NEW DIRECTIONS IN DENTISTRY

REED'S INTERNATIONAL LETTER

February 1992

Dear Friends

"Vision" and "mission" are essential to daily decision-making. If you know how much enough is, and where you're going to be when you arrive, the following outline "memo" accelerates.

ENTITLEMENT. . .

MEMO: Dr. John Q. Toothsaver & Team

RE: Practice Data

Enclosed is the practice data for the last few years as well as projection (budget) for the coming 1991 fiscal year. These projections suggest that the practice will gross $406,453 at the end of August 1991.

The assumption is that the practice will have a gross collected production of $500,000, beginning September 1991, and ending August 31, 1992.

The $500,000 goal is broken down into production by doctor and hygienist:

Projected Dentistry $375,000
Projected Hygiene $125,000

The amount of increase from the year just ended:

Dentistry . . . . $ 69,209
Hygiene . . . . $ 10,137

This works out to a daily dollar increase (assuming a 155 day work year) of $65.40 more per day in hygiene and $446.50 per day for you, Dr. Toothsaver. Hopefully these amounts will feel realistic to you.

The big change from the year just ended to your new year is the expense side of the ledger.

Each package has a "Vital Signs" informational in it. Please familiarize yourself with this information. You will find it to be a helpful tool in managing the areas of the practice for which you are responsible.

For example, in the fiscal year just ended, it appears that the cost categories incurred the following dollar and percentages of gross expense:

	1991	%	1992 Goal	%
Lab Fees	$ 24,336	6.00%	$ 29,936	6.00
Clinical Supplies	$ 34,452	8.48%	$ 35,000	7.00
Office Supplies	$ 7,482	1.84%	$ 9,204	1.84
Team Compensation	$120,334	29.61%	$125,000	25.00
Fixed Expenses	$110,494	27.18%	$ 85,681	17.14

Higher productivity can be achieved through each individual supporting the philosophy of optimum oral health.

You will notice there is a slight increase in the amount of funds dedicated to team compensation. More importantly, the percentage allocated to team is now in line with what a economically healthy practice must have to stay in business.

The thing about a percentage share in the gross collected dollars is that if the practice were to gross $600,000 in the next twelve months, you, as a team, could share or split $29,666. Said another way, divide this by the number of team members participating in profit allocation and it could be as much as $6,000 more income versus your last year's compensation **EACH!** At $500,000 this amount is a $4,666 dollar split. Anytime fees are raised, you get a raise. Anytime th practice goes above goal, you share in 25%.

Can your practice do $600,000 or $700,000? Based on what has been done by other practitioners, the answer is YES! For Dr. Toothsaver to produce $475,000, he would need 7.02 gold inlays (one surface) per day and if hygiene produced $125,000, a $65 dollar a day increase, you, the team, could see over the next year a $6,000 increase in your income. The enclosed graph shows what your allocation in dollars might look like at different levels of practice productivity combined with a 7% annual fee increase.

One of the ways higher productivity can be achieved through the practice, is through each individual supporting a philosophy of Optimal Oral Health. The hygiene program can include the People Without Perio philosophy as well as identifying **every OPPORTUNITY FOR CARE** with which a patient presents. If this type of program is taken to heart, you will have more production than your schedule will allow.

What should the owner/dentist earn from his practice? This brings us to John Q. Toothsaver, President and Chief Operating Officer of John Q. Toothsaver, DDS, PC. As an investor, Dr. Toothsaver has chosen to take the money he could have invested in Certificates of Deposit at the bank and put it into a company investment called his practice. If Dr. Toothsaver decided to take some risk wit

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his money and yet "play it safe" he could have invested his money into high grade investment bonds and earned around 10% on his money. Instead he felt he could get a better return by investing the money in his practice. If this is true, and statistically it is, Dr. Toothsaver should expect that each year his investment should give him 10% interest on his money. Since Dr. Toothsaver works there as well, like you, he is paid for the work he does, most dentists can become an associate at a practice of another dentist for 30% of what he/she produces, much like a hygienist. If this is true, then Dr. Toothsaver would be able to make 30% for what he produces and 10% investing his money somewhere else. This means that last year, if everything went well, Dr. Toothsaver should have made:

Dentistry Produced \$305,791 x .30 =	\$ 91,737
10% Interest on \$406,453	\$ 40,645
Gross Income for the Year	\$132,382
Dr. T's Actual Income	**\$109,299**

This is a low figure considering an investor should not only get 10% return on his investment, but he should also get a 10% return **of** investment plus his salary for working and producing in the office.

For the coming year:

Projected Production \$375,000 x .30 =	\$112,500
10% Return on Investment \$500,000 x .10 =	\$ 50,000
Additional Risk Premium and Return **of** Invested Capital	\$ 50,000
Total Estimated Income for Fiscal Year	**\$212,500**

Memo prepared by Neal Van Zutphen, Pentegra's CFP.

