extends to the philosophy of being "phoneless." The batched call controlling of the incoming calls to emergencies and new patient calls only, (the entire balance of communication being discretionary outgoing calls that are initiated by a crew of people who are collateralized rather than pyramidal in their administrative philosophy) is so overwhelming that a niche market is created where valued inter-relationships flourish. Marketing other than internal marketing of this nature is totally non-essential, and even undesirably negative.

"The older I get, the fussier I am about who likes me" has come to the fore. The people who are values driven and appreciate care, people we enjoy, have become our chosen segment of a targeted market that is highly remunerative in things spiritual and economic. The "out house" marketing of yellow pages and the media does work in a non-selective way to move people, but it is a counter-productive force in personal care practices.

Dentists who are problem-oriented can today, more efficiently than ever, be problem-solvers; however, those teams of people who are values-oriented literally have no problems in that as they drive to enhance and enrich the spectrum of those things they cherish, the answers to the needs

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become accomplished in the spin-off of events without "problems" being a focus.

All of this is illustrative to the "conceive, believe, achieve" philosophy that has been around for so long. . . an inviolable sequence.

Perhaps the key for me was the work of the great, late Robert Barkley who, in an unprecedented fashion, provided us with the concept of CO-DISCOVERY in the hearts, minds, values and mouths of those who come to us for care.

Following co-discovery in a values-driven way, Barkley provided us with the concept of CO-DIAGNOSIS which semantically speaks for itself.

Hot on the heels of this phenomenon: CO-TREATMENT planning which began at the pace of the person coming for care. . . we, as a service team provided him/her with that which s/he valued.

It is astoundingly true that people pay gladly for that which they value, so the myths in dentistry. . . such as cash sensitivity, price sensitivity, piecework sensitivity, and time sensitivity . . . fade into total insignificance for those who conceive as did Barkley.

If one considers the series of caring in thoughtful steps to marketing the veneering or laminating of labial and buccal surfaces for cosmetic and functional reasons, as our new technology so aptly allows, the foregoing philosophy forms the mattress upon which the "win-win" event will occur.

Barkley certainly, prior to his untimely death in the mid-70's, was about to precipitate for us another concept. . . the CO-DEVELOPMENT of the fee. As one dialogues with the person coming for care, it becomes obvious that his/her values . . . not ours. . . . are that which will determine the close of the transaction, the degree of appreciation, and therefore, the degree to which the discretionary economic energy at his/her disposal will be applied.

We have heard people say, "Is that all? I thought the fee would be more!" . . . not realizing that they were telling us that our values were far less than theirs. Since most of our values emmanate from an ignorance, rather than an acute awareness of the fixed and variable cost of providing services and a sensitivity to our guests' appreciation of our services, and our "low middle-income origin" mentality precludes our embracing a fee for serving others as they perceive the value of the service, we consider "fee for service" only a semantic description that differentiates us from HMO, PPO, IPA, etc.

The New Dentist of the 90's, and at the turn of the century, will either be serving the commercial forces that presently exist in the health services, that have taken over the private care health service orientation in our country, or one will be "personal care" providing unique, interdependent and servitude-oriented procedures to people who care.

So, without question, Barkley's work with Pankey in regard to the

We do things differently because we see things differently.

Competition. . . the incentive to do better.

The bottom line is excellence.

In a word . . . quality.

"sliding fee schedule" (some 40 years old now) is unperceived by most in dentistry. . .and the co-development of a fee that is fair . . . grows only in the practices of a few private care oriented dental crews.

Parenthetically, I'll be surprised if there are twelve persons who really understand the Pankey Philosophy in this country.

Without question, the co-development of the fee is alive and well today and being practiced in the offices of "personal care" oriented, values driven dental teams.

An interesting story comes to my thinking. This story has been quoted by Ron Goldstein and myself throughout the country since its occurrence during the Hinman Meeting a couple years ago. I was privileged to visit Ron's office, and during the tour, Ron and I got off in a corner and briefly discussed the fee structuring of our services as we provide them to our people.

Ron asked, "What do you charge for a crown?"

My answer was, "Two hundred to two thousand, depending on a whole host of variables." He seemed somewhat surprised. I asked quickly whether Ron, in the face of a cosmetic or mechanical need, would prefer to have an upper central laminated with porcelain and properly bonded and placed or would he prefer a full crown.

His answer snapped back, "I'd much rather have my tooth covered with a veneer properly accomplished than to have my tooth crowned."

In rapid fire, my then question was "What is your fee for that service?" and he said, "Less than what I charge for a crown."

This became a decisional launching pad for the conceptual "values driven co-development" of the fee.

"Strange," I said, "that you have a fee that is considerably less for a service you value considerably more, and that probably takes more care, skill judgement and time to perform than (the dinosaur of philosophies). . . piecework. Obviously a service that takes longer, requiring more skill and providing a service that is more highly valued should, through co-development of the fee, reward the servant gladly and with gratitude to a higher degree than a full crown which may destroy unnecessarily the incisal guidance, the contact, morphology, food-flow pattern, and phonetics that already exists physically and functionally (if indeed not emotionally and propreacceptively) in the mouth and reality of the person.

Dentists probably are more responsible for creating dismorphophobia, that strange distorting, incurable disease, than any other etiological force.

The best dentistry is "no dentistry," and people gladly remunerate us for being well, and for staying well, and being assured that they are functionally sound. If only we can conceive that the "less" we do, the more happily and gratitudinally we are rewarded for our services.

This concept in itself becomes a brilliant and powerful marketing tool that when made available, dialogically, to the market, we enhance our uniqueness, we express our interdependency or interconnectedness and we will be selected to be the servant that provides the care.

