NEW DIRECTIONS IN DENTISTRY

REED'S INTERNATIONAL LETTER

April 1990

Dear Friends

The following "vital signs" are like those developed for the human body. When using such measures it must be remembered that the framework, constitution, and other system-related information about the organism (business) be considered before a crisis is declared. For instance, if a slightly overweight, office-working person who got little exercise registered a blood pressure of 125/83, very little effort would be made to alter that person's lifestyle on that measure alone. Considerably more concern for lifestyle would be shown if the same person were showing a blood pressure of 180/100. As it is for the body, it can be for the business. With these types of guidelines, it is not so much that you "hit" or maintain the mark so much as it is "how far out of whack" you get.

Thence cometh the title

VITAL SIGNS REVISITED

This is also a game of what is "right" for you, and not "what does everyone else do?" These guidelines lose validity in newer practices, or those that gross below $250,000. They are still respectable targets, but not hitting them does not mean "let's find the nearest window to jump out of." Likewise, in those practices between $500,000 and $1,000,000 and up, a myriad of factors. . . from location to the number of dental and hygiene producers. . . can distort these guidelines a great deal.

Probably the single most important measure comes in the form of the question, "How much is enough?" . . . for the time, energy, investment. . . for the finest dental results in the local area. . . for the other opportunities you give up to be the driving force in the practice. . . and for the lifestyle and leisure time that the resulting economics allow you. How much must you grow and change in order to attain your long-range goals? Trying to force the practice into any set of guidelines without knowing what it will look like when you "get there" is like beating your head against the wall. It feels sooo good when you stop!

Once you have the goals identified, the objectives set, and the plan to achieve them in force, these guidelines can serve two purposes. One is to assess whether you are on track and on time. The other is to answer questions such as "Is where I'm going

still where I want to be, knowing what I now know about what it takes to get there?" and "Did I get there and not recognize the station as it went past?".

With all of this considered, we find that for practices with no more than two dentists and no more than two hygienists per doctor, a total overhead percentage between 50% and 60% is desirable and reasonable. It reflects the appropriate rewards for the activities of business owner/producer/manager and allows ample reward for the team necessary to support a level of production between $250,000 and $750,000 without being too "pricey" for most dentists to justify for themselves.

. . . headaches and heartaches of the larger business. . .

For practices that require large numbers of "staff", or multiple dentists, or large "18-wheeler" facilities to support productions between $750,000 and $2,000,000 plus, we see less than a 70% overhead as a must. Any owner(s) of such practices that don't require a minimum of 30% take-home from the headaches and heartaches of running the larger business would probably benefit more from selling the practice and facility and investing the proceeds.

For the purpose of this printing, a practice with only one dentist and two hygienists is used. That practice is grossing $500,000 per year, 30% of which is produced by the hygienists. There are no more than two dental/hygiene/recall assistants. One person is involved in the role of administrative/recall and scheduling. A part-time person is acceptable, but not required, to handle the bookkeeping and receivables work.

The facility is 1500 square feet of space with one dental room, one emergency/overflow room and two hygiene rooms. It has a telephone/administrative area, a presentation room and a small reception area with a juice and coffee bar.

1. Collection Percentage: 96% or more of the services rendered are paid for by the time final restorations are placed. It is undesirable (even with third party, insurance involvement) for this to vary more than 5% either way for more than three months running. Internal monitoring of this percentage should occur on a daily, weekly and monthly basis. (Monthly, periodic, and annual monitoring in Pentegra's Continuum is available.)

2. Receivables Ratio: Total receivables rising above 12–15% of the annual production for any length of time can result in a growing collections problem.

3. Current Receivables Ratio: Receivables that are 90 days or older should not rise above 5% of the total receivables. Doing so indicates the need for better financial arrangements. Any accounts owing for greater than 30 days should be subject to an 18% per annum interest rate. There should be no amounts older than 120 days without special payment arrangements or

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collection action (contract plus interest payment arrangements, third party loan assistance, dental or medical or commercial credit card acceptance or post–dated checks can aid in bringing receivables in line, but should be the exception, not the rule). Any accounts outstanding for over one year should be turned over to collections or gifted with the dismissal of the person from the practice.

4. Key Overhead Components: These should fall within the ranges listed:

   a) Laboratory costs should run 10% to 15%.

   b) Dental supplies should be from 3% to 5%.

   c) Salaries for the dental team, including hygienists, should be from 20% to 25%, including payroll taxes.

   d) Rent or facility debt service should be held between 4% and 7%.

   e) General and administrative – 10% to 15% (this includes utilities, telephone, maintenance and repair, legal and accounting, marketing, etc.).

   f) Debt service for other practice–related purposes should be less than 5%.

   g) Salary for dental provider of between 15% and 30%.

   h) President/owner–operator (return on invested capital, ROIC) salary between 10% and 15%.

   i) Return of invested capital between 10% and 15%. This in the form of reinvestment in practice assets, or in principle and interest on notes held by the owner against the corporation.

   j) Pension contribution: 4% to 12%. Calculated as up to 25% of owner's salary up to a maximum of $30,000 total contribution per year. Some plans may allow higher figures.

5. Total Overhead Percentage: Holding this between 50% and 60% is optimal for practices producing between $250,000 and $750,000. For the practice described, see Addenda A for what might occur at a 50% overhead.

6. Market Load: If the inventory of treatment plans presented and not performed is less than 25% of the desired annual production, then the number of active files (current recall, cases produced or in process within one year) multiplied times anywhere from .2 to .4 is the

Accounts outstanding over one year. . . gifted with the person's dismissal.

Case presentation skills must be enhanced. . . Napili 5, July!

number of new patients needed within one year. If each of these new patients needs, and accepts, an average of two crown fees worth of dentistry, the year's production is cared for. <u>If this number is greater than the number of new patients accepted in the last year, marketing or referral base enhancement is called for.</u>

7. <u>Uncompleted Case index.</u> If the presented and not performed dentistry (as derived in Addenda A) in these files is greater than 50% of next year's desired gross production, and the number of new patients seen last year is between 20% and 40% of last year's total patients seen, then slippage is occurring internally as opposed to in the market. Case presentation skills, or financial arrangements, must be enhanced to re–present the dentistry available within the practice and to succeed with a greater number of the new patients who are already coming to the practice. Team support of the current practice base is being measured here as well as the perception people have, overall, of care, environment, follow–through, and the respect they have as they perceive the dentist's skills. The only marketing enhancement required might be in looking at the kind of patients being attracted from the market as opposed to those desired from the market. New patients should be accepted on a screened referral basis only against the "top one hundred" profile.

New patients accepted on a screened referral basis. . .

8. <u>Production per Hour:</u> If this number is helpful in developing appropriate fees for service performed in the practice, the following concepts may also be helpful:

If last year's gross plus growth (10% or more) is a desirable gross for the upcoming year, and 70% needs to come from dental production, 30% from hygiene, take the new gross times .7 and divide by the number of hours available for dentistry in the year, and add new gross time .3 divided by the number of chair hours expected from the hygiene team.

Taking last year's total overhead and splitting it between the producers available (as above) then dividing by each pro–vider's available hours next year will give the cost per hour of produc–tive activity in the practice. Dividing this by the desired or targeted total overhead percentage for next year will give the amount of production per hour that is required to replace last year's gross.

If the method used above produces a desirable

change in net income for the coming year, a growth factor need not apply. If last year's total overhead percentage was used and it is found that cost reduction is impossible or marginally effective, then multiply the resulting per hourly rate times a factor of 1 plus the percentage of desired growth over last year's gross.

These methods will at least produce figures that can be applied against today's fee schedule or today's chair time per procedure to generate the stimulation to change the case/price construction, or the chairside procedures, the fee schedule or whatever other factors that would seem to have an effect on profitability. (This is, in fact, where Pentegra can do the most good for a practice.)

Addenda B represents how a ten-year model for the practice described might look. Historically, the practice has seen a 12% growth, most of which has been from more complete case presentation and acceptance and a constant rise in fee level due to inflation and continuing education. Therefore, without much change a 12% growth is expected over the next ten years.

Production expenses would be expected to rise proportionately with this growth. Most of the fixed expenses would be expected to rise with only the effects of inflation at 5%. An exception in this case would be salaries and payroll taxes which are kept at a combined 22%. This allows employees to share in the growth that they help to create, without the hassles, tracking (and, often, mistrust) that can accompany many of the bonus/incentive programs that are popular today. Team concern for growth is not stymied by the doctor re-investing or spending for tax effect within the practice.

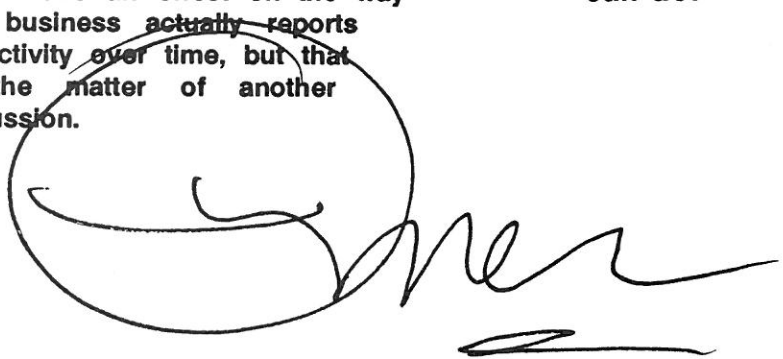
Team concern for growth is not stymied.

These items can be covered out of the 50% that is left for the owner-producer in the practice. The doctor's re-investment and re-education to enhance the practice value is repayed to him upon the sale of the practice, yet is kept at a level that allows a quality lifestyle for the doctor.

If spending is kept at these levels the total overhead percentage actually goes down over time. This allows for debt service and debt repayment to occur with a negligible effect on overhead. These are also considered to be a part of the owner's investment in the practice.

Pentegra can do!

Tax considerations, of course, might have an effect on the way this business actually reports its activity over time, but that is the matter of another discussion.



Napili News

NAPILI has settled into the Pentegra "digs", it's quite a change. . . please come and see us in our new arena. You're always welcome! Join us for the following opportunities:

Napili 5 - Micro-teaching Experience in Case Presentation - July 18 - 21 "On the road" -- CAMELBACK -- in Phoenix! This is seminar will assist in taking your million dollar practice out of the files, into your treatment rooms!

Napili 2 (Team-Building. . . one of my favorite over-worked words) in SUNDANCE. . . Reminder: Make flight reservations into Salt Lake City, rent a car, drive to Sundance. Check in, freshen up, meet us in Provo (a relaxing, mountainy, pastoral, 20 minute drive) for a group picnic late afternoon. The magnificent, unforgettable 4th of July Celebration at BYU begins at 7 p.m.

The workshop begins, A.M. Thursday, Friday and Saturday, breaking up about 4 P.M.to allow time for hiking and/or excursions into the environs. Bring binoculars, there's a good vantage point for scoping Bob Redford's ranch!

Napili will host the picnic, tickets for doctor/spouse and two team persons for the Celebration (if you need extra tickets for children, husbands or wives, let me know early, I can order them for you, they're $25 or less.) Make reservations with Kathy at Sundance, (801-225-4107) and don't forget to let us know that you're going to be with us!

Omer has a new format for this workshop. . . it's updated and timely, based on the March Quarterly. No limit, all adventurers/memory makers/futurists (and families) welcome!

We're taking our grandchildren. . . it's a heart-expanding experience. Believe me! or better yet, come, see for yourself.

Marci Reed

President
Napili Seminars

NAPILI PARTICIPATION

JUST A NOTE TO BRING YOU UP TO DATE. . .

The real estate problems are being resolved, but slowly. The attorneys love it! The practice is doing great, the retirement fund is doing well.

Napili/Omer has been a catalyst for major changes in my life which have contributed more to my happiness than any other change. I appreciate the contributions you have made; I have told you this before and feel strongly and emotionally about this. You and Napili are truly special.

At this time I have most aspects of my life under control. When the smoke clears from the real estate dealings, I'll know more about my economics.

I would like to be retired from clinical dentistry in seven to ten years, but am not willing to give up what little security I think I might have (I truly know I have none).

I sense many ideas in your mind have changed. . . I'm still implementing ideas you told me to believe in and adopt ten years ago. So, maybe there is hope for me as a student, maybe I can accelerate my learning curve.

Have you seen this: "I watch them tearing a building down; a gang of men in a busy town. With a yo-heave-ho and a lusty yell, they swing a beam and the side walls fell. I asked the foreman, 'Are those men as skilled . . .as the men you hire if you had to build?' He gave a laugh and said, 'No, indeed. Just common labor is all I need. I can easily wreck, in a day or two, what builders have taken years to do.' I thought to myself as I went my way, which of these roles have I tried to play? Am I a builder who works with care, measuring life by the rule or square? Am I shaping my deeds to a well-made plan? Patiently doing the best I can? Or am I like those who walk the town, content with the labor of tearing down?"

It applies, professionally and personally, doesn't it? I want to be the builder who works with care, shaping my deed to a well-made plan. Thanks for helping me see the way.

KWS

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ADDENDA "A"

	"Normal Range"	Actual	Dollar Value
Gross Collected Revenue			$500,000
Laboratory fees	10% - 15%	12%	$60,000
Dental Supplies	3% - 5%	4%	$20,000
Team Salaries	20% - 25%	20%	$100,000
Rent/Lease/Mortgage	4% - 7%	5%	$25,000
General and Admin.	10% - 15%	9%	$45,000
Net Profit	40% - 50%	50%	$250,000
Debt Service	0% - 5%	2%	$10,000
Dental Provider Salary	15% - 30%	20%	$100,000
Owner-Operator Salary	10% - 15%	10%	$50,000
Return of Invested Capital	10% - 15%	12%	$60,000
Pension Plan Contribution	4% - 12%	6%	$30,000

ADDENDA "B"

PROFORMA FOR PRACTICE PERFORMANCE - VITAL SIGN PRACTICE

ADDITIONAL DEBT COST					
	---------	COLLECTIONS FOR----> 1987	$340,736	NO ASSOCIATE PLANNED	
		1988	$387,200	AS REQUESTED ON	
		1989	$440,000	16-Jan-90 04:47 PM	
		COLLECTIONS IN CURRENT YEAR	$500,000	ASSUMPTIONS:	
NEW LOAN		CURRENT PRACTICE DEBT	75,000	OWNER PAY IF ANY	
INTEREST RATE	10.00%	INTEREST RATE	12.00%	HYG. COLLECT %	30.00%
AMORT. PERIOD	10 YEARS	PAYOUT PERIOD	5 YEARS	HYG. PAY %	
INTEREST ONLY	YEARS	INTEREST ONLY	YEARS	ASSOCIATE LAB FIRST?	NO
PAYMENT AMOUNT	/MONTH	MONTHLY PAYMENTS	1,668.33 /MONTH	ASSOCIATE COLLECT %	
BALLOON DUE IN	10 YEARS	BALLOON DUE IN	5 YEARS	ASSOCIATE PAY %	
BALLOON PAYMENT		BALLOON PAYMENT	($0)	INFLATION	5.00%
				GROWTH TREND	12.00%

COLLECTIONS		1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
1990 ---->CURRENT YEAR		1	2	3	4	5	6	7	8	9	10
OWNER COLLECTIONS	350,000										
WORKDAYS PER YEAR	192.0	192.0	192.0	192.0	192.0	192.0	144.0	144.0	144.0	144.0	144.0
DAILY COLLECTION	1,823	2,042	2,287	2,561	2,868	3,213	3,598	4,030	4,513	5,055	5,662
PROJECTED COLLECT.		392,000	439,040	491,725	550,732	616,820	518,128	580,304	649,940	727,933	815,285
HYGIENE COLLECTIONS	150,000										
HYG. DAYS/YR.	384.0	384.0	384.0	384.0	384.0	384.0	384.0	384.0	384.0	384.0	384.0
DAILY COLLECTION	391	438	490	549	615	688	771	864	967	1,083	1,213
PROJECTED COLLECT.		168,000	188,160	210,739	236,028	264,351	296,073	331,602	371,394	415,962	465,877
ASSOCIATE COLLECTIONS											
ASSOC. DAYS/YR.											
DAILY COLLECT.											
PROJECTED COLLECT.											
PRACTICE COLLECTIONS	500,000	560,000	627,200	702,464	786,760	881,171	814,202	911,906	1,021,335	1,143,895	1,281,162
SPECIALTY ADDED COLL.											
PRACTICE TOTAL COLLECTIONS		560,000	627,200	702,464	786,760	881,171	814,202	911,906	1,021,335	1,143,895	1,281,162

If the growth rate above is greater than the inflation rate please refer to related materials and reports for justification of rate. If not it is assumed that the practice will grow at an inflationary rate due to increases in fees only. If growth trends are evident in either associate or hygiene collections, they will be treated seperately. Anticipated Specialty added collection from specialty or marketing will be evident by a set amount over time or a set amount with it's own growth rate. Collections are calculated by multiplying last years daily rate times one plus the growth rate, and multiply that result by the number of days to be worked in the current year.