The additional rate of return is compensation for the risks of running your own business. If collections are down, the team still gets paid and the doctor passes on his paycheck. The risk of being sued for more than \$1 million dollars seven-ten years after the services are rendered is another. **The lower the risk the lower the rate of return; the higher the risk, the higher the rate of return should be.**

Of course, nothing in this budget/projection is written in stone and we have yet to put together a model which is "perfect," so your input will be helpful to us to get you numbers which make the most sense. If you have questions, don't hesitate to call.

Omer

Napili News

The American Academy of Dental Practice Administration's meeting, at The Phoenician in Scottsdale, promises to be magnificent. . .hope to see you there, March 4 - 7.

A few of us will miss the final "gala" as we'll be departing late afternoon for an overnight flight to the Asian Pacific Dental Congress in Auckland and from there to the South Island to hike the Milford Track.

We will return for the **Team-Building** workshop in Nashville at the Marriott Hotel. Four of Omer's team people will be with us. I'm aware that "team-building" is a bit like psychobabble. . . it is, in fact, a "wet-gloved" "hands on" experience presented by doctor and team, dental healthcare professionals. . . who continue to be "in office" for those persons coming for care. Nashville, an airline hub, is the site chosen in response to survey requests for a team workshop in the East. . . **February 27-28-29. $1650/doctor, spouse and two team persons, $350/additional person.**

The People Game - Dentistry, a workshop for doctor and spouse will be presented in Phoenix, **April 2-3-4.**

We have an exclusive safari planned around the South African Dental Congress, 6-19 August. We'll be in the Kahari Desert at tented camps for gameviewing, we'll be at Victoria Falls and Etosha. Serious travelers, come, join us!

Marci Reed

President
Napili Seminars

NAPILI PARTICIPATION

"MAKE MY DAY. . . . ."

Dear Mr. & Mrs. Smith:

My staff and I often discuss what makes any day at the office better or worse than another.

Smooth scheduling helps. So do crowns that fit on the first try, and equipment that doesn't break down.

More than anything else, though, what makes a day good or bad for us are the people we meet in the course of doing our jobs.

Lately we've tried to imagine a perfect day at the office.

Which people in our practice would be on the schedule, and what is it about them that always brightens our day?

Each of us listed the patients we always enjoy seeing and the qualities we think make them enjoyable.

We all agreed that the favorite fifty, or one hundred, or however many made the list, shared an appreciation for their dental health and an enthusiasm regarding our services.

They followed our recommendations at home, made prevention and maintenance a priority and told their friends and family about us.

They offered their opinions, told us a good story and left us with a laugh or a smile.

We want you to know that your name made our "perfect day" list.

We thank you for allowing us to provide your dental care, and we appreciate your trust in us.

We always look forward to seeing you. . . and we wish you all the best in 1992.

PG and Team, West Palm Beach

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SHORT RUN ANALYSIS OF PROFIT ALLOCATION vs. TYPICAL RAISE STRUCTURE

Short run model seems better for team at Typical Raise Structure until higher numbers are achieved.
Higher numbers work better for Dr. under short run.
Team and Dr. Goals always at odds under this structure.

	1991 Actual	1992 Target One	Target Two	Target Three	Target Four	Target Five	Target Six
Gross Collected 1 Growth in 1 yr.	$406,453.00	$450,000.00 10.71%	$480,000.00 18.09%	$510,000.00 25.48%	$540,000.00 32.86%	$570,000.00 40.24%	$600,000.00 47.62%
Team 2 Compensation 3 % of Gross	120,334.00 29.61%	128,757.38 28.61%	Typical Raise 128,757.38 26.82%	Structure @ 128,757.38 25.25%	7.00% 128,757.38 23.84%	128,757.38 22.59%	Good for Dr. Bad for team 128,757.38 21.46%
Net Salary 4 Increase Growth in 1 yr.	19,811.00	8,423.38 7.00%	8,423.38 7.00%	8,423.38 7.00%	8,423.38 7.00%	8,423.38 7.00%	8,423.38 7.00%
5 Team Allocation 25.00%	101,613.25	112,500.00 Okay for team Bad for Dr.	120,000.00	127,500.00	135,000.00	142,500.00	150,000.00 Good for team Good for Dr.
Variance from desired 6 Allocation	($18,720.75)	($16,257.38)	($8,757.38)	($1,257.38)	$6,242.62	$13,742.62	$21,242.62