The Goldstein visit is an exciting opportunity to express the functional existence of values driven human behavior.

Actually, every human decision is a values driven phenomenon. If we would only go humbly to the presence of the person coming to us for care, having taken a course in how to listen so they'll speak . . .rather than a course in how to speak so they'll listen. . . we will indeed accelerate our practice and reduce the marketing load that so many of us feel besets us.

I believe .5–1% of annual gross of the team is an appropriate marketing budget.

In treatment consultation, we have abandoned, long–since, the "before and after" slides, the waxed up models and mounted study tools. They are essential in our understanding and designing the craftsmanship but serve only as mute witnesses at the level of non–verbal communicating in our consultation.

Rather, we are using the mental image of need, answer, source, time and cost (promulgated by Pankey 40 years ago) and the human modeling of people from our crew who are restored to optimum health and have maintained themselves in a state of wellness with their own effort.

We will depend on "co–scheduling" during our consultative periods so that someone who has had the procedure and enjoys the wellness we are wanting to share with others will be present during the time block when those coming to us for care are scheduled for "case presentation" and their dialogue with each other is far more powerful than any "tool" we could use.

The circuit riders still using the techniques of the 60's and 70's that were then so popular have refused to recognize that our society has moved on to the power of the mind and that whole brain function and hemispherical consideration precludes our being in a position of strength when we consider education the primary marketing tool.

Having them feel understood and being their servant is far more accelerating in their buying our services than any other marketing method could be.

This marketing approach, and these principles, make dentistry fun again . . .for those who discover them. . . and provide a powerful, glowing, subjective environment of friendship and care that is unavailable in almost any other way.

Omer

Reality is a personal inter–cranial perception.

Napili News

Omer and I are busy getting our heart/pulse rate in sync for the Colorado River Raft experience, 23-31 July. . .

. . .and right after that we'll be packing for the traditional Model-building and Economic Core of Model-building (NAPILI 3 and 4), Sheraton Princeville, Kauai. . . (workshop space still available, hotel is "space available", so if you can go, even at this late date, call Ginny or me at 602-955-5721 and we'll get workbooks, etc. in the mail.)

The South Africa Foreign Travel Workshop to Pretoria and Botswana is fully subscribed (well, if two or three more want to go, we can work it out). . .I'm really excited about the trip. . . and happy to be traveling with such a goood (!) group.

I'm having three-ring notebooks silk-screened for storing copies of the International Letter. . . $14.95 . . . if you'd like to have one, please let us know at once as the printer will require "number needed" soon.

The Wednesday Special, inlay rehab course, scheduled for September 23 is confirmed. I still have six spaces available, call if you're interested.

Kathleen and her crew will present the NAPILI 12 for hygienists, chairsides, and other important crewpersons. . . September 24-26. I'll be sending a mailer, but it fills quickly, so let us know if you'll. . .

COME, JOIN US.

Marci Reed

President
Napili Seminars

LETTERS, WE GET LETTERS. . .

". . .We have been doing extremely well; everything clicks. Never had this much fun before! To give you some examples. The paradigm busting is sensational. I have fallen in love with gold inlays. It's fun!

"Works like Omer said. The ease, the beauty and pride of doing inlays gives me a new high.

"Is it possible to net 50%? YES!

"Someone said something like this. . . 'If it's been done, it's probably possible.'

"Now I have created an unprecedented problem. . . the problem of having too many good clients. This is happening as we are weeding out the unwanted patients. . . unloading dead weight. I wonder where I heard this. Maybe Shakespeare said it!

"We will soon begin our building program. Hoping to have a facility that will give us even more joy.

"It's going to be a front deskless office. How does that sound to you?!"

And this:

"Just a quick note to say 'Add my name to the list of dentists who have returned to the standing position to operate.'

"What a liberating experience!

"After listening to your comments on the Pilgrimage tapes, I immediately converted one treatment room back to stand-up height.

"I had been a confirmed 'sitter' for 18 years (thighs parallel to the floor and all).

"Another bridge gone. Burned that sucker right out!

"Thanks for the insight."

Keep those cards and letters coming!

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REED'S
INTERNATIONAL
LETTER

OCTOBER 1987

Dear Friends

An "open letter", submitted to NAPILI as information, shortly after the Model-Building (Napili 3) and Economic Core of Model-Building (Napili 4) workshops, August 1987 . . .

AN AWARENESS CRUNCH

Dear "Long Term Debt Management Person:"

For twenty years, between 1950 and 1970, the dental business had good stable years. The client tolerated reasonable profit margins by today's standards. But with the ratcheting of inflation and interest rates, a pricing disparity ensued and dentistry began to lose control of its destiny.

The disparity was primarily characterized by no fee increases during a rapidly inflating period of time. The lesson that the industry has learned is that too much of our gross is going to expenses. Dentistry used to be: Cost plus margin equals fee. Now dentistry is primarily philosophically: Fee minus cost equals margin.

While inflation has stabilized for the moment, our analysis indicates that our staying power is lean. Therefore, since 1970, these changes and competition for the discretionary dollar will have a significant impact on dental profit margins. For years our industry has talked about improving productivity and reducing costs but has not been totally successful.

It is tough to take direct action and to be a leader in leveling overhead costs. In order to improve our holding power, our practices will have to increase their critical mass; i.e., surplus in dollars, in people coming for care, and in owned assets. (And in cash collection, reduced debt and reduced overhead.)

Furthermore, the "hurdle level" or the adequate level of critical mass will continue to increase in our current environment.