PRODUCTION EXPENSES		CURRENT YEAR	1	2	3	4	5	6	7	8	9	10
	PERCENT											
LAB FEES	12.00%	60,000	67,200	75,264	84,296	94,411	105,741	97,704	109,429	122,560	137,267	153,739
CLINICAL SUPP.	4.00%	20,000	22,400	25,088	28,099	31,470	35,247	32,568	36,476	40,853	45,756	51,246
SELLER COMPENS.												
ASSOC. COMPENS.		(NO ASSOCIATE)										
HYGIENIST COMP.		(HYGIENE PAID WITH OTHER SALARIES)										
SPEC. COST/FEE												
OFFICE SUPPLIES	0.50%	2,500	2,800	3,136	3,512	3,934	4,406	4,071	4,560	5,107	5,719	6,406
MISCELLANEOUS												
TOTAL		82,500	92,400	103,488	115,907	129,815	145,393	134,343	150,465	168,520	188,743	211,392
PERCENT OF TOTAL GROSS		16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%

Current production expenses are based on prior performance and grow in proportion with total gross unless otherwise specified. Unless office supplies and miscellaneous expenses are listed on past performance reports a percentage based on national averages may be used. Any incidental or one-time expenses on the owner's profit and loss statements may be omitted to show true trends. The spec. cost/fee may be based on the number of active patient records as reported in the practice.

ADDENDA "B" (cont.)

FIXED EXPENSES			1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
CURRENT YEAR			1	2	3	4	5	6	7	8	9	10
RENT/MORTGAGE	5.00%	25,000	26,250	27,563	28,941	30,388	31,907	33,502	35,178	36,936	38,783	40,722
MAINT./REPAIR	0.50%	2,500	2,625	2,756	2,894	3,039	3,191	3,350	3,518	3,694	3,878	4,072
UTILITIES	1.10%	5,500	5,775	6,064	6,367	6,685	7,020	7,371	7,739	8,126	8,532	8,959
TELEPHONE	0.55%	2,750	2,888	3,032	3,183	3,343	3,510	3,685	3,870	4,063	4,266	4,479
STAFF SALARIES	20.00%	100,000	112,000	125,440	140,493	157,352	176,234	162,840	182,381	204,267	228,779	256,232
PAYROLL TAXES	2.00%	10,010	11,211	12,557	14,063	15,751	17,641	16,300	18,256	20,447	22,901	25,649
LEGAL & ACCT.	1.12%	5,600	5,880	6,174	6,483	6,807	7,147	7,505	7,880	8,274	8,687	9,122
PRINT/POSTAGE	0.40%	2,000	2,100	2,205	2,315	2,431	2,553	2,680	2,814	2,955	3,103	3,258
INSURANCE	2.00%	10,000	10,500	11,025	11,576	12,155	12,763	13,401	14,071	14,775	15,513	16,289
COLLECTIONS EXP												
OTHER EXPENSES	0.83%	4,150	4,358	4,575	4,804	5,044	5,297	5,561	5,839	6,131	6,438	6,760
BUSINESS TAXES												
EMPLOYEE BENE.												
TOTAL		167,510	183,586	201,390	221,120	242,994	267,261	256,196	281,546	309,668	340,881	375,543
PERCENT OF TOTAL GROSS		33.50%	32.78%	32.11%	31.48%	30.89%	30.33%	31.47%	30.87%	30.32%	29.80%	29.31%
TOTAL EXPENSES		250,010	275,986	304,878	337,026	372,810	412,655	390,539	432,010	478,188	529,624	586,935
		50.00%	49.28%	48.61%	47.98%	47.39%	46.83%	47.97%	47.37%	46.82%	46.30%	45.81%

DISCRETIONARY EXPENSE			1	2	3	4	5	6	7	8	9	10
RE-INVESTMENT	5.00%	25,000	26,250	27,563	28,941	30,388	31,907	33,502	35,178	36,936	38,783	40,722
PROF. DEVEL.	7.00%	35,000	36,750	38,588	40,517	42,543	44,670	46,903	49,249	51,711	54,296	57,011
OWNER SALARY	10.00%	50,000	52,500	55,125	57,881	60,775	63,814	67,005	70,355	73,873	77,566	81,445
DENTAL SALARY	20.00%	100,000	105,000	110,250	115,763	121,551	127,628	134,010	140,710	147,746	155,133	162,889
PENSION OWNER	6.00%	30,000	30,000	30,000	30,000	30,000	30,000	30,000	30,000	30,000	30,000	30,000
TOTAL		240,000	250,500	261,525	273,101	285,256	298,019	311,420	325,491	340,266	355,779	372,068
PERCENT OF TOTAL GROSS		48.00%	44.73%	41.70%	38.88%	36.26%	33.82%	38.25%	35.69%	33.32%	31.10%	29.04%

INTEREST EXPENSES - LOAN			1	2	3	4	5	6	7	8	9	10
MORTGAGE												
NEW LOAN												
CURRENT LOAN		75,000	8,373	6,896	5,232	3,356	1,243					
TOTAL INTEREST			8,373	6,896	5,232	3,356	1,243					
TOTAL EXPENSES AND INTEREST			534,859	573,299	615,359	661,422	711,917	701,960	757,501	818,454	885,403	959,002
INCOME SUMMARY - PERCENTAGE(10 YEAR AVERAGE)												
PRACTICE INCOME	100.00%		560,000	627,200	702,464	786,760	881,171	814,202	911,906	1,021,335	1,143,895	1,281,162
LESS EXPENSES	82.69%		534,859	573,299	615,359	661,422	711,917	701,960	757,501	818,454	885,403	959,002
ADJ. GROSS INC.	17.31%		25,141	53,901	87,105	125,338	169,254	112,242	154,405	202,881	258,492	322,160

PRINCIPAL PAYMENTS - LOAN (PAYMENTS EQUAL THE EQUITY GAIN IN PRACTICE - NOT AN EXPENSE)

	AMOUNT	1	2	3	4	5	6	7	8	9	10
NEW LOAN											
CURRENT LOAN	75,000	11,647	13,124	14,788	16,664	18,777					
TOTAL	75,000	11,647	13,124	14,788	16,664	18,777					
ANNUAL PRE-TAX CASH FLOW		13,494	40,777	72,317	108,674	150,477	112,242	154,405	202,881	258,492	322,160
PERCENT OF TOTAL GROSS		2.41%	6.50%	10.29%	13.81%	17.08%	13.79%	16.93%	19.86%	22.60%	25.15%

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May, 1990

Dear Friends

The concept of identifying and removing resistors to accelerated practice, as reviewed each year by Napili 3 (Model-building), Napili 4 (The Economic Core of Model-building) and Napili 8 (The Anatomy of an Accelerated Practice) and the intensification of culture in the first of five tracks followed in developing a networking team, the inventory provided by University Associates, (Lorna P. Martin), as an instrument for growth, I find to be extremely appropriate and useful. This "blurb" is dedicated to inserting this tool into the hand of progress and abundance. Thence cometh the title

INVENTORY OF BARRIERS TO CREATIVE
THOUGHT AND INNOVATIVE ACTION

Creativity was once widely held to be limited to a few talented individuals. However, an impressive body of solid research over the past few decades has conclusively proved that most of us were born with rich and vigorous imaginations and that creative ability is almost universally distributed. Creativity as a fundamental trait is possessed by every person. . . and yet, very few people make use of their creative potential. Creativity is contingent upon the preservation of the curiosity and wonder we had in early childhood, and that, unfortunately, is the one thing that is conspicuously absent in most grownups.

Given the premise that most small children are very creative, one might wonder what helps or hinders creativity. Over time, the inhibition of creativity increases as children conform to the social pressures of the educational process and/or as they interact in society.

Eventually, layers of behaviors are developed that thwart the creative potential. Very often a person's sense of creativity is not challenged. . . the spark does not emit as much energy, it shrinks until no radiation emits from it. If a person's creative spark is not challenged or if this energy is restricted, this confinement becomes tighter and tighter until the spark is finally extinguished.

An individual's creativity never really becomes completely lost. By retraining ourselves to unstifle creativity, we can unearth our hidden potentials and bring them to the surface again to make use of them for a more creative and fulfilling life.

Unearthing and enhancing human potential such as the ability to create or innovate is critical for the human resource development practitioner who attempts to increase both individual effectiveness and organizational performance and productivity.

Increasing individual effectiveness requires increasing creativity in addition to unlearning nonproductive and self-defeating behaviors in oneself and in others.

Creativity can be re-awakened; indeed, there are certain factors that block the creative process and a conscious effort to avoid or overcome these blocks can enhance creativity.

One natural starting point for an intervention designed to tap or enhance creativity has been to attempt to measure one's present level of creative ability. Another approach to intervention has been to demonstrate and implement techniques that facilitate creative problem solving. The identified studies reveal that both of these methodologies work. Yet both of these methods seem to put the cart before the horse. The literature clearly indicates that an alternative and perhaps more logical starting point might be the identification of specific barriers or blocks that inhibit an individual's creative effort. This information then can be used to prescribe strategies to reduce the immobilizing effects of such blocks. This approach enables individuals to free up their creative potentials by avoiding or altering blocking behavior and by implementing healthier and more creative alternatives.

The literature indicates an alternative and logical starting point.

Theoretical Framework

The inventory of barriers to creative thought and innovative action was designed to identify and to measure the degree of inhibitors affecting a person's ability to create and innovate. Its underlying hypothesis is that creative and innovative behavior will increase as a result of feedback obtained from the addenda instrument and the subsequent awareness and understanding of a person's identified inhibitors.

Investigations of the factors associated with the creative process and the individual originated with Carl Rogers who attempted to correlate characteristics of the individual and the environment to creative performance. He asserted that a relationship exists between an individual's internal psychological make-up and creativity; for instance, individuals who display creative behaviors generally are open to experience, lack rigidity in thinking, have the ability to deal with conflicting information, and are not unduly influenced by criticism or praise.

In addition to these internal psychological characteristics,
Rogers; also postulated external environmental conditions that would affect an individual's creative ability. For example, creativity would be increased when the external environment provided for greater psychological safety and freedom for the individual. In essence, Rogers believed that this could be accomplished by accepting the individual, by removing external evaluation, by using empathy, and by providing freedom for the individual to think and feel.

Other empirical studies are consistent with Rogers' view. Although these studies identify creativity enhancers rather than barriers to creativity, one can conclude that if the factors associated with increased creativity are lacking, creativity will be decreased or inhibited. The barriers to creative thought defined in the literature can be categorized into the following three major groups:

- Perceptual blocks (or the way a person sees things);
- Cultural blocks (or the way a person ought to do things); and
- Emotional blocks (or the way a person feels about things).

These common barriers can be described further as follows:

Perceptual blocks include factors such as:

- Failure to use all the senses in observing;

OMER K. REED, DDS

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- Failure to investigate the obvious;
- Inability to define terms;
- Difficulty in seeing remote relationships;
- Failure to distinguish between facets of cause and effect.

Cultural blocks include influences such as:

- A desire to conform to an adopted pattern;
- Overemphasis on competition or on cooperation;
- The drive to be practical and economical above all things;
- Belief that indulging in fantasy is a waste of time; and
- Too much faith in reason and logic.

Emotional blocks include elements such as:

- Fear of making a mistake;
- Fear and distrust of others; and
- Grabbing the first idea that comes along.

Barriers to creativity have been described as mental walls that block the problem solver from correctly perceiving a problem or conceiving its solution. Two major categories of inhibitors are identified: structural barriers, which include psychological, cultural, and environmental blocks; and process barriers, which include elements related to cognitive style.

The barriers that frustrate writers prove to be the same as those that thwart creative people in any business or industry. The barriers are primarily emotional blocks that constitute the most serious inhibitors to creative functioning, such as:

- Personal feelings of security (such as low self-esteem, feelings of anxiety, fear of criticism, fear of failure, or lack of curiosity);
- Need for superficial security (such as lack of risk taking or not trying new things);
- Inability to use the unconscious (such as not using visualization or fantasy);
- Inability to use the conscious mind effectively (inability to organize data;
- Work-oriented barriers (such as "keep trying," "always prepared," "ready?"); and
- Environmental barriers (such as the need to find the proper setting, and to give oneself every advantage).

The work of J. S. Morgan (Improving Your Creativity on the Job) sparked the development of this instrument that identifies barriers to creative thought and innovative action. The theoretical underpinnings of the instrument itself systematically integrate the literature on barriers to creativity and enhancers to creativity to provide the necessary framework.

The addenda instrument measures elements that are both internal and external to the individual based on, but

Barriers thwart creative people in any business or industry.

This instrument identifies barriers.

not limited to, the work of Carl Rogers. This instrument identifies barriers that inhibit creative thought in a personal sense, issues related to self-esteem; elements that deal with self-confidence, and behaviors associated with risk taking. It also examines the barriers that the environment might impose, such as factors related to the availability and use of time, issues of privacy, imposition of limitations, and physical facilities.

The instrument measures internal and external elements.

Additionally, the instrument was designed to take into account the cognitive style of the individual. The instrument identifies variables related to intuitive right-brain thinking, as well as elements typically associated with systematic or logical left-brain thinking.

The instrument also was intended to consider various elements associated with independence and the need to conform on an internal or personal level as well as in a group or work-related setting.

The Instrument

The instrument consists of 36 items, set up in a six-point Likert-scale format. These items identify and measure barriers in the following six categories or trait groups:

1. Barriers related to concept of self. These examine the variables most often associated with an individual's self-esteem, self-confidence, handling of rejection, and ability to confront differing opinions.