1 Because of Dr.'s desire to improve returns from practice higher targets are attractive. Control over other expenses are easier to manage. Therefore, Dr. is willing to see team receive allocation surplus (see #6).
2 Since team perceives Typical Raise Structure as a tradition they often have trouble supporting enhancements in practice and changes in fee structure that are necessary to achieve growth. When Dr. feels resistance to growth he seeks to control cost to achieve profit.
3 Dr. tends to achieve appropriate business ratios through enforcing a Typical Raise Structure.
4 Team only sees moderate salary increases at all levels of growth for themselves and has difficulty supporting appropriate growth. This tends to accelerate a vicious cycle or "tug of war" where someone has to loose in order for someone else to win.
5 Profit allocation allows Dr. to win appropriate business ratios and higher bottom line results. Team wins higher growth potential with no games played, never has to fight for raises again.
6 Negative numbers push Dr. into "poverty" or cost control mode. Positive numbers push everyone to team performance and higher levels of development.

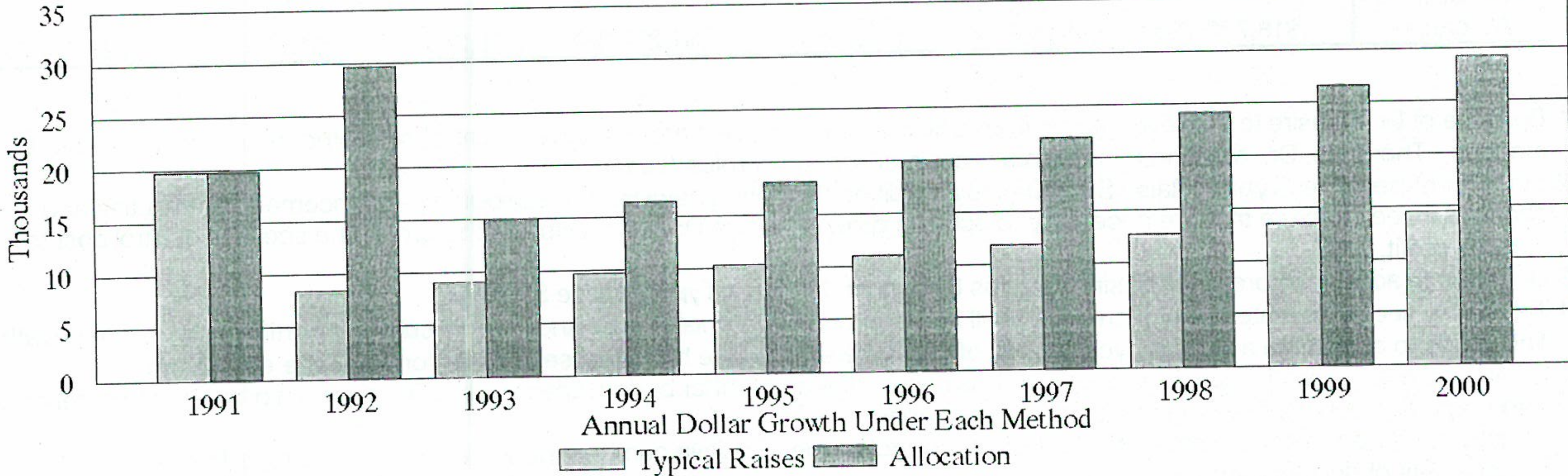
LONG RUN ANALYSIS OF PROFIT ALLOCATION vs. TYPICAL RAISE STRUCTURE

Although Target Six is drastic growth in year one, it allows smooth growth over long range model. Using Target six with a 10% growth of practice after 1992 long range comparison is more "win-win" for all. Compare Allocation to Typical Raise Structure at a 7% . Base compensation rises under allocation at the rate of 7% as well. (Bas comp. = Wages, Taxes, Insurance and Benefits). Profit Allocation amounts based on Total Team Allocation of 25% .

Year	1991 (actual)	1992	1993	1994	1995	1996	1997	1998	1999	2000
Gross Collected	$406,453.00	$600,000.00	$660,000.00	$726,000.00	$798,600.00	$878,460.00	$966,306.00	$1,062,936.60	$1,169,230.26	$1,286,153.29
Typical Wages	120,334.00	128,757.38	137,770.40	147,414.32	157,733.33	168,774.66	180,588.89	193,230.11	206,756.22	221,229.15
Dollar Growth	$19,811.00	$8,423.38	$9,013.02	$9,643.93	$10,319.00	$11,041.33	$11,814.23	$12,641.22	$13,526.11	$14,472.94
Total Team Allocation	101,613.25	150,000.00	165,000.00	181,500.00	199,650.00	219,615.00	241,576.50	265,734.15	292,307.57	321,538.32
Base Compensation	120,334.00	128,757.38	137,770.40	147,414.32	157,733.33	168,774.66	180,588.89	193,230.11	206,756.22	221,229.15
Profit Allocation	Not affected this year!!	21,242.62	27,229.60	34,085.68	41,916.67	50,840.34	60,987.61	72,504.04	85,551.35	100,309.17
Dollar Growth	$19,811.00	$29,666.00	$15,000.00	$16,500.00	$18,150.00	$19,965.00	$21,961.50	$24,157.65	$26,573.42	$29,230.76

(Profit Allocation equals Total Allocation minus Base Comp.)