One of the options, of course, is to do nothing, like many offices which have taken that choice. Due to the long-term nature of our business, unlike the airline industry where dislocations occur quickly, you probably won't see the same phenomenon in dentistry until after the turn of the century.

"Doing nothing" is obviously not a very good option because we would quickly lose the vitality of our organization.

It seems very apparent to me that that which we have worked so hard to build. . . that is, our pro-active team of people serving appreciative folks coming for care. . . must be enhanced and all options for strengthening these policies must be taken.

When everything looks bad, turn about and look some more. You may have been facing the wrong direction.

We have opted to take a position. Our strategy, I believe, has something to do with the fact that we have just completed 15 years of service to the community in the same place with practically the same team of people. That brings a mature broad base strength from which we can carve the future.

1. We target and focus on those things that we do very well.

2. We responsibly price our services to the market and have a business plan budgeted to make certain we can work through these troubled years and at the same time gain long-term financial strength for our organization.

3. We have significantly cut our expenses and are continuing to focus and monitor cost reduction.

4. We have weathered a severe economic crisis in the last 12 months and are current with all payables. Our position is sound.

5. We have disciplined the organization to make certain that our recall/update of records, patients and hygiene is optimal.

6. We have made certain that our services in prevention are at the cutting edge.

7. We have focused on a specific segment of the market: those people who are values driven and those who choose to keep their teeth for a lifetime, and specifically we recognize the "graying" of America.

The daily struggles we have in implementing our strategic plan in a difficult market (where I don't see any abatement for years) suggests to me that it would be important for the long-term viability of our organization that we make sure that our current project to revamp, re-define, re-budget continues to evolve into a permanent position of strength.

It is essential, of course, that we not only hold onto our current crunch program, but that we continue the momentum in our plan for increased productivity, reduced cost, and a growing net.

We have a dedicated team with cohesiveness and longevity that is unusual.

We have developed the industry's most effective, face-to-face distribution system in the individual private care marketplace.

OMER K. REED, DDS

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I believe it will be possible to offer an extremely competitive service as compared to the offices operating under the traditional systems in dentistry and at the same time generate excellent margins of profit for the long-term.

We are budgeted for September 1, 87 through September 1, 88. We post the daily results of performance against objectives for each income center.

We are meeting twice monthly, face-to-face, to review, renew and to communicate with each other. We functionally have team meetings in addition to that for problem-solving.

I believe we have a unique opportunity to survive and thrive in the 90's.

We realize that the organizational renewal will include the adding of an associate dentist with either an equity association, interneship, or a pre-sale of the practice interrelationship-partnership carefully and contracturally arranged to broaden our base of productivity and reduce our cost percentages.

"Associa-nomics" is the name of the game in this cost distribution.

Our energies in the next 24 months include a philosophy of work for debt elimination and for current employee retention. Money already invested in the practice for equipment, furnishings, leasehold improvements, instruments and supplies represents a substantial investment. This investment is usually utilized only about 30-35 hours per week, greatly under-utilizing capital investment.

If we bring another practicing dentist into the office, we can broadly expand our hours and the office can continue to function while the established team is not in the office.

The biggest factor between our present net income and increasing it is the fixed overhead. Sixty to seventy percent of all expenses incurred for the operation of our practice falls in the category of fixed expenses.

No matter what the level of production is, these expenses must be paid.

The unrelenting fixed expenses can cause a tremendous negative cash flow when one is vacationing or out of the office.

Adding other income centers will provide a way to distribute these fixed expenses over greater practice income.

Adding an associate will require an extra salary for one assistant, but other expenses will not increase. The fixed costs will remain the same.

At present, the practice is experiencing "solo economic dependency." Adding an associate will not usually result in the patient volume being divided between the two doctors.

In fact, experience shows the opposite to be true. Practices

Creative vision. It's the ability to see not only what is, but what could be.

Performance is maximized when a clear and significant sense of mission is known.

When you have a small company, a lot of fear, and great opportunity, you can do amazing things.

including an associate usually experience a growth not previously possible.
Associates usually will involve themselves in community affairs and generate a following of their own.

Our contract will carefully encourage this.

While adding an associate may in a brief period decrease, somewhat, the net income of the practice, the increased production as a result of a new associate's efforts will soon offset this.

We send some people out of the practice for other care. We feel this can be effectively reduced and the drain on potential income will not continue if the assistant chosen has the needed sub-specialties.

We've, in part, become a victim of our own success. In some instances there are more people than we can adequately care for in a given period so they're booked ahead an unusually long time.

In these cases, the inclusion of an associate in the practice will reduce the appointment time and therefore enhance the practice.

An associate will insure the stability and continuity of patient care, furnish regular emergency care in my absence and provide on-the-spot consultation for professional opinions and informal peer review.

This will also allow me to relieve myself of many emergencies and focus on a narrow scope of procedures, and a segment of the target market that is more desirable.

I'm including the income projections for adding an associate and the general expected result, which is based upon previous history with existing associates in the practice.

We are restructuring the scheduling time of the entire hygiene department; we are increasing the hours worked annually by my team.

We are structurally increasing our fees and reducing our costs, carefully modifying all the variables that are essential in a business equation.

On the basis of this projection, we intend to negotiate our future.

Our budget is a definition of our objective for 1988. The corporate goals are clear.

We are working a metric or decimal year in our calendar which will make a unique reporting and monitoring system available and provide for us a new way to see. . . a comparative parallel to our regular calendar months.

We will constantly review the current history of the industry and compare it to our own history.

We will continue to honor the hygiene-driven market that furnishes our practice with

strength and new people for care.

We will be re-structuring our working agreements.