It is not a test. . . no right or wrong answer.

2. Barriers related to need for conformity. These examine the variables most often associated with an individual's inclinations to break away from tried and true patterns, to take risks, to express one's ideas, and to scrutinize traditional views and standard practices and policies.

3. Barriers related to ability to abstract. These examine the variables most often associated with an individual's tendencies to use the unconscious mind, to abstract, to view things in holistic or visual ways, and to rely on gut hunches or intuition.

4. Barriers related to ability to use systematic analysis. These examine the variables most often associated with an individual's tendencies to use the conscious mind, to apply logic, to think in linear or sequential ways, to organize oneself and one's ideas, and to rely on facts or data.

5. Barriers related to task achievement. These examine the variables most often associated with an individual's work patterns, persistence, attitudes toward others, and resourcefulness.

6. Barriers related to physical environment. These examine the variables most often associated with an individual's preferences as to physical surroundings, dealing with distractions, use of personal space, and need for privacy.

Administration

Team participants should read the instructions, realizing that the instrument is not a test that has right or wrong answers, but a device designed to indicate one's barriers to creative thought and innovative action.

Don't spend a great deal of time pondering each response. . . the first "guess" is usually the best one.

When the team has completed all of the items on the instrument, a discussion of the dimensions measured by the instrument is helpful, estimating or predicting the subscale categories in which they believe themselves to have barriers, as well as the categories in

which they believe themselves to be relatively free of barriers.

Scoring

Each participant should be given a copy of the Action Scoring Sheet, which identifies six categories in columns labeled A through F. Each column contains the numbers of the items directly related to that column. Each participant should transfer his or her scores to the scoring sheet and add all values in each column to obtain totals for each column.

Each participant should also be given a copy of the Action Profile Sheet and will plot their scores on the graph. The vertical axis represents the numerical scores; the horizontal axis, the categories of barriers. The participants then should draw lines connecting the plotted points. The final version will appear as a line graph.

The high scores are the barriers or hurdles to overcome in order to increase one's creative thought and innovative action.

Interpretation and Processing

When participants have identified their own individual barriers to creativity, this information can be interpreted and processed in two steps. First, a "facilitator's" column scores can be examined by the group for significant divergence or variability among columns. For instance, the facilitator's scores might indicate a high degree of inhibition with regard to one column, with all other scores indicating relatively equal patterns. That score would be examined closely for its fit to reality and its significance for the facilitator.

Second, the participants are asked to form groups of two and to exchange scoring sheets and profile sheets. The partners take turns interpreting one another's scores and follow this with a brief discussion of the instrument and the impact of the scores.

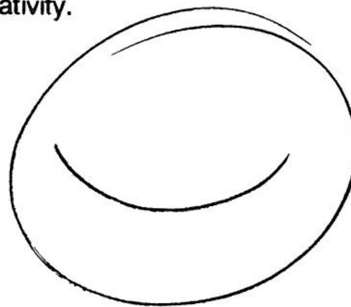
The participants may wish to post scores and discuss them as a group. Sample questions that might be asked include the following:

1. Which scores seem to fit? Which scores do not seem to fit?

2. Based on your knowledge of the other team persons, which column scores would you have predicted/ Which surprise you?

3. How can you use this information to work together more effectively?

Alternatively, each participant may be assigned a confidential code number. Graphs then are posted, identified only by code number. The group members choose the individual they think best fits that graph and offer a written or oral rationale for each selection. This activity offers an opportunity for further individual and group insight into the ways in which members stifle or cultivate their own or the group's creativity.



Creative, innovative behavior will increase.

Napili News

As you can see, I'm using new software for this newsletter; the old axiom "you can't teach an old dog new tricks" just isn't so! (I have, however, lost a few handfuls of hair. . .)

May 31st, we're off to Kenya, Tanzania and Belgium with 21 "safari seminarians." (Napili 6 for 1990) The Colorado River Raft Trip is ON for 1991, 8 days beginning on the 21st or 22nd of June. Early registration is acceptable. . .in fact, encouraged.

Some JULY DATES to note: The first ever FREEDOM FESTIVAL in Sundance, Utah - begins with supper on the 4th at BYU, then on to the Festival at the Stadium. Meetings, team-building (new format), are in Sundance, Thursday - Saturday.

July 18 - 21, Closed Circuit Video Experience in Case Presentation (in Phoenix). Limited space available, we want everyone to have ample exposure to the closed circuit video "role playing" aspect of this unique experience. It is probably true that most doctors have, in their charts/files, a "million dollar practice". . . either unpresented, or unaccepted. Come, hone your consultative skills in this non-threatening arena. You'll discover hidden talent, in yourself, in your accompanying person, and in your fellow attendees. This workshop is great fun; a wonderful way to learn. (The next Case Presentation workshop will be offered October 10 - 13.)

Napili 3 and 4, and the Reunion, and the two Masters programs: Mauna Lani Bay Resort, Big Island, July 26 - August 3. Welcome! NOW is the time for making memories with family and Napili network.

We look forward to hearing from you, and to having you COME, JOIN US. . .

Marci Reed

President
Napili Seminars

TAKING OFF

Taking off uses more energy. . . it's when the most power is always needed.

Observance, alertness, and following the checklist is a rule that should be heeded.

With the many decisions to be made during takeoff, it's often too scary for a few.

But once you reach your cruising altitude, you can relax and enjoy the view.

At cruising altitude and throttle back, the ride is smoother for the flyer.

If it's not as smooth as you would like, more power will take you higher.

It's then that the machine is at its most efficient, it's smooth and very quiet.

The same applies to the dental practice, if only you know how to fly it.

My office is really taking off now, we're climbing like we should.

I'm really glad you were in the tower, clearing me so I could.

Thanks for the clearance, Omer,

Your friend, Bill D.

"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, 2999 North 44th Street, Suite 650, Phoenix, AZ 85018."

INVENTORY OF BARRIERS TO CREATIVE THOUGHT AND INNOVATIVE ACTION

Lorna P. Martin

Instructions: For each of the statements in this inventory, refer to the following scale and decide which number corresponds to your level of agreement with the statement; then write that number in the blank to the left of the statement.

Strongly Agree	Agree	Agree Somewhat	Disagree Somewhat	Disagree	Strongly Disagree
1	2	3	4	5	6

______ 1. I evaluate criticism to determine how it can be useful to me.

______ 2. When solving problems, I attempt to apply new concepts or methods.

______ 3. I can shift gears or change emphasis in the abstract.

______ 4. I get enthusiastic about problems outside my specialized area of concentration.

______ 5. I always give a problem my best effort, even if it seems trivial or fails to arouse enthusiasm.

______ 6. I set aside periods of time without interruptions.

______ 7. It is not difficult for me to have my ideas criticized.

______ 8. In the past, I have taken calculated risks and I would do so again.

______ 9. I dream, daydream, and fantasize easily.

______ 10. I know how to simplify and organize my observations.

______ 11. Occasionally, I try a so-called "unworkable" answer and hope that it will prove to be workable.

______ 12. I can and do consistently guard my personal periods of privacy.

______ 13. I feel at ease with colleagues even when my ideas or plans meet with public criticism or rejection.

______ 14. I frequently read opinions contrary to my own to learn what the opposition is thinking.

______ 15. I translate symbols into concrete ideas or action steps.

______ 16. I seek many ideas because I enjoy having alternative possibilities.

______ 17. In the idea-formulation stage of a project, I withhold critical judgment.

______ 18. I determine whether an imposed limitation is reasonable or unreasonable.

Strongly Agree 1	Agree 2	Agree Somewhat 3	Disagree Somewhat 4	Disagree 5	Strongly Disagree 6

______ 19. I would modify an idea, plan, or design, even if doing so would meet with opposition.

______ 20. I feel comfortable in expressing my ideas even if they are in the minority.

______ 21. I enjoy participating in nonverbal, symbolic, or visual activities.

______ 22. I feel the excitement and challenge of finding a solution to problems.

______ 23. I keep a file of discarded ideas.

______ 24. I make reasonable demands for good physical facilities and surroundings.

______ 25. I would feel no serious loss of status or prestige if management publicly rejected my plan.

______ 26. I frequently question the policies, objectives, values, or ideas of an organization.

______ 27. I deliberately exercise my visual and symbolic skills in order to strengthen them.

______ 28. I can accept my thinking when it seems illogical.

______ 29. I seldom reject ambiguous ideas that are not directly related to the problem.

______ 30. I distinguish between the trivial and the important physical distractions.

______ 31. I feel uncomfortable making waves for a worthwhile idea if it threatens the inner harmony of the group.

______ 32. I am willing to present a truly original approach even if there is a chance it could fail.

______ 33. I can recognize the times when symbolism or visualization would work best for me.

______ 34. I try to make an uninteresting problem stimulating.

______ 35. I consciously attempt to use new approaches toward routine tasks.

______ 36. In the past, I have determined when to leave an undesirable environment and when to stay and change the environment (including self-growth).

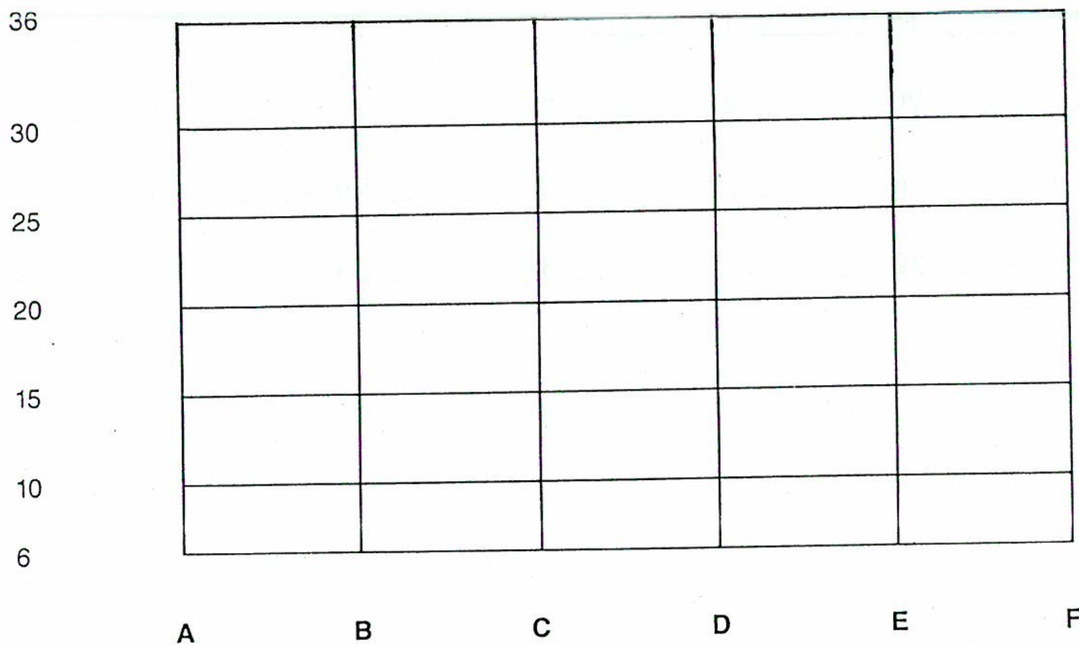
BARRIERS TO CREATIVE THOUGHT AND INNOVATIVE ACTION SCORING SHEET

Instructions: Transfer your inventory responses to the appropriate blanks provided below. Then add the numbers in each column, and record the totals in the blanks provided.

	A	B	C	D	E	F
	1. _____	2. _____	3. _____	4. _____	5. _____	6. _____
	7. _____	8. _____	9. _____	10. _____	11. _____	12. _____
	13. _____	14. _____	15. _____	16. _____	17. _____	18. _____
	19. _____	20. _____	21. _____	22. _____	23. _____	24. _____
	25. _____	26. _____	27. _____	28. _____	29. _____	30. _____
	31. _____	32. _____	33. _____	34. _____	35. _____	36. _____
Column Totals	_____	_____	_____	_____	_____	_____

BARRIERS TO CREATIVE THOUGHT AND INNOVATIVE ACTION PROFILE SHEET

Instructions: Plot the scores from your scoring sheet onto the following graph. The vertical axis, which represents your numbered scores, ranges from 6 to 36. The horizontal axis, which represents the columns on your scoring sheet, ranges from A to F. The key at the bottom of this page identifies the barriers in each column. Connect the points you have plotted with a line. The high points represent your barriers.



Key to Barriers

A = Barriers Related to Self-Confidence and Risk Taking

B = Barriers Related to Need for Conformity

C = Barriers Related to Use of the Abstract

D = Barriers Related to Use of Systematic Analysis

E = Barriers Related to Task Achievement

F = Barriers Related to Physical Environment

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THE NAPILI PHILOSOPHY IN PRACTICE

REED'S QUARTERLY

A SUPPLEMENT TO REED'S INTERNATIONAL LETTER

JUNE 1990

IN THIS ISSUE

THE "CONTROL PROGRAM" REVISITED

TEN COMMANDMENTS OF CHANGE

MATURITY

My observations include that in the last decade and with dentistry's current "polytechnical" revolution, we have tooled up to treat the effects of disease rather than honoring Barkley's old adage and continuing to recognize that "treating without preventing" is like "chasing without catching". The following comments are not new, but are, I feel, worth repeating.

There is a sequence of powerful sequellae that proceeds from certain events. When the morality of preventing the causes, as recognizable, prior to repairing the effects is policy, dependency is reduced and personal freedom is accelerated, bilaterally.

In practices where prevention prevails (as a subspecialty), the condition of the person coming for care is determined by thorough examination. Tools used for this thoroughness of examination include a social as well as a medical interview, the health history. Careful consideration of the person is assured by using the tool called "listening" (and hearing); x-ray and explorer are supplemented with the perio probe and palpation (American Cancer Society Soft Tissue Examination). Dental tape is used to include the sense of smell (the mouth odor test). Sight, smell, touch, listening-hearing. . . all are critical in the examination and the subsequent diagnosis, treatment planning and prognosis.

The preventive philosophy then dictates that the person with etiologic agents such as plaque, calculus, the lesions of these causative factors (caries, inflamed gingiva and the advanced lesion of periodontal disease, the pocket) are NOT sent to the hygienist but through the preventive aspect of the practice.

There the person coming for care is instructed in ways to control the causes of dental disease, once called the "control program".

This program is rarely considered as a part of the hygienist's role in treating the person coming for care. The hygienist's therapeutic skills come after the "patient's" awareness of his oral condition.

What, then, is the role of the hygienist?

The hygienist has a dual role in definitive prevention. She interrupts existing pathology by mechanical and chemical means; i.e., scaling, rootplaning, coronal polishing and sulcular irrigation of soft and hard tissue.

With or without anesthesia, from a histologic sense, many of the "prophylactic" procedures are not "prophys" at all, but "gum treating" sessions. . . not preventive in nature, but corrective. (RE: Del Webb's package and tape on "insurance". . . 151 Brigham Road, #2, St. George, Utah 84770)

The hygienist's second role is in preventing the causes of disease not removable by the person coming for care -- a "per-periodontist" therapy.