Dr. Tooth Saver's Team Compensation Study
Comparison of Growth Capabilities



(Note this beginning. . . and watch carefully!)

NIPPON LIFE'S U.S. SUBSIDIARY UP AND RUNNING

Iowa regulators have given the newly launched Nippon Life Insurance Company of America the final go-ahead to start underwriting business. The company is licensed in 44 U. S. States and the District of Columbia.

The company, which will be domiciled in Des Moines, Iowa, plans to underwrite and offer group life, health and disability insurance and pensions, underwrite and to perform direct servicing.

According to a Nippon spokesman, the company will market primarily to the estimated 3,335 Japanese-owned companies currently doing business in the U. S.

Standard & Poor's Vice President, Timothy W. Clark, however, expects that, if they are successful in that market, they will expand beyond it. "It's a logical next step."

Nippon is seeking licenses in the remaining six U. S. states but can currently write business there through NLI Insurance Agency Inc., a wholly-owned subsidiary that Nippon Life established in 1984 to market to Japanese subsidiaries.

Nippon, the first life insurance company established in the U. S. by a Japanese parent, will get a $43 million capital infusion from Nippon Life in Japan.

Akira Ogata has been named president of the new company. He is currently president of NLI, which has been working with U. S. life insurers to service Japanese clients through offices in New York, Los Angeles and Chicago, according to a spokesman.

"We will take full advantage of what we have learned these past years working in the American insurance market," Mr. Ogata said. "Moreover, we intend to design employee benefits plans, provide a full range of employee services in Japanese and offer a toll-free telephone line to better serve our customers. By doing so, we hope to provide even more extensive services to Japanese-owned companies in the U. S."

Nippon's activities in 1991 have put it in a "very strong position" in relation to its competitors in the U. S., Mr. Clark said.

"We would expect to see other Japanese companies following the same route," Mr. Clark said, adding that "within the next several years" the Japanese will have a strong presence in the U. S. life market. Nippon plans to have about 40 employees initially, including 16 who are being sent from Japan. Executive offices will be located in Des Moines and New York City, with branch offices in Los Angeles and Chicago.

Collection of group life, health and long-term disability premiums and benefits payments will be carried out by Hartford-based Travelers. Des Moines-based Principal Financial Group will provide investment services and administrative support for group pension products.

"This will be a joint team effort with Travelers and Principal to bring quality service to our customers," Mr. Ogata said.

(NATIONAL UNDERWRITER, JANUARY 13, 1992. . . Cynthia Crosson)

REED'S INTERNATIONAL LETTER

Dear Friends

I believe the future of dentistry in the next twenty years in some part comes out of its past. Who we are relates to where we were when. A great mass of values and decision-making equipment remains glued to the self-image of the dentist, his self-esteem, and that of his team. This self image is the window through which the world is seen and considerably flavors truth and reality in the present.

21st CENTURY. . . A REALITY CHECK
(Within Reach, but Beyond Belief)

Having had the privilege of averaging over three seminars, lectures or symposia per month for the last year, being pit-soaked across North America in the attitudes of dentistry, I sense that the present out of which the future will emerge is perceived by dentistry inseparably as being three-fold . . . philosophic, economic and polytechnical.

In an economic sense, I see dentistry perceiving the marketplace as "up the down escalator" with world economy influencing local communities, if not in fact. . . in attitude. Yes, there are many practices that have broad bases and/or articulate service-oriented teams that are continuing their growth patterns by intent, however, the reports come to me that new person frequency and the investment they make in themselves when they come to the practice have fallen off sharply effecting the attitude and performance of the dental team.

I sense that this factor inhibits the dentist's future focus, and like most American businessmen, perhaps views his business plan as having a six months' life expectancy. I strongly believe that a minimum of ten years for marketplace, productivity and finance is critical to small business and I have direct contact with those in dentistry who believe and function in this manner. I sense their practice stability is in large part a function of their self-esteem and their self-image.

Their "attitude" determines their "altitude" . . . and the progress continues.

Philosophically, I see major changes in the approach to thinking as dentists review how they speak and act as they interface with their market. Such

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paradigm shifts as transferring from a piecework fee schedule to a non-piecework fee schedule allows the team to see their service in the fixed and variable cost per unit time base plus profit rather than on the abstract disassociated piecework fee schedule basis.