Since you have been a friend to our practice in your capacity with the bank, I am seeking your counsel in restructuring our current position with long-term debt management strategies.

I realize bankers aspire to help, and I am prepared to discipline myself to achieve the results I have designed. To resolve my current position and to create debt liquidity by 1992 . . . to have what I define as economic independence. . . I plan to:

1. Increase my productivity. I will increase the thoroughness and latitude of my diagnostic programs, increase my skills in treatment consultation, do internal marketing to increase the volume of new client activity, accelerate the recall program and patient record update so as to accomplish the dentistry that has not been treatment plan and/or accepted.

(A recent report by the National Institutes of Health states that it is substandard care if dentists do not inform patients of any situation in his/her mouth that is less than ideal.)

Fees will be increased by 20% as of September 1, creating an increase in revenue of $80,000 over last year.

2. Change my debt service. I need to change to whom I owe money, and how I repay it.

I am not going to go more deeply into debt, but will reorganize and consolidate. I need long term debt management.

3. Change my behavior. The staff and I have agreed to "crunch" by adhering to the enclosed budget and "crunching" on all items except rent, salaries, lab expenses, and equipment, saving $3-5,000 per month.

My spouse and I have agreed to be more disciplined in our personal lives. We will sell one car and purchase a less expensive one, do the yardwork ourselves, reduce our entertainment expenses, and sell our condominium. We will even sell our home if necessary.

Having greater liquidity has top priority for us at this point.

(I will even give up golf and the country club membership. . . with willing reluctance.)

4. Change in practice management. I will work five days a week instead of only three.

"Crunch month" is amazingly simple.

Set financial objectives. . . and stick to them.

We will fill the schedule with existing recall and our new client load.

We project an additional $2000/month by adding Friday morning to the hygiene schedule. By seeing patients on Wednesday afternoon, we will create another $8000/month. (A total of $10,000/month, with minimal increase in expenses since the fixed costs are already in place.)

Take control of the practice.

The budget is stringent and strict; we will not exceed the allotment in any area.

I have spoken with "Dr. X" about a possible merger; he's very interested. It is my objective to have a merger accomplished within the next four months with him, or with someone else.

(I've already spoken with another senior doctor who is also interested in this win/win situation.)

Increase treatment acceptance.

My proposal includes providing the senior dentist with an equipped operatory and an assistant and 40% of his produced dentistry. (More by far than he is presently netting.)

If his production is $10–15,000 per month, it would increase the revenues by $6,000, while not significantly increasing the overhead.

In summary, I have a need for assistance in resolving my current financial position, creating liquidity.

I propose a restructuring of debt on a 20–year note with a three– to five–year balloon. This will be accomplished by:

1) Increasing production and fees ($15,000/month).
2) A change in our office behavior ($4,000/month).
3) A change in our personal behavior ($2,000/month).
4) Adding Wednesday afternoon and Friday morning ($10,000/month).
5) Adding older associate ($6,000/month).
6) Potential new business ($15,000/month).
7) See addenda for new young associate ($54,000).

We realize our resources are limited and there will be a competition for these resources as continue our plan.

Manpower is currently frozen. All projects are frozen unless out of present resources.

We are going to liquidate a sizable piece of our outstanding receivables and shorten the receivable time. We are going to accelerate our new patient load by 10%, going to increase our fees by 20%, we are going to increase our scheduled work time by 30%.

It is our intent to eliminate short term and long term

liabilities that will be specifically named.

It is clear to us who is in charge of our destiny in running this program and we have proper measurements in place to determine the success or failure of our venture.

We choose a preferred prosperous future rather than a probable future.

Chance has not worked well, so we now want to try choice.

I'm extremely determined to get my financial plan together. I need your assistance.

I went to Hawaii for the two Napili workshops believing it was my office staff's fault we were in this condition. . . I have returned realizing "I have met the enemy. . . and it is me."

Sincerely,

Dr. Ernest Lee Aware

Additional Income Projected As A Result of Adding An Associate

Production. . . . .$	150,000
Associate's Pay	50,000
" Assistant. . . .	20,000
Lab Fees/Supplies	26,000
Contribution Margin . . $	54,000

BUDGET

Salaries/Taxes . . . . . $	12,300
Dental Supplies.	750
Hygiene Supplies	1,300
Lab Fees	3,500
Maintenance.	100
Dues	400
Insurance.	1,130
Legal/Accounting	200
Office supplies.	300
Telephone and Answering Service.	450
Miscellaneous.	500
Rent	6,600
Bank P & I	4,500
Equipment Leases	1,800
Computer	2,500
TOTAL $	36,300

Ask, and it shall be given. Seek, and you will find. . .

Napili News

There are only 85 more shopping days until Christmas! The Napili calendar is full, which means those 85 days will pass by rapidly.

REMINDER: The Napili 8, Accelerated Practice, workshop, 14-17 October. The format has been changed, we'll be presenting for the entire group, all on one day, the selected clinicians (Dr. Ed McElroy, Drs. Scott and Julie Ford, and Dr. George Winn) and David Weiss, a well-known, respected tax attorney will be with us on Saturday afternoon. It is possible that one or two surprise speakers may appear as well!

October 23-24: Omer will be speaking with the Upper Pinellas County Dental Association in Clearwater, Florida. Call Dr. Patrick LePeak (813) 584-5548 for reservations.

October 26-November 13: South African Dental Congress/Napili 6 International Travel Workshop.

December 2-5, People Without Perio (Napili 11) workshop, presented at Embassy Suites, Camelback.