The true prophylaxis consists of the polishing of plaque and calculus free surfaces of enamel, dentine and cementum; to smooth and polish these surfaces to prevent plaque organization, to make the tooth more easily cleansable at the hand of the "patient".

She smooths roughened CEJ's, margins of restorations, the contacts and surfaces of these restorations. The fluoride included is also preventive as it attaches to the prepared hydroxy appetite, crystalline structure of the enamel rod.

The hygienist smooths roughened cementum on root surfaces through careful root-planing. She stimulates the capillary bed by thorough flossing and massage and with warm saline rinsing. Healing is an inside job, not created from without.

"Patients" are instructed to continue this routine on a daily basis.

This is true interceptive preventive philosophy, assisting a treated, healed, disease-free mouth, and through correction and reinforcement, assisting the person coming for care to keep his dentition in tact and disease-free.

When the person coming for care is aware of:

(1) his need,
(2) the answer to his need,
(3) his time involvement with the disease process,
(4) and is pre-informed of his economic involvement for the above. . .

. . .he rarely objects to investing a fair fee with the hygienist to have his mouth prepared for his own maintenance, and for the plaque-free healing condition required for pocket therapy or the grafting procedures of soft and hard dental tissues, four to six times per year.

"The mouth, in its entirety, is an important and even wondrous part of our anatomy, our emotion, our life; it is the site of our very being.

"When an animal loses its teeth, it cannot survive unless it is domesticated; its very existence is terminated; it dies.

"In the human, the mouth is the means of speaking, of expressing love, happiness and joy, anger, ill temper, or sorrow. It is the primary sex contact; hence it is of initial import to our regeneration and survival by food and propagation.

"It deserves the greatest care it can receive at any sacrifice." (F. Harold Wirth, D.D.S.)

Dr. Charles Mayo, one of the founders of the Mayo Clinics, knew the definite connection between bodily health and oral health when he stated, "preventive dentistry can extend human life ten years or more."

"Brushing is a hoax."

"It's a sad fact that most people might as well have never owned a toothbrush for all the good they've ever done with it. Most people can brush their teeth as many times a day as they want and keep right on having dental disease.

"Tragically, far too many dentists still cling to the concept that brushing will, in fact, stop dental disease, and continually admonish their patients to do a better and better job.

"Then, years later, with dental disease <u>never</u> having been controlled and after losing several teeth, both the doctor and his patients get frustrated at the ineffectiveness of their efforts."

<u>This quotation from the man who was one of the nation's leading teachers of the "control" program, Dr. Robert F. Barkley.</u>

(Rocky Mountain Rendezvous honors Bob Barkley each summer with a fantastic family retreat/workshop. . . 1990 marks the tenth year! Contact Bud Ham, 9311 East Pioneer Drive, 303-841-5929, Parker, Colorado for more information.)

In 1815, Dr. Parmley wrote, in a dental text, "It is my observation that if the white material is removed from the teeth and gums with a face cloth. . . and a store string is used between the teeth where space allows, the mouth will heal. . . . ."

In order to understand the "control program" we need to go back to the time when two bacteriologists, the Dean of the Tulane Medical School and the Dean of the University of Texas Dental School, were conducting research, independently, into the causes of dental disease.

They each made different scientific discoveries concerning the relationship of bacteria to dental disease, and when their findings were correlated, the conclusions were astounding.

The facts discovered:

1) Approximately 96% of all the harmful bacteria within the mouth live in the tiny crevice near the gum line between the tooth and gum.

2) The damage done is not related to the <u>number</u> of bacteria present but rather to their state or organization.

What do we mean?

It was found that bacteria must be organized, or clumped together in tiny colonies or clusters, before they are capable of producing harmful effects such as decay, tender and bleeding gums, foul breath, etc.

The presence of bacteria alone in a <u>disorganized</u> or <u>unclumped</u> state produces no harmful effects. (With the exception of A.A.)

3) We do not have to live with bacteria, we've learned how they live and know how to destroy them; when bacteria have been disorganized, it takes 24-30 hours for them to re-organize.

The more we can do to prevent and remove disease causes, the less we will have to repair and restore the effects of disease.

Dental disease is a cause-and-effect relationship resulting from neglect. Dentistry cannot do for the patient what the patient will not do for himself.

We dentists can stop taking people's teeth out and start teaching them to control and eliminate dental disease.

Thorough examination and a firm overview is essential prior to restoring the effect of disease in the mouth so that it can be restored to as cleansable and as permanent a state as possible.

Where the control of dental disease is a reality, dentistry takes on the nature of a long-

term investment in good health instead of a repeat business situation.

In a preventive program in the dental practice, the primary responsibility is not to research or to provide statistical information, but to provide treatment for people, to provide knowledge and instruction regarding the preventive aspect of dental disease for the person coming for care.

It's true that there is more than one way to accomplish the removal of bacterial plaque and to control dental disease.

The following philosophies and methods have been simple, useful and very successful at Valley Dental Group.

Prevention in dentistry means removal of organized bacterial plaque. If, once a day, the patient can effectively disorganize the bacteria in his mouth, control and elimination of dental disease is possible.

The mouth can be free of decay, will not have gingival inflammation, will not have detachment of gingival tissue from teeth and will not have an offensive odor.

Dental disease can be prevented from recurring and patients can, for the most part, keep their existing teeth for the rest of their lives.

My biggest satisfaction in dentistry is the observation of wellness created with the hands and lives of people coming for care to Valley Dental Group for the last 30 years. They make my inlay rehabs and crown and bridge look good!

The Valley Dental Group team verbalizes the philosophy that the dentists in this office believe that controlling the causes of disease is at least as important as correcting the effects, and . . . "we're selfish enough to want the best for our people."

Proper hygiene technique must:

(a) be effective (produce dental cleanliness),

(b) be safe (no damage to hard or soft tissues),

(c) be easy to teach, learn and perform consistently (technique in itself is not so important as satisfying the criteria of disorganizing and removing bacterial plaque) and

(d) be efficient (whatever aids are used to remove bacterial plaque are not an end in themselves, but a means to the end.)

Mutually understanding this philosophy eliminates arguments over brushing methods, brush and bristle types, and which aid is better than another. Equipment used is certainly of some importance as each tool serves a useful purpose, one doesn't take the place of another, though some are interchangeable.

In order to thoroughly clean and disorganize bacterial colonies, inform the patient that he must:

1) floss the complete tooth, especially under the gum margin, using an effective flossing technique.

2) brush thoroughly, particularly the tongue side of the teeth and cheek surfaces of the back teeth (including the tongue and inside of cheeks).

3) use disclosing tablets or liquid to determine efficiency of cleansing (awareness stimulates motivation).

4) rinse mouth thoroughly with warm salt water.

Our philosophy is to make the preventive program <u>people-oriented rather than patient-oriented</u> and to interact with the person coming for care on a personal basis rather than a "mouth and teeth with dental plaque."

We help the person to examine his lifestyle relating to dental problems and to guide him to discover ways which will enable him to make healthy decisions in regard to his personal dental hygiene.

In order for the person to be faithful to the preventive program, new habits must be formed, which takes time.

The preventive therapist (teacher) has the responsibility of transferring information to the person (learner); that the person has the ultimate responsibility of keeping his mouth clean and preventing recurring disease.

Behavioral change (new habits) occurs when:

1) "Patient"/learner and teacher understand the same objectives.

2) "Patient"/learner learns in small increments, at his rate, not at the teacher's rate.

3) "Patient"/learner's mistakes are corrected immediately.

4) "Patient"/learner is reinforced and/or complimented.

5) Results of learning are evaluated together.

In summary:

1) The pupil or student learns what he is interested in learning.

2) Learning depends on wanting to learn.

3) Learning depends on not knowing what the answer is.

4) Learning is largely an emotional experience.

5) Self-image, self-esteem and the interpersonal relationships of the patient and the teacher are involved.

6) A "patient" learns best when he is free to create his own responses in the situation.

7) Learning is integral, integrative and creative.

8) Learning is not editive.

9) Learning does not occur unless what is learned can be put to use.

10) Every patient learns in his own way, not in the teacher's way.

11) To learn is to change.

Remember, repeated personal involvement: person-to-person concern, treat "person" not "mouth", help the person coming for care to become aware of the need, create desire.

Stimulation of motivation and behavioral change are in direct proportion to the quality of the relationship. Wow!

Dentistry is truly a "people game."

The dentist and/or preventive therapist cannot do for the person coming for care what that person will not do for himself.

With all these things in mind, the organized preventive program usually convinces the person coming for care of his own maintenance ability rather than the dentist's therapy through education (cause and control of dental diseases), motivational demonstration in his own mouth, training, using his own hands, mind and eyes to perform the necessary steps.

We feel the preventive philosophy and instruction is best accomplished prior to any therapy (except emergency) at the hands of the dentist or hygienist.

At this point, I see the faces and hear the voices of some of this Quarterly's regulars saying, "Yeah, yeah. I know all this." Take a close look. Why is to know not to do? These basics are more often ignored than practiced.

Key Tools for Creating Behavioral Change: (First in the dentist and/or team person. . . and then in the person coming for care.). . . and these are essential for successful treatment acceptance.

1. High trust/low fear environment.

2. Understanding the teacher-learner equation.

3. Acknowledging the importance of motivation through problem-solving.

4. Thorough understanding of inter-personal, cultural relationships in the dental environment.

5. Skill in the use of communications knowledge.

6. Knowledge of the means by which one can precipitate change in people.

One cannot be motivated by others, one is motivated from within.

The conditions to which one is exposed at any given time, plus his own experiences, are what determines how one will motivate himself.

Conditions that are acting or can act upon the person coming for care to cause him to accept the idea of preventive dentistry and home care, if recognized, can be created to turn him on and overcome those that turn him off.

De-motivating Conditions (Negative)

1. Exposure to non-motivated individuals or skeptics (including books, articles, etc., which are anti-preventive.)

2. Ideal dentition. . . little or no past experience with dental disease, the "never me" syndrome.

3. Low dental IQ. . . no understanding of dental disease, no fear or concern ("parents lost their teeth at 40, so I guess I will, too.")

4. Bad experiences with dentists. . . suspicion of dentistry and the dentist.

5. Unsuccessful experiences with home care in the past.

6. Personal problems. . . taking precedence over present or potential dental problems ("with a broken arm, how can I floss?).

7. Personal convictions or lifestyles; those which are in direct conflict with principles of prevention, (being a physician, "I can take care of it other ways, besides, I'm too busy.")

Look for these red flags.

These are conditions which, as long as one or more of them are present, will result in a turned off, tuned out person. Fortunately, they can be reversed, but only if recognized and, in dialogue, neutralized by the following motivating conditions.

Motivating Conditions (Positive)

1. Exposure to highly motivated persons or missionaries of prevention (including articles, books, etc.)

2. Poor dentition. . extensive experience with dental disease.

3. High dental IQ. . . good understanding of dental disease and advantages of complete dentistry.

4. Good experiences with dentists. . . confidence in dentists and dentistry.

5. Personal convictions or lifestyles . . .in harmony with principles of prevention. . . concern for maintaining good health and appearance.

The key is that any time de-motivating conditions are neutralized and motivating conditions are emphasized or substituted. A successful prevention program exists for the dentist and his staff who recognize this and approach the person coming for care with the

idea of creating the conditions necessary for SELF-motivation.

This includes educating, developing the desire for and demonstrating the rewards of preventive dentistry.

In reviewing this review, many "oldtimers" may be "bored to tears." You will recognize "chapter and verse" in the above dialogue. It is my purpose to urge a renewed commitment to the basics, both clinical and behavioral, for the wealthy sequence in satisfaction and value. . . yes, even money. . . saved and earned by both parties in the equation.

But you may have guessed. . . I have an ulterior motive. There is a new world, more fierce than fluoride. . . it's just around the corner.

Our recent return from third world Africa creates an ache in me for a "time warp" to accelerate the arrival of a new "interceptive" in the form of a toothpaste which is a tooth brightener and which releases O_2 while used in brushing. No present paste does this. It is a stain remover. (A six-month clinical trial at a University showed less stain at three and six months versus baseline.) It helps remove dead cells and bacteria from the mouth, helps to prevent plaque build-up, helps remove oral mal-odor (tobacco, liquor, and from diseased gums). Brushing with this paste prior to using the mouth wash with its therapeutic will increase the effectiveness of the mouth rinse. It reduces dental plaque formation at each of its many formative steps, including the interception of pellical formation. It helps prevent gingivitis and periodontitis. It kills decay-causing bacteria (streptococcus mutans) and kills the bacteria that starts dental plaque (streptococcus sanguis) and kills the bacteria associated with periodontitis (actinobacillus actinomycetumcomitans, bacteroides gingivalis, bacteroides intermedius, and fusiform nucleatum). It kills fungus Candida Albicans that are the associated denture stomatitis. Due to its bactericidal action, it reduces chances of a "dry socket" following tooth removal. It eliminates "ropey" saliva prior to dental treatment procedures by breaking down salivary mucins.

As a mouth rinse properly used, it removes oral malodor by chemically neutralizing the cause, not by masking with another odor. This is achieved by eliminating hydrogen sulphide, methal mercaptan and dimethol mercaptan. This includes onion and garlic odors and promotes "kissability".

Bad breath usually comes form gum disease more than anything. This rinse will make one' sex life better because kissing is the first contact between partners.

It neutralizes other odors such as from liquors and tobacco. It has up to three hours of odor protection, as determined by gas chromatograph study.

It is non-alcoholic, making it preferable to religious groups and to recovering alcoholics.

It removes the debris of dead bacteria and dead cells as well as food; it breaks down early dextran formation, and raises the oxygen tension of plaque and saliva, thus reducing the growth of anaerobic bacteria that cause periodontitis.

It kills decay-causing bacteria (streptococcus mutans). . . senile caries, a thing of the past for root surfaces.

It can be used as a periodontal pocket irrigant to keep pockets from being actively infected, such as horizontally cracked teeth, distal or lower second molars or molar furcas.

It is a wound debriding agent, and will remove dead cells associated with diseases such as erosive Lichen Planus or Desquamative Gingivitis. This, together with its bactericidal capacity, allows more healing than previously. . . great for canker and cold sores.

The yet-unpublished wonder is in its final stages of preparation and will undoubtedly be the "breakthrough" in therapeutics in the 90's.

In the meantime, those with chronic adult periodontitis continue to respond quickly and benefit long term from the primary message and behavioral patterns described in this Quarterly. The rest remains in the hands of an acutely skilled diagnostician and therapist.

This may be a good place in which to repeat (worth repeating!) the

Ten Commandments of Change

1. Change is more acceptable when it is understood than when it is not.

2. Change is more acceptable when it does not threaten security than when it does.

3. Change is more acceptable when those affected have helped to create it than when it has been externally imposed.

4. Change is more acceptable when it results from an application of previously established impersonal principles than it is when it is deictated by personal order.

5. Change is more acceptable when it follows a series of succdssful changes than it is when it follows a series of failures.

6. Change is more acceptable when it is inaugurated after prior change has been assimilated than when it is inaugurated during the confusion of other major change.

7. Change is more acceptable if it has been planned than it is if it is experimental.

8. Change is more acceptable to people new on the job than to people old on the job.

9. Change is more acceptable to people who share in the benefits of change than to those who do not.

10. Change is more acceptable if the organization has been

REED'S QUARTERLY

Focusing on the practical application of Napili concepts in Dr. Reed's dental practice, Valley Dental Group, and other participating dental practices around the world.