With productivity and non-piecework approaches, dentists are, with their teams, providing a far more sophisticated service in an affordable manner. In the case of the posterior restoration the old favorite amalgam is rapidly being replaced by quadrant inlays, both the cosmetic and the cast gold variety, in a manner that is revolutionary.

Inlays at the amalgam fee. . .

The dental team can provide inlays at the amalgam fee plus the lab fee and double their net. Time studies that have brought this to focus are so abruptly changing the knowledge base of servitude that the insurance company finds itself deeply frustrated. Another paradigm shift that seems inevitable is also now very evident. Insurance entered dentistry some years back and produced no spike in the profit or the gross, only in the cost. By actual measure, the cost of producing the services at the insurance company level increased the delivery cost by at least 30% by spreading office visits, cutting the efficiency of delivery per unit time, paperwork, education, and major attitudinal and communicative resistance.

When business is monitored with appropriate handles, things change positively. Practices that have functioned on the basis of **fee minus cost equals profit**; i.e., the dentist takes home what's left, have changed. **Cost plus profit equals the fee** in any business environment is a much more monitorable and adequate way to assure a profit picture. Profit is not a four-letter word, loss is, and during a "down escalator" economy, it's essential that schedules be compressed, that the "people game" be accelerated and that the economy of the small business be thoroughly understood.

This people game is accelerated by other paradigm shifts, one of which is the elimination of the front desk. Where the person coming for care is met by the on time team person who stays with the person coming for care for the entire process rather than handing the person on to another with a "that's not my job" attitude or procedure.

By stop-watch study, the front deskless procedure has been shown to reduce the in-office time by over 30%, clearing the way for humanness and "presence" in servitude as has no other behavioral system. The administrative process also has shifted toward collateralization. No more pyramidal industrial model of "boss/grunt" relationship but leadership emerging situationally in the seamless teams as people emerge with personal power to strengthen the service to the individual person coming for care. This philosophical paradigm shift is taking hold across North America. I believe the "hundredth monkey/critical mass" in regard to these factors near its arrival point.

NORDSTROMs has learned that when people are cared for as persons, change takes place. In a world where the choice to remain the same no longer exists, take note! When "customers" and "patients" become "friends," "visitors," "neighbors," or "guests". . . when they are seen as the "ruling party". . . it's a new world.

Thanks for the ride, hierarchy. . . after 2000 years as the only organizational

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system, hierarchy's death rattle can be heard! Tom Peters notes that "flat firms" are clobbering "steep firms" everywhere!

The dental team that enjoys collateralization. . . where the person on the "front line" is in charge for the moment. . . this team is soaring above the "down escalator."

"That's not my job" is no longer heard in the dental environment as everyone has access to everything they need or want to know. Open book management, anyone?

We live in a time when exponential change accelerates beyond our awareness. The mass market "if it ain't broke, don't fix it" world is gone. If it works, and we understand it, it's probably obsolete. (If it ain't broke, you ain't looked hard enough!) These factors are disconcerting and disorienting to bureaucratic, static organizationalisms. . . of whatever size.

A problem that dentistry is confronted with is that periodontal therapy will not work when the treatment is rendered within the limits imposed by the third party carriers, including many of the HMO's and PPO's. As we review the treatments that they allow, it appears obvious that they base their allowances on outdated information. These programs generally pay for surgical procedures, not the newest, most effective procedures (the morally essential precursors to surgery) but the ones that are still considered to be acceptable. Knowing the difference, patients would not likely appreciate being treated with those older procedures.

There is also a definite trend to only provide services which are "coded". . . there is no code for prevention. When treating periodontal disease, or any other chronic disorder, unless the focus is on prevention there will be an extremely high failure rate. Prevention is the only thing that can really control health care costs, and that is most likely what people want. Co-therapy, the person coming for care caring for self, is essential prior to our care.

We cannot blame third parties. Their objective is to control health care costs, which should be an objective we share. It is unfortunate that what they all "allow" has been based on treatment that is outdated.

Actuarially, they are in business to earn money, not care for people, and this substantiatable difference is obvious.

Of course, these third parties are spending millions of dollars advertising their participating practitioners. We can't afford that kind of advertising, but we also can't afford to forget why we entered the health profession . . . to have enjoyable relationships with the people we care for and to provide quality care. We cannot fear the "one-on-one" conversations regarding our beliefs and concerns about this subject. Honesty and integrity will be a bigger practice builder than avoiding conflict and only telling patients what they want to hear. We must help the people coming for care make informed choices, based on their specific needs, rather than what their insurance will pay.

The tragedy of this is that dentists who don't understand the economy of their practice approach insurance programs as "mother's milk" and find it difficult to wean themselves. Weaned they will be as the insured is not happy with his benefits, the purchaser or

Everyone has access to everything they need or want to know.