The 1988 Calendar is being printed and will be mailed very soon. We'll be celebrating 25 years of Napili Seminars; we've scheduled a unique seminar in Phoenix and Hawaii. . . 5-13 August, it'll be special, we're anticipating a true Hawaiian Napili (the word means "togetherness") experience.

So. . . COME, JOIN US!

Marci Reed

President
Napili Seminars

NAPILI PARTICIPATION

WE'RE AWARE AND MONITORING

". . . our experience at Princeville (N-3/4) left us feeling lifted up out of our rut, seeing new possibilities for our practice and our lives.

"As we mentioned. . . we realize that behavior changes only when it is monitored.

". . . since August, we sent a letter to all patients scheduled for recall in September, informing them that we would no longer accept assignment of benefits for prophys, and that we expected payment over-the-counter. . . and we monitored the response. It worked so well, with so little resistance that we sent the memo to all our active patient families. (. . . may seem like a small step, but it was important psychologically for us in our ability to tackle our own mental paradigm busting.)

"We also severed our ties with Delta Dental. We monitored the response here. So far we've only lost two families, but they're definitely in the 'bottom third' of the practice. We're sure the full effect of this decision hasn't been felt as yet. We'll keep monitoring.

"With just these two changes, we feel better about the practice. But it's only a start. We've generated a list of all the desirable patients who may wish to become assistants in the office. . . and a list of all the active families in the practice to begin identifying the top one hundred and the bottom third. We've had four office meetings to introduce the team to the concepts and they have the difference between subjective and objective clearly in mind. They've all memorized the goal-objective-plan-action-monitor-modify cycle and have individual assignments on creating their own.

". . . we realize that we may be getting ahead of ourselves. With all the time we spent model-building. . . we really focused on personal goals. While we did look at the eocnomic core of our practice, we did not really focus on general goal-setting for the office. We are planning to spend a day next week accomplishing this. . . and will send you an update report of our unachieved future goals, objectives, and deadlines.

"It is great. . . to be challenged to grow. Thanks."

Drs. Carol and Steve Snow

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NEW DIRECTIONS IN DENTISTRY

REED'S
INTERNATIONAL
LETTER

Dear Friends

I first heard Dr. L. D. Pankey, with Dr. Harold Wirth, in Amarillo, Texas, 1959. These missionaries came to speak to the Dental Association for two days. A benevolent colonel, USAF-type, "released" some of us (TDY) to enjoy. . .

FIFTY-FIVE POINTS -- LESSONS FROM HISTORY

These notes are verbatim, off the yellow pad, from a lecture I attended in 1962. How appropriate, 25 years later, and for the turn of the century.

1) Documented case presentation, use texts of similar cases from current books, etc. Better than slides and models.

2) Get patient conditioned prior to case presentation (gingival, TMJ, etc.), get to know patient, then start rehabilitation. "Starts" eventually even out to point where you are busy with rehabilitation.

3) Re-sell your case after completion, even if pre-paid. Make your patient into a missionary. Empathy, keeps your rehabilitation practice from "drying up". You provide your patient with "peace of mind" answers that come to them during conversations with other (potential rehabs) in quantity sufficient to provide enthusiasm and interest (desire) on the part of someone outside your practice.

4) Each rehabilitation should send in one, after completion, if you're doing post-case presentation properly. Your criterion of success is just this: If each one does not, you know you are failing to do the post "re-sell" adequately.

5) Keep them on call list. Every four months, see them socially, comment then: " nothing needs to be done." They develop a firm confidence for rehabilitation. "Will it last?" Question is automatically answered and the image of your work begins to be one of permanence.

6) Re-present your rehabilitation again at five years. They are the real salesmen!

7) You build for yourself and for other men in the community. Even send an "overflow" case out to key men in your community once in a while. . . good relationships.

DECEMBER 1987

"We make money the old-fashioned way. . .
we earn it."

8) "Class II" patients in some practices are better than "Class I" patients in other practices.

9) Use before and after photographs to re-sell case.

Give patient a copy. S/he will keep and use them.

10) Re: Pankey Manual: "Man becomes what he thinks about. We gravitate toward those people, things and events we love."

11) Money is not made, it's earned.

The government makes dollars at the mint, the dentist must earn dollars.

If people feel we've earned what we ask, then we are in good shape.

12) What does patient want?

Your time? Your care? Skill? Judgement?

13) Patient can be driven out of one office at $2,000 fee and have his/her mouth reconstructed in another office and not ask what the fee will be until it's completed. . . and gladly invest $4,500 without tension.

The difference being the feeling of money tension the patient "feels" from the dentist and the staff.

Conceive . . .
Believe . .
Achieve!

14) Pankey insists that patient has "no way" of knowing what the dentist is going to do for him.

Therefore, post- presentation of fee is strong position because patient will then know what's been done for him and that the doctor has earned the fee.

Obvious corollary is that the degree of understanding the patient can achieve, and that the doctor can transmit prior to the procedure, is the degree to which the case presentation prior to case (including dollars) will be successful.

Summary: It is possible to do rehabilitative dentistry with short-term doctor/patient relationships and pre-case presents if empathy and rapport are at a high level. . .the need, answer, source, time and cost being carefully understood and agreed upon.

15) Post-case presentation is not done on the day of cementation (after decementation, equilibration and post-op prophy appointments).

16) "What the mind can conceive and believe, it can achieve." (Doctor must be willing to pay the price, too.) Often useful information to give to patients, so quote the above quote to patients. (Doctor must understand.)

17) Sympathy with patient leads to poor dentistry.

Empathy leads to rehabilitative dentistry.

Do your best. Not what you think the pocketbook can afford.

18) Patient can do what s/he wants.

"Whatever you want, oh discontented man, step up. . . pay the price, take it."