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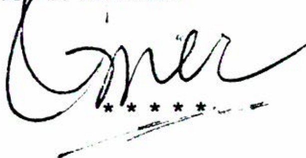
trained to plan for improvement than it is if the organization is accustomed to static procedures.

Change is the only constant we have.

Nothing will ever be attempted if all possible objections must first be overcome.



* * * * *

Maturity, Some Comments. . .

Maturity is the ability to control anger and settle differences without violence or destruction.

Maturity is patience, the willingnesxs to pass up immediate pleasure in favor of the long-term gain.

Maturity is perseverance, the ability to sweat out a project or a situation in spite of opposition and discouraging setbacks.

Maturity is unselfishness, responding to the needs of others, often at the expense of one's own desires or wishes.

Maturity is the capacity to face unpleasantness and frustration,m discomfort, and defeat without complaint or collapse.

Maturity is humility. It is being big enough to say "I was wrong." and, when right, the mature person need not say, "I told you so."

Maturity is the ability to make a decision and stand by it. The immature spend their lives exploring endless possibilities, then do nothing.

Maturity means dependability, keeping one's word, coming through in the crisis. The immature are masters of the alibi, confused and disorganized. Their lives are a maze of broken promises, former friends, unfinished business and good intentions which never materialize.

Maturity is the art of living in peace with that which we cannot change.

(Note. . . in regard to this last statement about maturity:

While we were in East Africa (Napili 6) my computer, terminal, keyboard, monitor, font capability were stolen!

The "memory" included this Quarterly and the July newsletter. . . it's a new system so I had not learned to do back-up (you can believe I'm **now** capable and disciplined) and therefore everything but the outline was lost.

Therefore, I'm trying to remain calm and at peace with that which I cannot change. . . i.e., the font that is customary for this printing.

Please adjust your bifocals, if necessary. Time will be on my side for the next issue.

* * * * *

Please take a minute to read the enclosed brochure regarding the Nashville meeting. . . it sounds like a lot of fun for mid-summer. . . and we'd enjoy seeing you there, as would Mike Tabor!

The Vancouver **INFORUM** regarding office design/lay-out/traffic flow patterns/front desklessness and productivity is scheduled for August 17-18, space available, one fee ($970) for doctor, spouse and any/all team persons.

REED'S INTERNATIONAL LETTER

Dear Friends

Antithesis has always been with us. The opposite side of the coin is often dramatic.

"To have the other person feel understood, rather than pushing him to understand."

"When I see it, I will believe it" has been replaced with "When I believe it I will see it."

"Time wounds all heals."

View the other person as that person sees self, subjectively, and seeing self objectively as the other person sees has proven to be an osmotic power of empathic communication that finally fulfills Robbie Burns old phrase, "Would some power the gift to gie us, to see ourselves as others see us."

"To lead and expect" instead of "push and direct."

Mood tapes and "escape" tapes on video have allowed us to vicariously experience everything from the helicopter water-level run of the Grand Canyon to the surf, the eagles, the mountains. . . all with full quadraphonic stereo.

And now

CYBERSPACE

Many years ago, Marci and I went to Disneyworld/Epcot in Orlando and enjoyed the "back of the house" tour where we were shown the massive bank of computers that operatively apply the magic of this "new city."

During the demonstration, a laser holographic image of a person appeared alongside one of the computers and spoke to us. Without question, it was only when the image of that person shrunk to an apparent four to five inches and danced from one computer top to another did we realize that our host was not "*real*." Reality and truth are seen through our own windows and we've long since beat the dead horse of our intercranial view of truth and reality.

The movie *Firefox* illustrated a "Buck Rogers" helmet that flew the airplane and fired the weapons as the pilot thought. . . the thought waves were really the entire guiding mechanism of the aircraft and only when the American pilot, who had stolen the plane, thought in Russian could he control the firing systems in the aircraft. Not far from today's truth.

August 1990

Today, American gunships are piloted by the helmeted who, when they turn their heads, turn their guns as the sighting is all accomplished by the mechanics of the pilot's body, particularly head posture and the pilot's vision through an artificial horizon on the helmet screen.

Today, projected on the windscreen of my sailplane is the entire image of the control panel read-out of lift and sink, thermal activity, airspeed and all the vital signs of flight so that the pilot's "head" is out of the cockppit as he peers through the data he needs and still retains his vision of the horizon and the outside world essential for decision-making, thermaling and safety.

Anti-matter anyone?

We're moving at a very rapid rate in a new world. . . DeepVision, the latest in Three-D television, has been developed by a group in London and they've rigged this very convincing Three-D system without glasses. It works for any movie, series or cartoon ever filmed. Jim Ashby, the developer, calls it "pseudo-stereo". It fits on any television set as a special de-coder screen, and it is described as having the effect of looking through the window. The image has depth, viewed from anywhere in the room. The screen inserts visual clues onto a tape, or program. The de-coder directs proper cues to each eye. Ashby borrowed from his own research in autism to marry technology to the human brain.

"Rather than supplying the brain with the entire picture, we supply it with just enough to allow it to fill in the rest," says Ashby.

Stations could broadcast all programming, even I LOVE LUCY repeats can now be seen in 3-D. The viewers, however, need the DeepVision equipped television to watch.

Ashby intends for the de-coder screen to be built into the television set and estimates that the additional cost per set will be somewhere between $80-170.

Again, man's perception and how the brain dysfunctions can constructively be put together to create an artificial reality, or "cyberspace." There are a number of different names for the non-existent space that is attracting a lot of interest.

The special world of cybervision is manifested in a number of different ways in different parts of the world. As in most early experiences in a science, these "Wright Brothers" around the world are struggling to get their "heavier than air" craft to "leave the beach."

In some instances the person puts on special clothing and is completely wired to the computer. Glove-transmitted and received data, goggles include video-type screens that impose optical images on the retina in a projection-type procedure. The computer-generated images of either real or imaginary world, then, appear to the viewer in 3-D with quadraphonic sound. It is more lifelike than watching 3-D television because it allows the user to act. The user can be sitting in the cockpit of an airplane, or be swinging the club on a golf course. With the flick of a gloved wrist, you can pick up a dental handpiece and do an counter-clockwise crown prep, fly an airplane, or "chop the head off an adversary."

A software program presently exists and many more will obviously follow which will allow people to see the world from any vantage point they choose. . . that of a pregnant woman, that of a husband or even through the eyes of an animal. Or they can interact with real people connected to the same "virtual world."

The research that's being done is being carefully guarded in some quarters and flaunted in others. There are serious purposes, such as teaching the surgeon how to handle the scalpel without drawing blood, or creating a workplace for people in real life laboratories even if they're separated by thousands of miles.

OMER K. REED, DDS

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People in the sciences at the University level or in companies including National Aeronautics and Space Administration are just beginning to use the first systems.

When this reaches the stage of the "Concorde" instead of the Wright Brothers' "flying contraption" can one imagine what can be accomplished. The concept interests big companies such as AT&T and IBM.

Recently CBS' Sixty Minutes reported on "virtual reality" including the word regalia essential for this process. The program featured Timothy O'Leary, the psychologist who was the 1960's cheerleader for chimically-altered states of consciousness. O'Leary now believes "virtual reality" is the best *trip* he's ever had!

Virtual reality seems to fall somewhere between human potential moment and the video game. Virtual reality will let people transcend their identities. For instance, you could be the president of the United States, or the socio-political power that governs the Russians. A person could totally experience things without much effort or time. . . feeling, seeing and hearing as if in a new body.

A book is currently being written about virtual reality. It will be published next year by Simon and Schuster. The author, Howard Rheingold, says the technology is in its early stages, but will change conceptually with the speed of light and will undoubtedly change the world.

Conveying experience through printed words or pictures, video included, is indeed difficult. What people read or see is usually interpreted by the filter, experientially, that guides their perception. With cyberspace, that perception and that filter can be altered instantly.

A computer science professor at the University of North Carolina - Chapel Hill is one of those who guards, perhaps quite closely, that which is being accomplished. Frederick Brooks maintains a civil tone, but is clearly unhappy with all the attention being paid the work that he oversees at the University. He says that a parade of visitors that began last year "precludes us even completing the work. . . a lot of people in computer graphics coming in and no end of reporters."

In Redwood City, California, Jaron Lanier has been working on this concept at VPL Research, a company founded primarily for this purpose. Lanier (30) is one of the technology's most effective proselytizers. He coined the phrase "virtual reality." Cyberspace seems to carry a bit of the sense as well.

A new "psychobabble."

Judith Singer, a novelist/screen writer, has written a new movie, A MAN, A WOMAN AND A WOMAN, which portrays virtual reality. "The implications leave me dizzy," says her husband, Alexander, director of "Cagney and Lacey", "Hill-street Blues", and who will be in charge of this new work. He says it's like "an out of body, electronic experience. I'm a non-drug person whose big adventure into thrillseeking is a cup of coffee," he says, "but using this equipment, I have flown, passed under objects, gone through objects. . . all while my body, of course, never leaves the ground."

Lanier wants more people to have an opportunity to use "virtual reality" equipment and is working with the computer museum in Boston to put a technical show "on the road." The museum hopes to have a program called *REALITY ON WHEELS* which will give people a chance to try the devices.

Myron Krueger, a computer scientist based in Vernon, Connecticut, has assembled and placed "virtual reality" at the Natural History Museum in Storrs, Connecticut. This equipment has been continually on display and open to any one who wants to use it.

Government and industry researchers are focusing on using goggles, helmets and gloves to create the sense of a different world. Krueger says that he feels the breakthrough will come in another way as body equipment is too cumbersome. In his world, the person interacts with objects and characters and other people on the screen in two dimensions. The many reports tell us of the widespread interest in cyberspace. The actual sensation of being touched, heat and cold, vibration and human sensation are reproducible. Stuart Brand, of Whole Earth Publications, a forerunner in that which is unique, makes a statement, "I'm 51 and probably too old to handle four or five immersion realities at the same time, but if I were in college at this point, I would be thinking to myself that *this is my technology.*"

Young Dentist Society, anyone?

Do you visualize the uses of this particular information that prompted its being included as a part of the International Letter?

Cyberspace allows one to manipulate reality, to create the artificial world, explains Eric Gullichsen, co-founder of Sens-8 Corporation, a Sausalito-based software company specializing in cyberspace. The world exists only inside the computer, but to the user it seems real.

Drive the Indy 500!

This certainly can be linked to our telephones or television making it impossible to tell whether one is watching a projected image or conversing with an actual person in the room. This can be total immersion as no video game has ever conceived of it.

Fire, Aim, Ready!

Alhle Spielberg, president of Norcross, Georgia Cyberspace Corporation, is marketing a lap-top computer that flashes images directly onto the user's retina. A special headband mounted eyepiece, developed by Reflection Technology, Inc. is used to provide these projections. The device creates the illusion of a full-sized image hovering in the air, two feet away, which only the wearer can see. This allows a live hologram to be present provided by the software program that completely violates one's ability to choose between one's formerly perceived reality and what is "currently happening."

Video imaging the dental person, in this particular incidence, would be simple because this program allows one to interact with self and/or others as selected. The computer screen will probably go the way of vacuum tubes before long, the way these researchers are hammering the technology.

See, 3-D, ten laminates produced on a CAD/CAM placed on the "smile" of the person coming for care with the end result completely displayed in 3-D color for and on the person observing.

The CIA and FBI have made inquiries, surgeons, warehouse managers. . . all are interested in what's going to happen. Good for dentistry to know that it exists.

I'm certain it will be a multi-million dollar market. Gullichsen and his two partners have taken cyberspace one step further. They've designed a system that permits the computer to track the user's body movements and adjust it to its artificial reality accordingly. The user may play racquetball with an imaginary opponent, running, jumping, swinging with all his might, but everything he sees on the court, including his own body, is completely presented by the software computer image.

The implications are profound. A top secret entertainment program product will be released by December 1991 by Gullichsen. It is possible to put a person in a completely different world just by dialing a piece of clothing. You'll be able to fly with or without the airplane to experience anything you want. Many who have experienced this consider it to border on a religious experience.

Mattel's "Power Glove" which is one of the hottest toys in last Christmas' season, a

glove invented by a New York-based entertainment company, can be hooked up to any Nintendo Game. It allows the players to punch, shoot, point weapons and to guide legions of space marauders. . . all with the natural hand and finger gestures. Millions of youngsters are already paying big bucks for a taste of that Nirvana. New generations of games will soon follow. The players will be allowed to grasp and move objects in three dimensions.

Breaking the touch barrier is neurologically the part of the game that will put it out of the Wright Brothers' ballgame.

Presently the software packages and the computers mimic sight and sound and are working on the tactile illusions.

Entrepreneurs like Dave Johnson, president of TiNi Alloy Company in Oakland, California, are working on the tactile project. They use a tactile array of tiny electronically-activation pins to stimulate the sensation of touching shapes and forms.

It is felt that cyberspace will change the way people live, work, play and even what people consider reality to be. *Anything we can conceive and believe, we can achieve* may be altered irreversibly as we change our conception of what it means to be a human being.

It's interesting for us to note this remarkable development and to keep our fingers on its pulse.

Those who are investing in video-imaging for the dental practice in the $20-30,000 range are encouraged to watch with great care for breakthroughs in holography and the new technologies of perception as to be able to see oneself in three dimensions and to even speak with oneself and to see the functional changes that can be created with plastic surgery and/or dentistry are just around the corner.

Napili 5 (Micro-teaching Experience in Case Presentation) has dynamically used video to provide the imagery necessary for re-tooling one's communication in dentistry. Much like an Olympic athlete can visualize himself running down the track, counting his steps and launching over the bar, landing in the pit at previously unheard of heights, so can the dentist learn new skills most rapidly in the presence of others who are willing to assist in the closed circuit video experience. Mental imagery will obviously be enhanced by cyberspace to a point that is almost unbelievable.

Count on it. . . Napili 5 will change from the closed circuit TV workshop that psychodramas the person coming for care and the dental treatment, consultation to a live discussion with Bob Barkley on the merits of co-discovering the value and fees of dental care with the persons concerned.

Beat Bjorn Borg. . .

Currently, imagery, or a functional dynamic use of imagination, is prescribed and used intentionally with great success in sports, career development, counseling, education, co-dependency and wellness medicine. Can you envision the points you want to make clear in communication with another person? Would you like to dry run that on closed circuit video and hear, see, feel and perceive your image to that other person? Can you imagine cyberspace putting you on 3-D and having you really meet yourself, subjectively and objectively?

The marriage of faith and trust for the person coming for care.

Without question, these tools can be used in developing a communicative team. We have seen closed circuit video assist team persons in "closing the sale' of scheduling, treatment consultation and the performance of the marriage of faith and trust for the person coming for care.

A new book, Envisionary Management, (produced by Quorum Books, Westport, CT) describes scenarios and activities

where mental imagery can help people in governance roles attain personal and organizational excellence from a strategy and structure point of view.

Seminars are beginning to grow in the area of imagery as an innovative breakthrough.

It's not wishing for the impossible. It's taking time to think and picture that which one chooses to do, as seeing that performance and participation are closely related and can be used for good (or for evil) in regard to our human behavior.