We can't afford to forget why we entered the healthy profession.

employer is not happy with the cost, the dentist is now becoming frustrated by the reality and the insurance company is not pleased with its profitability in these packages. Watch them leave dentistry in the next half decade.

So long, mass market. . . I see each practice being personally so unique that it is a niche market. There are no non-niche markets any longer. The oft neglected subjectives such as friendliness, empathy, response-ableness are the primary tools in the successful practices of the future.

Friendliness, empathy, response-ableness. . . primary tools in a successful practice.

Private, personal care is more in demand than there are dental teams to provide it, fully realizing that private care in this manner cannot provide for all the existing dentists, it certainly is an excellent focus for those who have chosen it and their practices will continue to grow "up the down escalator."

Meskin, of JADA fame, and Dick Oliver, University of Minnesota, in their work with data from NIDR and NIH, show tremendous transition in the 90's and the turn of the century dental market. People over 55 have the greatest discretionary dollar use and net worth and 70% of the nation's wealth. The "graying of America." Dental use over 55 is no longer declining, but is increasing up to 30% with dental expenditures between 55 and 80 being 75% self pay.

Dentistry provides the great American Dream.

"Recycle" dentistry is our future.

Over 90% of the dentistry in this next decade and on into the future will be re-doing what has been done for people who value its re-do and are willing to pay for it. We have three decades of <u>replace</u> dentistry to do, and after that, the repair market is bleak.

The <u>vital signs</u> of a successful, healthy dental business will show 50% maximum fixed and variable overhead, allowing the 50% remaining to capitalize the business and salary the ownership. <u>Anything worth doing must be scheduled</u> and <u>anything monitored improves</u>.

Scheduling success and monitoring it will be the new tools properly applied to dentistry's future.

These are the "good old days" as dentistry now sees its team in new light. Asset wealth instead of income wealth will be our focus. Dollar averaging, mathematical progression will be the freedom producer of the future.

The best inflation/devaluation/depression hedge is being in the dental business, pro-actively. In an economic sense, dentistry provides for its team people, the dentist included, the great American Dream. . . the "no work" lifestyle option.

Long-term independence is defined as accumulating 13 years of your final income. To start from scratch, this means saving 10% of your income for 40 years, 30% of your income for 20 years. Dentistry, when practiced by plan, provides a future of economic independence for all team persons.

Dentistry is being forever altered by the attack on etiology through prevention and interception. New therapeutics introduced as toothpaste, mouth rinses, and sulcular irrigants presently available in approved cosmetics products, under-going FDA therapeutic approval, will, in the next decade, eliminate the "seed in the soil" of dental disease. Bactericidal rinses and toothpastes that are colorless, odorless, tasteless, non-alcoholic and

non-preservative containing, that are safe and equal in efficacy to Betadyne, the iodine compound, in their "kills on contact" action are now available.

If the seeds are gone, and simultaneously psychoneurimmunological process is better understood, the global village in which we live will be as free of dental disease as it is of polio, and the practitioners that go with them.

In this age of "AIDS", this wellness interception and maintenance is the communicative and philosophical heart of the matter for all people. It's better to stay well than to get well; it's better to keep up than to catch up.

Simultaneously, we are blessed with an outbreak of polytechnical "star wars" equipment that clearly spells our future. Radiovisiography removes 90+% of the radiation in imaging dental structures, giving us the ability to zoom, to scan, to alter clarity and shade, diagnostically improving our view and reducing radiation to the ridiculous. This particular piece of hardware, in my practice and at my rate of productivity can be amortized, return **on** and return **of** invested capital at 10% within 11 months. Three plates of eight exposures can be transferred to an IBM-type PC for recall, or printing so that the traditional full series of diagnostic films can be transferred to the persons record, to another office, either by floppy disk or modem, or via means of print-out with the high intensity screens and printers of the day, a truly paperless office now exists... no filing or retrieval problems. This imaging, done with less radiation, meaningfully replaces all ordinary x-ray machines in our office. Since the occasional x-ray film can be taken with the same machine, it's imperative that the "star wars" operatory have the new person experience include radiovisiography rather than the regular x-ray position.

TekScan allows us to store our "wax bites" and our "carbon markings" and analyze occlusal and myofacial pain dysfunction patterns, as well as normalcy in the new person coming for care, all on the same IBM/PC compatible. Wow! Deviations in the temporomandibular joint's function can be noted and recorded.