OMER K. REED, DDS

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If you fail in presenting, it's because the patient has no desire, or no price.

You cannot find out about price without first exhausting research on desire, because ability to obtain price is in direct proportion to desire.

Desire FOLLOWS understanding of need.

19) Pankey refers to reconstructive rehabilitative, restorative, rejuvenative dentistry as more responsible dentistry.

Not just putting in a tooth and an inlay or crown, but restoring that person's mouth. . . correct occlusion, cosmetics and increased longevity of dental structures.

20) The dentist has the least problem presenting and the least problem getting acceptance for the case he knows best how to do. (Believes and is enthusiastic.)

21) Good post-graduate study is essential, not just running all over the country, but budgeting the time, being selective, and getting good at what you do.

A case of "know thyself". . . including getting to know the best men in the community and nearby areas, convenience is part of it, but excellence prevails.

22) Occlusion is a contributing factor to dental disease, not a primary factor.

23) Evaluate case in depth. The best dentist must examine thoroughly, diagnose and treatment plan thoroughly, practice load need not be massive.

You can't accomplish many cases if you do what patients need.

Be thorough.

Patients buy what they want, not always what they need. You must make them want what they need.

24) "Dentistry does not push hard enough to create desire in patients for their needs.

If we don't believe it in the first place, we're licked before we start." (Pankey)

25) Dental schools teach you how to work for and care for indigent patients.

26) Class I, Class II, etc. is intellectual, sociological, and economical classification that patient establishes for himself, NOT your classification of patient.

27) Key close. . . "I have a responsibility to you to either do what needs to be done for you, or to get you into the hands of someone who can."

(Pankey's "fish, cut bait, or get out of my boat.")

28) Key strengths for a dentist: Be an examiner, diagnostician, treatment planner and have a firm well-defined philosophy of dentistry.

29) Holding Program: buys time to solve problems in patient's arena, re-present then available.

30) "Don't put inlays into the 'hills and valleys.'"

The "people game" . . . dentistry.

A decision is the acceptance or rejection of a course of action.

The Cross of Life must be in balance.

31) There is magic in giving nothing less than your best.

32) Work, play, love and worship (the Cross of Life, Dr. Kepler, Mayo Clinic, 1932.)

33) Over 50% of the Mayo patients do not have organically-oriented problems.

The Cross of Life is out of balance. Psychosomatic.

34) Paul Dudley White: Many diseases cannot be prevented, treated or controlled, because people will not DO what they already KNOW.

35) Big frontier is in the behavioral sciences. (That which Pankey has been studying since 1930.)

36) We already have enough knowledge in dentistry to save people's teeth.

Seven-story buildings are being built (with government funds) for research, and we still turn out dentists without any skill in the behavioral sciences, let alone knowledge that those sciences exist.

Perfecting personal performance.

37) Let's DO what we already KNOW. . . communicate, get plaque off, no sense "researching" when people don't know how to keep their teeth clean yet.

38) It's not work that kills us, it's the frustrations.

Getting our labs to do for us what they should, and our personnel, our overhead, family responsibilities and taxes . . . those are the responsibilities that bear down on us.

39) You can always tell a man from Harvard, but you can't tell him very much. (Pankeyism)

40) If you really want to get along with a woman, look at her as if you are going to kiss her, but don't. (Pankeyism)

41) You can't get patient's Cross into balance always. . . or even sometimes.

You CAN keep YOURS in balance, which will allow you to accept the patient as s/he is.

The patient will feel this refreshingly rare quality of understanding that you have. . . creating within him the willingness and ability to change. S/he feels understood.

42) Eye contact is a firm tool in establishing a communicative rapport.

43) On the initial exam. . . listen.

LISTEN.

Ask questions. Are you happy? If not, why not?

44) Pankey's 22 questions are a key to the other person's Cross. See PEOPLE, not PATIENTS.

45) Building a practice is one thing, controlling it after it's built is another.

46) KNOW what you want to do.

DO what you want to do.

47) Quit doing denture work. (Meigs Jones "greatest day in my life.")

48) Pankey says, "The key to success is to have a good practice, good fees and keep your expenses down."

49) There isn't too much wrong with having an inexpensive home and a happy family.

50) "Everyone working here has a personality problem. . . including me."

If you see me doing things that need correction, I want you to tell me.

(Yes, doctor, and I'd want you to do the same for me.)

Okay. . . now DO IT. . .

51) This helps you keep respect and loyalty from your staff/team/crew.

It cannot he demanded. It must be earned.

52) Be certain assistants are "paired" carefully to operator. . . .fast operator, slow assistant or vice versa. . . re-train or replace.

53) Pankey said the SAME words in 1959. Now more appropriate than ever (1962), a near timeless philosophy.

54) One key question: "Why did you leave your other dentist?"

Then SHUT UP and listen.

55) Pankey says directly to the person, in discussing economics, "With one group of people, money should make no difference; another group is sort of in the middle; a third group must make a real sacrifice to accomplish their dental rehabilitation. It's a real economic hardship.

"You're in this latter group and we're going to help you arrange to do your case."

. . . .

Something to think about.

We get respect
the old-fashioned
way. . .
we EARN it.

Napili News

What a fantastic experience was our South African Dental Congress tour! The only negative I can think of is the upside down feeling that overtakes me at 2:30 each day. (A.M. when I'm wide awake, and P.M. when my body tells me it's bedtime!)

There are some errors in the Silver Anniversary Napili calendar (I admit that "I dood it.")

Note: NAPILI 11: May 4-7, 1988.

NAPILI 8: November 9-12, 1988.