Guided imagery will be dramatic.

Guided imagery, then, with the use of closed circuit video and cyberspace, when it's available, will continue to be dramatic as teaching tools when teaching is used as a trigger word to indicate the potential for learning, growth and/or change.

In one's mind, or on closed circuit video, when one walks through a sequence of new behavioral patterns, the experience is then available for recall and retrieval as synthetic or psychodrama situations are stored and recalled in exactly the same manner as real experiences.

The creative thinking that is required for a strategic procedure precludes storage and recall as the primary learning tool.

Praise . . . used as a teacher/learner tool.

Now that which is so near and dear to us, memory and recall, may be once again available as we can, with cyberspace, complete the guided imagery of our rehearsal and then live carefully through that which the mind's eye has found to be real in the past.

Reuel Howe, in his book, The Miracle of Dialogue, implies the creative "interactive" that precedes the "proactive" in our human inter-relationship, praise being used as a teacher/learner tool, can be rehearsed so the backlash of using it in adult-to-adult communication will not erroneously be accomplished.

Understanding goals, setting objectives to achieve those goals, tangibilitating the intangible . . . certainly are handles of our past Napili experiences that remarkably fit when one considers cyberspace.

One spends more time in planning one's three-week vacation than one does in preparing the balance of one's life.

Do you remember how you decided on your last vacation?

You went through a series of thoughts in your mind's eye and decided on. . . East Africa, Napili 6.

How you can avoid the mistakes that you toughed out last year is carefully planned, what clothing and gear you needed to take along (you took too much last time!).

The whole imagery of founding this three-week experience from the foundation of knowledge, and Marci's agenda, is one of the supportive retrieval and recombination things that can strategically be of use.

Cyberspace will certainly allow the reality and recall and be dramatically beyond what we've ever perceived.

Pentegra certainly assists in the imagery of life; the people on the team being of all ranges, chronologically, is of great value.

To envision our goals and to design the preferred environment and future will be extraordinarily enhanced by the tactical breakthroughs that are showered on us by this new technology.

Imagery can help us to build plans for the future through building mental pictures and helping us select alternative actions.

Seeing in one's mind's eye is one thing, seeing it in cyberspace is another.

The dialogue between people in the culture of a communicative dental team and the person coming for care will be 3-D and quadraphonic . . . Wow!

. . . and case presentation?

We intentionally use words and body language as message senders, as symbols to evoke mental images and receivers.

The receiver then encodes the image and gives feedback, also in words and/or symbols.

Since the communication prior to this is rich in imagery, we, as persons, are an integral part of the total communication system.

To this point, we've not been able to enhance that, but have to self-contain it.

I can easily see a time when one would walk through a typical work day from beginning to end, with all the characters that strut on that stage, team and persons coming for care, being three-dimensional and relationally hooked to the communicative process.

One can better handle the daily challenges, the scheduling and the usage of time will be realistically provided by the cyberspace imagery.

Obviously the software and the video input for sophisticated systems will be remarkably technical.

The sensory images of your environment, including the sense of smell, will be an exciting challenge.

Fragrances have been popular for generations as subtle manipulators.

I hope to follow, in one of the next Letters, with some of the taste, smell research that's been accomplished as it will apply to our environments and to our successes.

The escape into cyberspace is certainly attractive to some. . . but the world has more room for those who turn these tools into positive, useful servitude and action.

These new tools contribute to improving personal and professional productivity.

They help us to see better that which needs to be seen, to hear better that which needs to be heard. . . and to act upon that which needs to be acted upon.

Cyberspace. . . dramatic beyond belief.

Napili News

By now you've heard of the 122 degree weather in Phoenix! (It's dry heat. . .) "Mad dogs and Englishmen go out in the noon day sun. . ." As does Bill Brahm, Barry Curry, Bill Mikkelsen, Mark Hassed and Angela DeSmit (Aussies), Pat Kelly and Trudy Gray, Denise Kreek, Bob and Gloria Limoges, Bob Martin, Jim Rubin, Dennis and Judy Streich, Chris Suzuki, David Wright and Holly Reed, John and Dottie Chaipin, Leslie LaKind, Greta Pino, and Chris Johnson: all in Phoenix during the "monsoon" season, mid-July, (a thunder-and-lightning experience) for the Wednesday Special (inlay rehab) and Closed Circuit Video Experience in Case Presentation. The stage presence of these professionals is. . . professional! This role-playing experience is a gigantic step in learning that is painfully fun!

You're invited to join us for another "stretch" experience in Case Presentation, OCTOBER 10-13. We'll have New Zealanders with us that week, so there'll be a great long-distance networking opportunity.

You're invited to join the network: Napili 1, The People Game - Dentistry, in Phoenix, September 12-15, a proactive workshop of current concepts in private care, erasing old tapes, accessing choice, the application of co-discovery and megatrend excellence in professional practice. . . and more!

Come, join us.

Marci Reed

President
Napili Seminars

N A P I L I   P A R T I C I P A T I O N

A SOLUTION TO STRESS

Marci and Omer: I came across this editorial in Southam's Publication, Dental Practice Management, by Erla Kay, Publisher. I like it, and I thought you might like it as well. The magazine article in regard to 'other than dentistry' interests was well-written and relevant, I believe, in regard to the 'poly-technical' world in which we, as dentists, are now involved. Vickie J.

"As life becomes more automated and more specialized, we quickly become members of the do it super-fast and super-well society and, unless we pay attention to the symptoms, we can too easily end up with the most common effect of stress. . . burn out.

"Repetition is itself the biggest culprit. Anything you must do over and over, hour after hour, can lead to a loss of interest. . . and the Catch 22 is that with all the modern technology designed to make everything faster and easier, mere loss of interest can grow into being super-bored.
. . .the solution?

"I don't think there is any one thing that will work for everyone. Recognizing the symptoms will make you question your life. That's a first step.

"Feeling tired more often. . . trying to please others all the time and never feeling that it's being appreciated. . . these are a couple of the common complaints.

"But maybe you should ask yourself: Are you too accepting of life as it presents itself? and what are you doing to add variety and enjoyment that will keep your stress levels down so that you don't become a victim of burn out?

". . . we interviewd three different dentists who have outside interests apart from dentistry that enhances their lives and enriches their personalitites. They have all been successful in combining their love of dentistry with their special outlets and there is no chance that burn out will be able to get a grip on their lives.

"1990 is going to be a tough year for a lot of people. . . . .the pessimistic undeterred economists still say 'things will get worse', the environmental problems and. . . closer to home. . . the day to day problems that are always present in the dental office.

"Stress can be insidious -- but it needn't be inevitable. Take a moment now and look at your life. Be totally objective. (In my opinion) . . there is no such thing as stress-free dentistry but you can make your life more comfortable if you try to combine pleasure with professionalism. You will find that they're definitely compatible."

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REED'S INTERNATIONAL LETTER

Dear Friends

The concepts in this newsletter will freestand as an idea system that is in its time. The application of the ideas will help marketing in your own practice; and/or expand your examination procedure. I believe it will assist in altering your fee structure, in aiming your entire team at the thoroughness of collecting important data prior to making decisions; or, indeed, may just establish examination, diagnosis, treatment planning and case presentation as a formalized check list in sequence!! I believe these ideas will be useful.

So, let's call this one

THE "MINI-MAYO" CONCEPT

The exciting experience we had twelve to fifteen years ago in visiting Tony Newberry's Harley Street/London preventive and diagnostic center opened my eyes. I had been in Rochester and had seen the Mayo Clinic and had, of course, seen the kind of work that was done at the Mayo Memorial Heart Hospital on the campus of the University of Minnesota, so the screening and collecting of data as a broad-base experience prior to diagnosing, treatment planning or presenting is a natural in my history.

In Harley Street, Newberry and a partner from Australia put together a preventive/interception clinic with no handpieces in it. A person is welcome to come to the clinic to be examined, thoroughly. The usual tests are accomplished that are probably done routinely in your office. The person is instructed in preventive procedure and even taken on to prophylaxis if s/he chooses, and then presented with a treatment consultation that outlines the diagnosis, the treatment plan. . . even estimates from an economic sense, and then provides the person with a copy of all documents so that wherever care is rendered it will be on the basis of <u>co-discovery</u> of these documented facts.

One of the impressive things about the Newberry clinic is the socio-political separation of the source of therapy from the communicative process that precedes it.

The Newberry team contacted embassies, consulates, medical doctors, hospitals, attorneys (solicitors), various lay organizations throughout London and had a brisk reputation and good business in the diagnostic procedure alone.

October 1990

Needless to say, the examination fee was not a loss-leader. It was calculated on fixed and variable cost, per unit time base, and was well worth the investment.

Tony and his partner had a "class one, triple plus" office two blocks away on Harley Street, and they also had satisfied a very niche, segmented target market that appealed to them. People who fit that profile were referred to Tony and his partner for further screening and the introduction to therapy portion of the process.

The few who were referred to their office for this purpose were usually pleased to stay because they'd found what they were looking for. . . and Tony and his partner were pleased to have them.

At first blush, you might say that this is an ignoble way to establish such a clinic. I beg to differ in that the majority of the people passing through this "machine" benefitted from it as a freestanding idea system and were not referred to Tony and his partner.

One of the good systems for establishing a serving mechanism.

I feel it's probably one of the good systems for establishing a serving mechanism outside the office so that the people who finally come to you for care fit the "niche". . . socially, economically, intellectually and technically. . . that you choose. In fact, it is indeed the ultimate in that idea system.

Both Mayo/Scottsdale and Florida have no dental clinics, only Mayo/Rochester indulges heavily in the dental aspect of the medical care for persons.

Does that wake you up?

Scripps, in the San Diego area, does a fabulous job of coordinating dentistry with the balance of the diagnostic procedure. How, indeed, could they ever, legitimately, be separated?

Screening is a marketing tool. Screening is a social service to the public. Two different operations. Nevertheless, they serve remarkably for a need that exists in the community that is ill-met by the current practitioner.

Differential diagnosis is not accomplished to a high degree in the general practitioner's office. We usually send people to the specialist for that kind of "sorting".

I propose that it can easily be accomplished, and quite thoroughly, in the generalist's office, should s/he so choose.

Treatment planning, economic projections and presentation are seldom found in the generalist's practice as well. Although those of you who receive this letter may find that hard to believe. **Believe me.**

Preventive instruction prior to prophylaxis as a part of the initial experience is also extremely rare.

It was a by-product of the American Society for Preventive Dentistry in the early 70's and enjoyed at least an awareness across the country during the late 70's and died a quiet death in the early 80's.

Most of the sophisticated practices that I know do not invest any time, stomach lining/heart muscle outside of the hygienist's operatory in regard to instructional procedure and in the hygiene chair is the least likely place for behavioral change to be initiated.

OMER K. REED, DDS

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The market is hungry for second opinions. Demand is instituted by hospitals, accident situations, medical doctors, attorneys or even interested individuals who really would prefer a sophisticated dental screening, (accomplished "free standing" without any 'axe to grind') either as a second opinion or as they go in for therapy in the office of their choice.

Certainly dental screening prior to major surgery to sort out those who have foci of infections and unnecessary transient bacteremias is the least we can do. And that is also extremely rare. We seldom see it in hospital environments or major medical teams.

The entire process can be automated with an auxiliary team and the technological breakthroughs that are occurring very rapidly in dentistry.

We loosely refer to it as a **polytechnical revolution.** It accelerates the ability of our team to help us with the screening process in a regular practice.

All things considered, this particular screening and package presentation could assure your fellow dentists, general and specialist, of your thoroughness and your willingness to turn the person back to the free market in a hungry/busyness problem arena.

I certainly see a fair fee for this exam being somewhere between $1200 and $2500, depending upon the necessary selections and procedural reports. Computers today are certainly available with programs already accomplished, IBM-PC compatible, that will not only listen to you as you speak and automate, but will also select out of word-processing the major paragraphs that you choose, triggered by code numbers of voice cues so this document can be accomplished rather efficiently.

Without question, I would go to the intensity that the specialties provide in properly assembling this screening process. Think with me about the endo, perio, pedo, prosthetic, ortho or oral surgery involvements. . . or indeed what would the public health dentist do in sorting/triage his marketplace.

Specialists have checklists that are unknown, or unused, by the generalist.

Each of these specialties has a checklist that they traditionally use that is either unknown or unused by the generalist, in large part.

Why is to know not to do?

In the case of the endodontist, the hot and cold screening that is done at the cervix of each tooth can coordinate the tooth on a scale of one to five, so can the electric pulp tester.

"Tricks of the trade. . ."

In a similar situation, they can cross-coordinate the reports with teeth of the same denomination in the opposite side of the arch so as to get a differentiation.

Vertical pressure, lateral pressure can be used to load the teeth for sensitivity as well as vertical and lateral percussion. . . all "tricks of the trade" used by the endodontist to differentially diagnose.

Out of twenty-eight teeth, four or five teeth may be isolated with tests and scores that alert the dentist and allow him to prescribe for the person prophylactic endo prior to rehab and/or during perio therapy so as to not only assure the post-core strength for the tooth prior to crown and

The person possessing the dentition determines his/her healthy longevity.

bridge (rather than <u>after</u> with the resultant cement seal breaks, etc.) and also to ease the discomfort of scheduling and/or trauma/infection that the person may experience when the predictability of endo being necessary in the next two to five years is rather statistically significant.

The periodontal check list includes at least six screening procedures. We would certainly feel strongly inclined to include pocket scores, plaque scores, bleeding point scores, mobility scores, recession scores, and mouth odor scores as being critically important. . . on each tooth, so as to get a picture comparatively and differentially prior to diagnosis.

All of these things, in my opinion, should be couched in the Barkley co-interview, co-discovery, co-diagnosis, co-treatment planning framework (even though the person may not be coming to you for care) because the credulence of your message, when you're not "politically" involved, is absolutely overwhelming.

The Perio-check is now FDA approved.

The oral surgeon has a checklist, the pedodontist. . . the orthodontist -- all specialists have checklists. These should be instituted. Myofacial pain dysfunction screening, occlusal tabulations to determine what the current position is and what the ideal position would be prior to any hands on care.

The thoroughness with which this is accomplished prior to any treatment is critically important to the interception of the co-dependency that is often created by the dentist. We would like to have this be pro-actively arranged so the person is not dependent on other than himself once the wellness is achieved.

<u>It's easier to stay well than it is to get well</u>. And that rests primarily in the hands of the person coming for care. Healthy longevity is determined more by the behavioral and the intellectual applications of the person possessing the dentition than by the operator in the dental practice with his "if it ain't broke, don't fix it" sickness model.

I know that these ideas are beginning to tug at you and I would continue with them in various forms so as to encourage you to continue your research and for you to form your own task list. . . for you to prioritize that which will, by the first of next month, give you your "mini-Mayo, squeaky clean" exam. . .as you see it. . . including health history, blood studies, whatever. And can we escape the microscope? Can we cross-coordinate the microscope with the now-currently available enzyme studies that can be easily and quickly tabulated as the break-down products from collagenase hyaluronidase and the rest are available in the sulcular fluids and can now be monitored with Perio-check, a recently FDA approved process for color-coding people who DO and who DO NOT have periodontal disease.