The new "star wars" polytechnical equipment must succumb to the income center, profitability, amortization as a practical business procedure. When one amortizes the cost of equipment over a period of time (seven years is my maximum) one has to determine the base line of productivity prior to the change produced by the introduction of the new procedure or equipment. We must know that this technique, procedure or armamentaria addition will, when added to our base line, produce a service that can be billed against its cost so as to produce profit in sufficient quantity to cover the cost of the equipment, plus the cost of using it.

The Francois Duret CAD/CAM, at $200,000, which can produce a quadrant of inlays with carved occlusals, contacts, marginal ridges, intaglios. . . ready to seat within an hour. . . a single crown, a three-unit bridge or laminates can be accomplished without impressions, temporaries or second visits.

The market value to the person coming for care can be calculated. I see, in a 42-month period, at my rate of productivity, this machine will have paid for itself as well as producing a

. . . the global village will be free of dental disease. . .

It's better to stay well than to get well.

Duret's CAD/CAM will be in the "Star Wars" operatory. . . on display at Napili 1, Phoenix, in April.

10% return to me on the invested capital during the time of its use.

Periocheck, Periotemp, the interceptors and verifiers of periodontal disease are amortizable in a matter of a few months as their impact on the budget at purchase price is considerably less.
If a video imaging machine or laser, on initiation, can produce a similar amortization, I'd buy one. If not, I'd be highly skeptical of the gimmick value in marketing myself to people coming to me for care. These items deserve a study.

These centers must not be loss-leaders in the practice.

An associate or a hygiene department that's profitable is certainly identifiably as important as the "other people's money" that we use to constructively place ourselves in debt and may loosely be referred to as OPH (other people's hands). These centers, as well as the new person experience, must not be loss-leaders in the practice, but must be positive income centers. Mayo Clinic in Rochester, Phoenix, and Florida, is respected for the powerful ability to diagnose, treatment plan and they don't do it as a loss-leader. Dentistry has long since let hygiene sink into that particular framework and has considered the new person experience as a non-income center function.

Run your own numbers...

Practices, properly accomplished (as a result of hard data studies we have, that I'm willing to share on request) when carefully analyzed, show 50-70% of the gross as they're practicing today could come from their hygiene department. Without question, 20-30% of that could be pure profit. A practice with 780 current personal records of people routinely coming for care, that is experiencing six new persons/month, and that grosses $540,000/year was studied "by the numbers." The code numbers available through the American Academy of Periodontology and the ADA, the differential diagnosis of the nine recognized perio diseases and the five classes of intensity, the current therapies, recognized by these diagnoses when placed against the stopwatch of performance with well-trained hygienists, uncovered over $500,000 of actively needed therapy in the practice year.

This is in addition of the practice gross of the previous year of over $500,000. The hygiene department consists of three hygienists, four chairs and two "associates" frontdesklessly assisting with prophylaxis, perio maintenance, perio therapy; double-scheduling hygienists every other day with two chairs and chairside assisting.

Run your own numbers on the future of dentistry when hygiene departments and the proper attitude toward "people without perio" is scheduled and monitored for wellness and success.

Twenty-five percent of the total gross for the team reward system in the practice puts the take-home pay at 140% of the "supply and demand" pay scale in their community. Hygiene that is wellness-monitoring and perio maintenance three to six times a year with co-discovery, co-diagnosis, co-treatment planning easily provides, in your practice, 35-70% of the gross with 20-30% of it as net.

In keeping with our view of the 21st Century and the remarkable paradigm shift that is occurring in dentistry, I must share with you that the Board Directorships which I serve and the businesses with which I'm familiar, rely heavily on "outside counsel" for their awareness and modification. Uncommon to dentistry, a real paradigm buster that is growing in popularity, I find that consultancies that can move in

and assist in the transition of profitability in all areas of one's life, including the practice. A concept that I hope will strike sparks on the flinty skulls of stone-age thinkers is the concept that "just because you're doing it yourself, you're saving money."

Ask yourself the question, "What, though impossible, if done would add to my life happiness, health, wealth, wisdom and peace of mind?" This question takes you to the edges of your paradigms of behavior and belief, lets you look over the fence. It's been done, so it's probably possible. If you give me $30,000 and I give you back $60,000 in any given year, would you take the deal? I believe dentistry will come ever more to outside consultancies for the enhancement of life and business in an accelerated fashion.

Our cloistered, monastic, small business existence has led us to believe that a do-it-yourself game is the only way to go. Selected dentists, in a "down escalator" time are showing growth of 70-80% in their net and accelerating their experiences as a result of consulting outside the immediate wall with those who have care, skill and judgement in the areas of business succession, personal enhancement, practice enhancement, crisis management and asset accumulation.There is no need to bear the fierce cost of re-inventing the wheel.A man who follows the crowd will usually get no farther than the crowd.