REMINDER: The Advanced People Without Perio three-week workshop will be presented ONE TIME ONLY.

Part 1: January 11-15, Phoenix
Part 2: February 15-19, Phoenix
(Designed for doctor and/or hygienist, unlimited attendance.) Clinicians will be:

Dr. Perry Ratcliff,
Dr. Norman Grim,
Dr. Paul Holmgren,
Dr. Omer Reed.

Part 3: March 14-18, Flagstaff
(Designed for doctor and/or hygienist, LIMITED to 24, must have attended the first two parts.) Clinical sessions, ratio of four students to one instructor.

More detailed information is available, call or write and we'll send it to you.

We look forward to having you. . .

COME, JOIN US!

Marci Reed

President
Napili Seminars

NAPILI PARTICIPATION

YOU'VE HEARD THIS ONE. . .

If I had my life to live over, I'd try to make more mistakes next time. I would relax, I would limber up, I would be sillier than I have been this trip. I know of very few things that I would take seriously. I would be crazier. I would be less hygienic. I would take more chances. I would take more trips. I would climb more mountains, swim more rivers, and watch more sunsets. I would burn more gasoline. I would eat more ice cream and fewer beans. I would have more actual troubles and fewer imaginary ones. . . . Oh, I have had my moments and, if I had it to do over again, I'd have more of them. In fact, I'd try to have nothing else. Just moments one after another, instead of living so many years ahead of each day. I have been one of those people who never goes anywhere without a thermometer, a hot water bottle, a raincoat, a parachute. If I had it to do over, I would start barefooted earlier in spring and stay that way later in fall. I would play hooky more. I wouldn't get such good grades except by accident. I would ride on more merry-go-rounds. I would pick more daisies.

YOU HAVEN'T HEARD THIS ONE. . .

I am the spring, I bloom many blossoms each day, I chug on like a grizzly bear, not leaving the stream til I've a fish in hand. I am burning red like the sun, not letting anything separate my dreams and me. For my dreams form a land on a planet full of love which I call home.

I am a basketball, a great player, the basket is my goal. And though I am small, I have the strength within me to jump higher than anyone, to reach the basket, to which I am very close, but very far from.

I move onwards, plowing anything that might stand in my way, like a tractor, but still gentle and kind, like a rose, is the inner me. I am sweet like an orange, and my thoughts multiply like the seeds of one. I am tough to give in like roast beef to a blunt knife. I am a solitary number one, who likes to be alone, but I will give in to a kind friend, of which I have plenty.

I improve each day, with a big step towards my goal. I brag a lot, you say? But it is good in this one way. . . be proud of what you are, and you will become better.

By Heidi Chestnut, Age 10 (Progeny of Sally and Arnie, Kingston, Ontario)

"Napili Participation Column is a communications vehicle dedicated to networking among Napili seminar attendees and REED'S INTERNATIONAL LETTER subscribers. Submit your dialogue for consideration to: Napili Participation Column, Napili International, 4515 North 32nd Street, Phoenix, AZ 85018."

Does everyone know but you?

Help for Halitosis

YOU CAN HAVE A BLUE-RIBBON BODY and a five-star mind, but if you've got bad breath, you've got problems.

What causes this timeless turnoff, and what can be done about it?

Here's what the experts say:

• **Infected gums.** About 95 percent of us will get some degree of halitosis from "blowing air over something that doesn't smell good," that something being inflamed gums, says Michael Lerner, D.M.D. To whip ailing gums back into shape, brush thoroughly and often (with a soft- rather than hard-bristle brush) and get into the habit of regular flossing. You may need to see your dentist if that doesn't work.

• **Dirty teeth.** Whether or not there are (as one 17th-century scientist maintained) "more animals living in the scum on a man's teeth than there are men in a whole kingdom," teeth can collect their share of odor-producing debris. Best for keeping oral bacteria to a minimum is frequent brushing (with or without toothpaste) or even just swishing the mouth with water.

• **A foul tongue.** An experiment done several years ago by Canadian professor of dentistry Joseph Tonzevitch, Ph.D., found that keeping a clean tongue may be even more effective at arresting offensive breath than keeping clean teeth. Measuring "morning mouth" in eight volunteers, Dr. Tonzevitch discovered a 25 percent reduction in this common problem when they brushed just their teeth, a *75 percent* reduction when they brushed just their tongues and an 85 percent improvement when they brushed both. Tonzevitch concluded that "tongue brushing is the single most effective method of decreasing breath odor." (The Romans did it, and Muhammad is alleged to have encouraged his followers to practice the custom also.)

• **An empty stomach.** Yes, skipping meals can create foul oral breezes because it reduces the production of saliva needed to flush away odiferous bacteria from teeth, tongue and gums. Stress also can lead to a dry mouth, which can cause double trouble when coupled with the increases in *stomach acid* that stress can whip up. (With that in mind, you might want to grab a piece of cheese and a nonalcoholic beverage at your next stressful cocktail gig.) Chewing gum and lozenges can also step up saliva flow, as

Help for Halitosis

(cont. from pg. 1)
can such healthy between-meal snacks as fresh fruits and vegetables.