An assembled video tape package of this would accompany the person coming for care as s/he is allowed to participate in the entire process.

A video camera on a tripod, video-taping the entire examination and interview process would have two VCR's working, one for your records and one for the person coming for care to take.

Wouldn't that knock your socks off?

Also, as a "leader" and a "trailer", informational comments can be made that would be extremely helpful. F[illegible] Zinman presently has two (and is

working on others). . . video tapes that give the informed consent package essential for implants and for periodontal disease. Dynamite stuff! Easily accepted by the person coming for care.

Can you imagine when such a video exists on esthetics, cosmetics, morphology, crown and bridge and the rest so that we can indeed help the person coming for care understand?. . .with third party verification.

The VCR would also, of course, pick up the person's spirochetes, their Aa, their black-pigmented bacteroides and the other things that they saw and understood and, in fact, even smelled because the sample was taken off the floss with the mouth odor test and put directly on the slide.

When people smell what they see, feel, hear and understand it in a way that's unique and feel understood in an environment that CARES, there is no way to stop the ongoing process.

The business of "paradigm" and the power of vision as recently portrayed on video by Joel Barker would also be a part of the introduction of this entire process so people coming for this exclusive package of diagnostic procedures and reports would be mentally conditioned with the Ericksonianisms of change that are essential.

I see a network of dentists through Napili/Pentegra who are internationally available for referral and/or review of this remarkable package of data that is all extremely verifiable in the mouth and lifestyle of the person bearing the package. This networking of referral would indeed be, in my opinion, much like Mayo, opening its own clinics near the markets they've chosen.

Think about that.

Let's talk about radiovisiography as the tool of choice and see how, with 80% less energy, and with immediate video exposure of the pictured tooth, teeth, gingival tissue, endo procedures or whatever. . . at whatever angulation you choose, and whatever density, and with detail. . . and with printable pictures that come off much more clearly readable in size and shape than our current x-rays. I have found people to be infinitely fascinated with radiovisiography as the new cutting edge "miracle" and firmly appreciate the reduction in radiation.

The Poly-technical Revolution is here!

The T-Scan, dynamite machine, will be the guts and the verifier of myofacial pain dysfunction syndrome as well as the therapy that follows it in regard to how we see the occlusal support, the neuromusculature.

Dentran will follow that. It is a computerized toothbrush with a read-out training program that helps people understand frequency, sequence, duration and loading of the bristles on the teeth. The sensors are actually light-indicated on a panel in front of the person during training so as to get stroke and pressure synaptically related.

People will no longer strip the gingiva off their teeth and you'll get their mouths plaque-free.

I can see these sensors being loaded into current "motorized" toothbrushes. They now exist in a fabulous training tool put out by a company in Canada that Dick Jones is operating. It's phenomenal. Dick is also working on

Stimulating motivational behavior is the responsibility of the professional . . . prior to any hands on care.

an endo instrument with a chip in it that has a tip that heats to the guttapercha temperatures used for testing endo, and which immediately chills down to the refrigerated ice temperature. . . all in one small little wand that fits kindly into the hand, and easily onto the neck of the tooth. We'll be able to use this as a scale of one to five to begin to score these teeth and communicate to our people in a remarkably new and thorough pre-endo report. Electronic pulp testers vary. Choose the one you like, standardize its use in your hands, and you'll be off and running.

Cue tip biting vertical pressure with quick release is an excellent diagnostic procedure, so vertical pressure-loading will be recorded on all teeth and also lateral loading with quick release gives us interesting information about teeth that are cracked or endo that is under-filled or failing. <u>These are the things we want to know before we begin our treatment, aren't they?</u> Vertical and lateral percussion, also used in endo, are remarkably important.

People Without Perio May 16 - 18, 1991

The person comes in with 140 surfaces available in their adult teeth and more than 10% of those surfaces have plaque on them; they either don't know they have it, or they don't know how to get it off and in either case that's easy to correct. If they know they have it, know how to get it off, and they aren't getting it off. . . they are a difficult behavioral challenge and to stimulate the motivational behavior that's within them is indeed the responsibility of the professional prior to any hands on care.

Do you call the carpenter when the house is still on fire? Is it morally correct to treat the person with etiology still acting when you know, and so do they, that this is indeed the case. I think not.

The preventive instruction can follow through as a part of this examination; it builds trust, increases faith, and prepares the person for the process of rehab in a way that's seldom been promulgated across the profession. I strongly believe that the therapeutic aspects of the CLO-2 formulas. . .both as sulcular irrigation and as a mouth rinse, in toothpaste, in appliance soaks and scrubs. . .provide an entirely new frontier for wellness and should be included as a part of this process.

Let's not forget Interplak, Interprobe and a host of other technologies that are all coming up on IBM-PC which is where I'm currently storing my radiovisiography images rather than filing them.

This is indeed a new time, and as my friend, Tom Russell, says, "Thanks for helping me see that the next rung on the ladder is within my reach."

We're on our way!

Microscopy deserves, almost, a separate newsletter as does RVG and T-Scan. I'm certain that will happen.

Ratcliff's differentiation with the microscopy is so far ahead of what's happening, generally, in the profession of either medicine or dentistry as he peeks through the only live portal that allows the view of the immune system in function. I must encourage him to produce the proper "psychobabble" outside of UPDATE for those of us who want to checklist it. Look for the <u>People without Perio</u> course to produce the objectives in the Magerian way so that the student will understand the philosophic and clinical aspects of microscopy.

Please hear me say that I see this as a free-standing project for providing a unique screening process for people coming for this, solely, as inclusively as it may also embrace prevention, but it does not associate itself at all with a practice.

Think about that.

The socio-political power of having that kind of operation is, I believe, exceptional.

I do not believe it's unfair that your niche market be served in addition to the arrangement as, although I believe history shows that this can free-stand, on its own and be a good income center, it can also be a great help for the segmented target marketing of your own practice if you're sophisticated enough to have such a target market in your mind.

Again, as I began this newsletter, I also mentioned that this might be an expansive idea system for the generative marketing and the thoroughness with which you begin to practice general dentistry in your own office and not be a free-standing idea system at all.

In either case, I believe it belongs.

The newsletter addenda will give you a quick review in the form of a letter to a physician who's on a hospital administrative team and who also has an exceptional personal practice in the specialty areas where his "flank" is exposed.

Obviously, this letter to a friend rambles on because of my informal nature.

If you were to write one for either your own private practice marketing or for the initiation of a comprehensive clinical experience for people, I would recommend that you do a survey of the available technical revolutions that are at your disposal as I've listed only a few.

The idea seems to be growing off the pad, and the executive health centers as well as the preventive dental health centers in London are in full swing.

It's been done, so. . . it's probably possible!

. . an idea system for generative marketing in your own office.

Napili News

It's finally Fall in Arizona! I now have a more clear empathy for the comment "I love to see the seasons change". . . Changing from 100+ degrees to less than that is the season change I love!

The kids are back in school, summer vacation is a pleasant memory, the persons coming for care ARE coming for care. . . time to re-new and re-create. . . the 1991 Napili calendar is going to the printer this week!

Omer and I are leaving for Australia on the 14th of November, excited about traveling to Adelaide for a team-building workshop (19-20-21) and then on to Melbourne for a closed circuit video, micro-teaching experience in case presentation (23-24).

The Million Dollar Roundtable, Napili 8, will occur in Phoenix 7-10 November. The format (paradigm) has shifted from the traditional three doctor rotational series to a potpourri of subjects and clinicians. We'll be discussing the polytechnical revolution in dentistry (laser, radiovisiography, T-scan, PerioProbe, Dentran, CAD/CAM) with appropriate speakers. . . Scott and Julie Ford, Bobbie and Perry Ratcliff, Jeff Zeig, Carl Hammerschlag, Roberta and Jean-Claude Haas, Terry Meyers, Cliff Ruddle, Kathleen Lang, Kary Wilson, Margaret Folch and . . . ta da! Suzie Redding who will bring our focus on prevention current! It will be, as well, a wonderful reunion of past and new attendees, clinicians. . . Tuition is $1675/doctor and spouse, $350/additional person. . .much more than enough for less than too much.

COME, JOIN US!

Marci Reed

President
Napili Seminars

NAPILI PARTICIPATION

A friend handed this to me today. . .

POSITIVE ENERGY CREATES SUCCESS

Every great work and discovery first existed in someone's mind as a vivid positive image. Mental pictures can create physical manifestations.

To create a climate for success to grow, think and speak well of your health and your work. Use positive self-talk on a daily basis. Don't dwell on ailments and problems or they may become stumbling blocks. Do some type of exercise, anything which promotes cardiovascular activity. A strong body and mind are inseparable. Regular exercise can add ten years of healthy living to a person's life.

We become and achieve what we think about most. We must set goals and get excited and enthusiastic about achieving them. Think about your goals every day.

Successful individuals have clearly defined game plans which they review constantly. They know where they are going every day, every month and every year. Things just don't happen in their lives. Successful people make them happen.

To be successful you must not let anything stand in your way. Remember, you never fail unless you quit.

After you have built up your self-esteem through hard work, commitment, and self-sacrifice, and your enthusiasm is bubbling over, keep it by associating with people who share your positive goals and work habits. Pattern your work after the leaders, who are best at what they do.

We take on the attitudes and habits of people we associate with regularly; so be sure to associate with people who are going somewhere.

Once you have achieved a level of success, reward yourself for your efforts. The success choices are yours. Make them every day and chart your own course straight ahead. (Robert Boshnak)

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THE EXPOSED FLANK (Letter to Physician, Addenda, October Newsletter)

"Dear John: This quick note is to initiate dialogue with you (and with the hospital) on an issue that might well be labeled The Exposed Flank.

The American Heart Association has alerted dentists to the risks of transient bacteremias following dental procedures, including the dental hygienist's "prophylaxis".

This risk is severe enough for a standard regimen to have been assembled for pre- and post-op antibiotic therapy to intercept implant, replant, transplant people from serious, even life-threatening, sequelae.

In Arizona and California, within the recent past, there have been two deaths, post-prophylaxis, as a result of cerebral abscesses traced (at least by the attorneys and the juries) to the bacteremia created by the dental hygienist's procedure. Both of the deceased were 'brittle diabetics', confessing to a sloppy lifestyle in relation to diet, exercise and insulin.

Nevertheless, the issue. . .their deaths. . .critically hinged on the dental team NOT pre-medicating diabetics (not American Heart Association criteria) prior to dental care.

No precedent or recommendation was available prior to this time from the American Dental Association, the American Medical Association, the Diabetes Association.

Nevertheless, the guilt hung on dentistry because it had not complied with the American Heart Association criteria and this 'pleased the jury'!

We now pre-medicate our known diabetes patients. The above history from the courts encourages their medical doctors of record to support us with their American Heart Association recommendations. Obviously the criteria for our pre-medication includes implants such as knees, hips, etc. . . heart valves, opthalmological and dental implants as well as the diabetics.

What are the implications in your implant/transplant surgical procedures, and your hospital's other major medical procedures, of a person having periapical or periodontal abscesses, flowing pus and transient bacteremias created by cleaning their mouths, or even having their meal?

It seems very appropriate for there to be a dependable, sophisticated, state- of-the-art screening for foci of infections in the head and neck areas prior to such invasive procedures, don't you agree?

The endodontic and periodontic screening and examination procedures
available today include brief, accurate measurements of the breakdown enzymes of disease, routine microscopy is available for near instant identification of the organisms intra-orally present and their virility and numbers. Heavy spirochetal infections are common in the oral cavities of today's public.

Oral swelling, bleeding, cysts, abscesses, cul de sacs and other chronic lesions can be identified by rapid, safe, inexpensive screening procedures. Radiation by use of radiovisiography (t.v. imaging system) reduces

exposure by 80% and is instant without developing and its print-out clarity exceeds current dental x-ray procedures.

In reality, my description is beginning to approach a "Mini-Mayo" concept as our current polytechnical revolution provides an armamentarium previously unavailable.

Five years ago when this concept was presented to the Good Samaritan Hospital in Phoenix, the directors took it seriously. A dentist was hired, a hygienist supplied, and the usual 'state of the art' dental arena was assembled.

The project began by screening the para- and quadriplegics in the resident rehab department of the hospital. The findings were astounding and highly appreciated.

The 'clinic' paid for itself over and over, interceptively and preventively, to say nothing of the emergency care that was also provided.

Second opinions or second physician's confirmation of the diagnosis and treatment plan in hospitals and/or for insurance programs are very common. Why is it that dentistry is so ego-ridden that it is insulted by even thinking about second opinion? Obviously it's critically important for your medical people and their dental treatment programs, and should be welcomed.

Executive centers exist in England for both medical and dental care. They include interview, discovery, diagnosis, treatment plan and are appreciated by attorneys, insurance companies, embassies, and the consular offices. As with Scripps and Mayo, they are reputedly popularized by the thoroughness and complementary nature of their work for the above-listed sources.

It has been shown that alert, caring persons as individuals concerned about their personal wellness and longevity also find these available diagnostic centers a Godsend.

It's clear to me that the time has come for an apolitical source with a comprehensive ableness implied by my concerns to be available in Phoenix for the essential screening, diagnosis, treatment planning and even economic estimation thoroughly accomplished and documented without the need for the person so screened to be treated by the screening Center.

Records are prepared and returned to the person screened or their referral source in a prompt, efficient, thorough manner. I have accomplished formal and subjective checklisting for a number of these procedures for persons not coming to me for care. I find second opinions in our area to be popular and, when properly documented, to be highly appreciated.

I find it to be an exclusive service, not widely offered.

Included you'll find a microscopic report of oral organisms, the Perio-Check report on the breakdown products of the disease as enzymatically studied with color indicators, the radiovisiography print-outs, the occlusal analysis accomplished on a computerized T-Scan and printed for your records, an accurate, mounted set of diagnostic models, a complete report periodontally including six scores (pocket, bleeding, plaque, mobility, recession and mouth odor) all of which are recognized indicators of periodontal disease. A provisional diagnosis is made as to which of the potential periodontal diseases and/or the admixture of them including the relative compromise of the immune system as can now clearly be diagnosed with microscopy procedures as has been originated by Dr. Perry Ratcliff.

A complete endodontic screening which includes the electronic vitality testing as well as heat and cold testing, percussion testing, vertical and lateral as well as pressure testing, vertical and lateral. These scores on a scale of one to five can be accomplished and a different view of the dentition in regard to its potential for future pathology can be ascertained.

The American Cancer Society oral soft tissue exam will be completed, documented and complete panoramic films taken and any indicated x-ray studies will be accomplished as a part of the documentation. The current health history that we have on our computer was designed by Perry Ratcliff. We find it to be extremely comprehensive.

The interview can easily also categorize the psychographic and demographic profile of the person which may be interesting to the referral source. Pediatric and orthodontic exams are reported as indicated and are available and will be accomplished as appropriate.

Preventive constructive therapy precedes any irreversible rehabilitative procedures.

The best dentistry is no dentistry.

Cutting edge procedures such as soft tissue grafting, cosmetics, esthetics, implants and corrective plastic surgery will be included as the recommendation will comprehensively include the in-house team as well as the thoroughness of a service grid of respected professionals from the community.

At any rate, John, I really feel that your private practice, which now proceeds with sophisticated surgical implant procedures and major invasive systemic procedures does so with a 'flank exposed' that's unnecessary.

It's easy to eliminate the foci of infection and/or to deal with them intelligently, to study and carefully understand the psychoneuroimmunological factors of the person as well as their immune system's current function to some degree and both your sophistication in practice and that of the hospital it seems in this day of litigious societal structure would best be served by a comprehensive screening such as this is.

I believe that the contingency suits that are presently bringing a third of the fee to the attorney are price-fixing of the finest order. I don't know how they can away with it when in our industry it would be construed to be a federal offense.

I further believe that the original law that allowed contingency suits of this sort were for the protection of the poor and I doubt seriously that issue by the interpretation of the law, if properly tested in the courts, would allow the current rage of misery that goes on as dentistry is now the 'rich young ruler'.

There's a new lady on the street and her name is SUE, and that's what everybody is doing. In fact, with some tongue in cheek and humor, I notice that attorneys are even beginning to sue each other. Three cheers for that confusion.

At any rate, John, this letter is designed, as I early said, to stir dialogue and to stimulate our next meeting.

The ball's in your court. Check your calendar and let's get together. Sincerely yours, Omer.

REED'S INTERNATIONAL LETTER

Dear Friends

Some years ago, a radiologist in California studied office records of a dozen dentists who had been in practice five years or more. His research uncovered, as x-rays and records were read, that there was over a million dollars of uncompleted dentistry in the files, excluding perio, which he chose not to attempt to diagnose with x-rays and records alone.

Thence cometh the title

FILE CABINET MILLIONAIRE

The available dentistry among the people coming for care, presently, if accomplished, would preclude our caring for anyone else in the practice, probably in a lifetime. I'm certain this is a true statement, if we were to include the "re-cycle" of even our own work, which has, over a chronological period of time for those of us who've been in the same location long enough, been a part of our practice.

We, of course, don't "own" the reasons that people are being "watched" in our practice, instead of receiving our care. We always see the issues outside of self. I choose to have this blurb follow "Mini-Mayo" simply because, with the thoroughness of examination that's being made available by today's poly-technical revolution and the conceptual application of our current skills, there's hardly any excuse for our not being at least aware of, and helping the person coming for care be aware of their need, the answer to their need, the source, the time and the cost.

The work of Bob Barkley on co-interview, co-discover, co-diagnosis, co-treatment planning. . . and the absolute paradigm busting revolution of co-developing the fee. . . provides new opportunities for us, never before experienced.

Treatment consultation, as now reviewed in the audio cassette series, REED POWER II, (if you haven't a copy, call 1-800-333-9769), includes the necessity of altering our skills for the large fee case presentation. We can no longer stand in the way of the person coming

for care and their having that care without accepting the responsibility personally.

The Napili 5 adage, "If they have the need for the care, they can afford to pay for the answer to their need, and they don't buy it, it's your fault" is much too strong a pill for most.

Do you know your "top one hundred"?

Nevertheless, it would be interesting for me to have you now review some of the "nugget-mining" that can be accomplished among the existing people in your practice through internal marketing as we consider the file cabinet millionaire status we all share.

I see it as being absolutely true that the new person experience in the practice is sadly lacking; that front desklessness and the non-piecework fee scheduling concepts have failed to break dentistry's paradigm for most of us, and therefore the language tools with which we think constipate our concepts.

Only when we can step outside of the paradigm of today will we honestly own up to the challenge of the "file cabinet millionaire". The personableness with which the individual coming for care is received by our office is accelerated beyond belief by the singleness of purpose that front desklessness provides.

When one is met at the door and never left, let alone when being met by the same person each time, the power grows.

Since the paradigm in which we live, once shattered, requires much fence-mending, a few "how to's" are in order.

The big IF is: Have you the testicular fortitude to see beyond your existing paradigm and make the major changes suggested in the last year's newsletters?

If indeed this has been accomplished, then the "how to" suggestions that I suggest will not only make sense, but bring full schedules and fee increases that are reasonable and healthy for the economy of our practices.

Once the new person experience has matured and carefully documented, it would be only fair that those people who are in your "top one hundred" and/or on your referral list for internal marketing, (those people who trust you enough to send their friends and relatives). . . these preferred people deserve an opportunity to enjoy your **now NEW** new person experience. So, why not invite them in for one. A note to them might read as follows:

"Dear Mrs. Jones: You've been in the practice for three years (five years, ten years. . . whatever) and since you've trusted us enough to send your friends and relatives, I feel it's only reasonable that I invite you as my guest, (at a reduced fee. . . however you want to write it) to experience the heavily modified new person experience in our office.

"Since you came to us ____ years ago, we have experienced a polytechnical revolution in our

OMER K. REED, DDS

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armamentaria for examination, diagnosis and treatment planning. We have also psychologically and technically been exposed to new idea systems that have made it a much more thorough experience. If anyone in the practice deserves to understand that experience, it's you!

"I would certainly not want someone that you refer to me to graciously thank you for their experience and, in describing it, surprise you with the things that you didn't know about.

"Therefore, after your next hygiene visit, I encourage you, rather than at our $300-500 new person examination fee, to come in for a $45 experience where we will take completely new records, interview you as if you were a new person in the practice, and carry forth our diagnostic procedures in a manner that will be educational for you and be helpful in accelerating your knowledge of self of our practice.

"Sincerely yours. . . "

Now, you see, this really gives this person an opportunity to do just as your letter recommends.

This also opens the door and lets them back in the ballgame for the work that's on their record that's either not been presented, or presented and not been accepted and/or accomplished. It certainly uncovers, with sophistication, a lot of opportunities for them to be whole in this brief life they're experiencing (prior to their not being employed, prior to their retirement and fixed income time) to be optimally rehabilitated and to be associated with the wellness of longevity that is deserved.

This idea has been proven to be pure dynamite.

You deserve to understand the experience.

For most of the doctors/practices reading this letter, there may be a lot of ground to cover in preparation for this letter being written. A complete re-vamping of the new person experience, a complete re-vamping of the examination, diagnostic armamentaria and a sincere effort to be "state of the art" if not "standard of care" in regard to the appropriateness of the measurements taken prior to diagnostic procedures and treatment planning.

The opportunity for these people to co-labor with you, dialogically, in these first four of the five significant steps will probably be new for most of them. . . and indeed, may even be new for you.

Does a doctor have to do all of these steps himself? No. And in some cases, it would be best if the doctor didn't do any of them.

Opportunities are uncovered for those persons coming to you for care.

Certainly, in the mini-Mayo concepts as of the last newsletter, most of the work can be done by other people on the team; in fact, perhaps all of it can be. We have some very sophisticated people in dentistry today in the form of cell biologists, dental hygienists, immunologists. . . the dental degree

A unique letter to the person who's trusted you for care. . .

This kind of energy is buried in the records of your current practice. . .

is not the only one that makes the mark in our time.

Joe Ellis, Houston, Texas, is not one who sits in the wings waiting for things to happen. He's come upon an idea similar to this and he's implemented it with his computer. If accomplished in your practice, it will also "knock a few socks off."

Enclosed as an addenda is one of the letters Joe has written to people who are five, ten or fifteen years in the practice (and/or all the above) celebrating the wellness that they have achieved since their rehabilitation and citing the economic investment not made since the time of that rehabilitative process and the years that have gone by since.

It's really something, you know, to have been rebuilt in 1965 and have spent more money per year at the barber/beauty shop since then than has been spent in restoring the mouth. . . and not be pushed to celebration.

Without question, if these people aren't on the top one hundred in practice and/or on the major internal marketing referral list, they will be by the time they so celebrate with you.

I would not hesitate to encourage a wine and cheese or open house, or barbecue. . . whatever. . . in an orderly fashion with private invitations throughout the year to accelerate the appreciation and to focus, consciously, on the dialogical power that can come from sharing this obvious information that remained buried in the records.

The file cabinet millionaire will also note that the "state of the art/standard of care" in wellness maintenance today requires a recare program that is decidedly more sophisticated than the average dentist conceives. The work of Jan Lindhe, recent Dean of the Dental School at the University of Pennsylvania, during his years in Sweden shows no cervical recession over an extended period of time with a large sampling of people who kept their own plaque off on a daily basis and were polished coronally and sulcularly irrigated six times a year, once every two months. Insurance pays for two, they pay for four and the wellness and longevity that they achieve is fitting the model they've chosen.

This would mean, in an average practice, an easy projection of 35% of the total gross being in the hygiene department. "File cabinet millionaires" would use this tremendous source of energy during practice transition or business succession as 1500-2000/week could easily be taken from a hygiene cash flow, such as this, for the buyer to pay the seller for the practice without encroaching on the production of either of them during their transitional or conversion period.

This kind of energy is unknowledgeably buried in the records of your current practice.

A number of the Pentegra members have between 600-1000 records in the practice and are producing between $600-1,000,000 a year with the low numbers and a relatively reasonable turnover of new people coming to the practice.

How many new people do you need if the rate of care is accelerated to the point where it logically could be with people who value your services?

The idea of adding new people in volume to the practice not only wears out the carpet, but it wears out my thinking box when it comes to doing less for more in order to make the mark.

There are more people demanding private care dentistry today than there are dentists providing it. The concept is ill fit to the mind of the average dentist in America today and in a time when the "18-wheeler" is thundering down the road to oblivion.

It would seem that some of the sophistication of single-chair scheduling and proper overhead design (with a schedule being "feed forwarded" to monitor its credulence) would reign.

The truth of the matter is that in far too few practices is this a reality.

This undoubtedly contributes to the thriving of Napili Seminars and the Pentegra consultancy.

The number is growing. The excitement is high.

The People Without Perio person practicing dentistry today has a remarkable awareness. He does endo screening, perio screening, oral surgery screening, orthodontic screening on the new person coming for care not having to extend to the extreme being offered by the super sub-specialist, just being thorough with the mid-range of knowledge and awareness empowering average practices to double their nets in twelve-month periods.

Let's clean up our acts, increase our production per unit time, decrease the overhead ratios by properly feeing our services and products, and enjoying the peace of mind deserved by professionals who are happy, healthy, wealthy and wise.

Omer

How many new people do you need. . . people who value your services.

Napili News

When this arrives, Omer and I will be winging our way to Australia, to Adelaide for a team-building workshop, and then on to Melbourne for a case presentation seminar. . .our second Thanksgiving in Australia. . . perhaps we'll start an Aussie tradition of turkey and all the trimmings in November.

Gary Manning, our London subscriber, has become a member of Pentegra, so Omer and I will do the on-site visit in early December. . . you know how it is, tough duty. . . but someone has to do it!

Napili 8 - The Million Dollar Roundtable. Wow! Such a terrific group of "past timers" and "new timers" . . . the networking works.

The 1991 Napili calendar is on its way to you even as you read.

January 9-13: Accelerated Napili 3/4 (Model-building, Economic Core of Model-building) is an opportunity to prepare the workbook in your home arena, bring it to Hawaii, stay where you choose (a tent on the beach?) and spend two half days, two full days in dialogue, group and personal, with your ten year plan. Reserve your workbook NOW.

I have two spaces remaining on the River Raft trip, June 21 - 29. We're offering a 10-day excursion to Norway, another great foreign travel experience, August 22 to September 1. . . the price is right, the dates are good, it'll be a new adventure for us and we welcome "joiners." Call me for more information, I have the itinerary and the cost is $2709/person.

Come, join us. . . we enjoy being with you.

Marci Reed

President
Napili Seminars

N A P I L I   P A R T I C I P A T I O N

DIFFERENT DRUMS AND DIFFERENT DRUMMERS

If I do not want what you want, please try not to tell me that my want is wrong.

Or if I believe other than you, at least pause before you correct my view.

Or if my emotion is less than yours, or more, given the same circumstances, try not to ask me to feel more strongly or weakly.

Or yet if I act, or fail to act, in the manner of your design for action, let me be.

I do not, for the moment at least, ask you to understand me. That will come only when you are willing to give up changing me into a copy of you.

I may be your spouse, your parent, your offspring, your friend, or your colleague. If you will allow me any of my own wants, or emotions, or beliefs, or actions, then you open yourself, so that some day these ways of mine might not seem so wrong and might finally appear to you as right. . . for me.

To put up with me is the first step to understanding me. Not that you embrace my ways as right for you, but that you are no longer irritated or disappointed with me for my seeming waywardness. And in understanding me you might come to prize my difference from you, and, far from seeking to change me, preserve and even nurture those differences.

"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, 2999 North 44th Street, Suite 650, Phoenix, AZ 85018."

Mr. W. O. Payne
4 Goodcare
Houston, TX 77904

Dear W. . .

I want to personally congratulate you on being well. By achieving your present state of wellness you are connected to a small, very discriminating group of people who share certain attitudes and values which bring forth a superior quality of life, both for yourself and for all those around you.

One of these values is personall freedom. . . self determination. . . steering your own ship. You have chosen a course which is now being shown to significantly increase both the quantity and the quality of your life.

Today I reviewed your records as part of a study to find out how people get healthy and attain age one hundred at the same time. Here is a brief synopsis of your last 15 years of dental care:

Initial Visit:

In 1973 you came in with many decayed teeth and infection (of which you were unaware) in your gum tissue. Remember? That was a long time ago. You chose to learn how to control your own disease and to begin a period of reconstruction.

Bionic Reconstruction:

Over the next there years (through mid-1976) you stopped your gum infection and we rebuilt the decayed and missing teeth so they were stronger, looked better, felt better, chewed better, and were more cleansable.

Wellness Care:

Since that time (1976) tooth repair has been almost non-existent. You have recently chosen frequent cleanings and dental health monitoring. Your dental repair bills have become less than your barber bills. You have become self-insured and independently healthy using us as your servants.

Study of our older ppopulation group is showing a ten-year increase in healthy life span in the last five years. These are people in their late 80's with no signs of slowing down. They travel, play golf, write, etc. . . They're headed, full steam, for active 90's. The profile of this group is similar to yours; bionic reconstruction over a two- to five-year period, followed by wellness care for ten years or more. Preliminary findings indicate that this increase in yuears may be related to a stronger immune system, due to control of periodontal disease for more than ten years.

Again, congratulations, W. Welcome to the "inner circle."

Please call if you want more information.

Here's to a healthy longevity.

Joe

[illegible]
[illegible]
[illegible], TX 7[illegible]

Dear [illegible]

I want to personally [illegible] you on [illegible] week. By [illegible] you [illegible] group of people [illegible] for [illegible] life [illegible]

[illegible] personal [illegible] self [illegible] significantly increase [illegible] ability of your life.

Today I reviewed your records [illegible] to find out how people [illegible] one hundred at the same time. [illegible] synopsis of your [illegible]

[illegible]
In 197[illegible] you came in [illegible] had [illegible] infected [illegible] [illegible] how [illegible] and to [illegible]

[illegible]
[illegible] and teaching them [illegible] so they were [illegible] better [illegible] acceptable.

[illegible]
[illegible] health has been [illegible] have become [illegible] have been [illegible] independently [illegible] yourself.

Study [illegible] years or more. [illegible] summary findings [illegible] that this increase in [illegible] may [illegible] stronger [illegible] disease for more than [illegible]

Again, congratulations, W. [illegible]

Please call if you want more information.

[illegible]