- **A pungent diet.** Sorry, but raw onions, garlic and spicy smoked meats can x-rate the mouth for as long as 72 hours, studies show. That's because these foods boast odoriferous compounds that actually enter the bloodstream when digested, producing odor as they eventually leave through the skin and lungs. One study reported in a 1936 issue of the *Ohio State Medical Journal* found that a 12-year-old boy exuded garlic breath as a result of the herb being *rubbed into the soles of his feet.*
- **Colds and other upper-respiratory infections.** A stuffy nose, chronic sinusitis, postnasal drip, tonsillitis and allergies can sour the breath, especially if obstructed nasal passages lead to breathing through, and thus drying, the mouth. Antibiotics from your doctor may be the best remedy here.
- **Digestive woes.** Poor digestion can taint the breath, but only in rare cases. The source may be an ulcer of the digestive system. (A quick test for this type of halitosis is to have someone check to see if your breath is bad even when you exhale through your nose.)
- **Menstruation, ovulation and pregnancy.** Hormonal changes associated with these events can affect the breath, possibly by stimulating the growth of microorganisms that inflame the gums, thus entrapping bacteria between the gums and teeth. Special attention to brushing and flossing during these times can help.
- **Medications.** The ulcer drug cimetidine (Tagamet) is one known breath saboteur, but antihistamines, decongestants and diuretics can also cause bad breath.
- **Smoking.** Because it sours the mouth and also disrupts digestion, smoking has been linked to halitosis for centuries.
- **Overuse of mouthwashes.** Mouthwashes may mask bad breath temporarily, but in the long run they can actually worsen the problem by irritating oral tissue and leading to the very sort of inflammation you *don't* want. If a quick perfume job is what you're after, chew gum, suck on a lozenge or try a quick rinse with a mix of water and a few drops of peppermint oil. ◆

Highlights in the History of Halitosis

1550 B.C. The Egyptians recommend in the Ebers papyrus that aromatic substances such as myrrh and frankincense be used to tame objectionable breath.

70 A.D. Pliny the Elder correctly theorizes that bad teeth, certain foods and advancing age can whip up foul oral winds.

1000 A.D. The King of Wales puts halitosis right up there with impotence as valid reason for a woman to leave her husband while maintaining right to his property.

1500 A.D. King Henry VII of England sends envoys to assess the suitability of the widowed Queen of Naples as a marriage partner, instructing that they "approach as near to her mouth as they honestly may to the intent of feeling its condition."

1604 A.D. King James takes a blast at smoker's breath, calling it "a great contempt, that the sweetness of man's breath, being a good gift of God, should be willfully corrupted by this stinking smoke."

1987 Americans spend an estimated half billion dollars annually in hopes of arresting bad breath.

How Can You Tell If You Have Bad Breath?

"One of the most distressing facts about bad breath is the inability of the person who has it to detect its presence," says *New York Times* health columnist Jane E. Brody.

If you've really got to know, however, there are ways, Brody says. Either have the courage to ask a friend or family member, or simply lick the back of your hand, wait a minute or two, and smell the results.

"PEOPLE WITHOUT PERIO"

According to recent statistics, 90% of the adult population has some form of periodontal (gum) disease. Some of the most easily recognized signs of gum disease are those that are often overlooked or even accepted as normal. These symptoms include: bleeding, swelling, redness, and tenderness in the gums, a bad taste in the mouth, and last, but not least, mouth odor. Some extremely heavy social factors come into play as one may lose intimacy with a loved one due to mouth odors. As the commercials tell us, and how true it is, that "even our best friends are loath to tell us" if we have bad breath. Consequently, the American people spend $430 billion a year for mouthwash, $1 million a year on breath mints, and $1.3 billion a year on toothpaste - all of which only temporarily disguise the tell-tale odor that signifies gum disease. (And there is nothing worse than bad breath with a touch of mint!)

Our "People without Perio" program is wellness oriented and provides the factors of time and relationship that help eliminate the constant rebounding of the disease many persons experience every time stress or other factors cause their immune system to take a dive. Tailored to meet the specific needs of each individual, the program is also flexible and personal. We have incorporated the freedom to treat an individual as frequently as necessary based on his/her own healing capacities and concerns, and the flexibility to apply as many of the current therapies as are necessary for resolution.

In the beginning, co-discovery allows for explanation of the range of disease and identification of the individual's place in that range. Also critical at this time is reassessment of priorities and values, and a determination to commit to a program. If patients are seen for frequent (3 month) cleanings following the program, the studies show that the results rival those of the complicated and expensive gum surgery. State-of-the-art DNA probe cultures utilize advanced biotechnology and detection of the specific DNA of the species to allow accurate discovery and measurement of the disease activity level of three of the major pathogens in dental plaque samples. By retesting specific sites, we are also aided in monitoring the treatment results. If the results of the test are negative, there is a 99.9% chance that the person is not in the active state of periodontal disease. The newly released chlorhexidine (Peridex) and special fluorides are being delivered to areas under the gums where the worst of the infection lies to help suppress bacterial levels and accelerate healing. Antibiotics, if necessary, are also incorporated into the treatment to provide a way to help eliminate the disease-causing bacteria.

Central to the success of the program, and so critical in deterring rebound of the disease, is personal plaque control. Carol, our talented preventive therapist, and Kathy, our hygienist in the Canton office, are effective in helping patients productively utilize their time spent in the war against plaque.

Along the road of improving their oral hygiene, many patients have shared their feelings of increased self-esteem, and gone is the fear of intimacy that can be fostered by mouth odors! Over and over we hear how patients feel about their mouths and teeth, and how all this ties in with how they feel about themselves.

We invite any of our readers who desire more information for themselves (or others) concerning the program, and/or individual reactions of our successful patients, to contact us.

-Barb Smith

This article appeared in the WORD OF MOUTH newsletter published by the BARSAN FAMILY DENTAL PRACTICE, Akron and Canton, Ohio.

It is clear and concise . . . great verbage for readability and understanding by the person coming for care. (In fact, the entire Barsan newsletter is exceptional!) Congratulations on this informative patient education article, hygienist Barb Smith!