The man who walks with the inspired is likely to find himself in places he's never been before. We have two choices in life, we can dissolve into the mainstream or we can be distinct. To be distinct one must be different. To be different one must strive to be what you were created capable of being. It may take some outside help to see yourself as others see you in sufficient quantity to accelerate that life experience. Life itself is a race, marked by a start and a finish. It's what we learn during the race and how we apply it that determines whether our participation has had particular value. If we learn from each other and each success and failure, and improve ourselves through this process, then at the end, we will have fulfilled our potential and performed well. We will indeed have become what we're able to be.

What, though impossible, if done. . . would add to your life happiness, health, wealth, wisdom and peace of mind?

Napili News

As noted, the Francois Duret CAD/CAM unit will be present and much discussed at The People Game workshop, Napili 1, April 2-3-4, Phoenix.

Space is available, as well, for the Colorado River Rafting experience. $1550/person, due now. Rafters will meet in Flagstaff at 6:30 p.m. on the 21st of May for orientation. We'll begin our float on the 22nd and will return to Flag by mid-afternoon on the 29th; back to Phoenix for a hot shower and clean clothes. . . then the traditional hosted Mexican celebration dinner. Dick Oliver and his wife, Jackie, will be featured guests, along with some other powerful River Rats! This is an unmatched experience, bring a child. . .it's more fun than final exams!

Omer and I are not skiers; We are, however, honoring requests for a workshop in the snow (brrr!). . . ***we'll be at Park City, Utah, March 27-28, two days' work-shop with a special agenda (yours),*** *$470, $130 for additional persons.*

The agenda for our South Africa venture in August is really exciting. ***There truly are some things in life that shouldn't be put off. . .***

WELCOME!!

Marci Reed

President
Napili Seminars

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

ROSES TO . . .

Neal Van Zutphen
Napili/Pentegra
Phoenix, AZ

Neal:

My wife and I want to thank you for being there when we needed you.

As we journey through life, we are fortunate to meet a few people who literally change our perception of the world around us and make us focus on the positive.

You are one of those people.

You will always be considered a dear friend and we appreciate all you and Pentegra have done for us.

You have been directly influential in helping us begin to get organized professionally and personally. . .showing us what has been, what is, and how to implement what will be.

This has given us hope and vision; brought us out of chaos and despair into purpose and excitement about the future.

I feel ten years younger and believe the paradigm of uncertainty and dread has been forever broken and the path into the wilderness is much straighter, greener, and bathed with light.

For such a young man, you have great wisdom and foresight. May God walk with you and your family all your days.

Sincerely,

GWT

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REED'S INTERNATIONAL LETTER

Dear Friends

"There once was a bright young man who was looking for a way to make good decisions. . . to have more success and less stress in his life.

Although he didn't make many poor decisions, when he did it created problems for him at work and upheavals in his personal life. His poor decisions were costing too much. He felt there must be a better way."

YES OR NO

Many of us have made some poor decisions or have been trapped by indecision. Why were so few of us ever taught, in school or on the job, how to make better decisions?

A book review of a text by Spencer Johnson, MD, co-author of The One Minute Manager, which will be available to the public sometime soon carries with it a strong, clean message far superior to the message on "management", obsolete by "leadership emerging" and the collateralization of administrative process.

Although all of Johnson's "one minute" work (one minute manager, one minute salesperson, one minute mother, one minute father, one minute teacher, etc.) was consistent in its theme, most of us found it less than useful when dealing with one another.

I do believe, however, that The Guide to Better Decisions story by Johnson will be extremely useful to each of us. To order a copy of this book before it's available to the general public, you may phone 1-800-457-1214.

A premier film, based on this book, shot on location worldwide will be available in 1992 on video tape to businesses and other organizations from Charthouse International Learning, Joel Barker's organization (Paradigm, and Vision, which most of you have seen).

The special advanced hard-copy edition, which I was gifted, is most pleasing. My friend, Scott Ford, (who has underground sources)

procured it and was kind enough to forward it to my attention.

Confusion to clarity in decision-making has not been easy for anyone, let alone those of us in dentistry who have been less than strong in the behavioral and communication sciences and/or the economic sciences.

Yes. . .No. . . Wow! Three ways to live.

Many of the points in the book make such good sense, I thought I'd give them to you in a brief review in an effort to encourage you to further study the story.

My comments will come in the form of quotes and ad libs and odds and ends; hopefully they'll lead you to make the phone call.

"I stop a poor decision to make a better decision." The act of organizing a decision-making process initiates with this comment. Making a better decision, one does a five-minute inventory.

For example, a decision that might take place in the workplace. What is one situation at work that I wish were better? Write a brief answer to this question on a piece of paper for yourself, and do it now. Your tentative decision for this is to (and choose one of the below NOW). .

1. Do nothing.
2. Do something, but I don't know what.
3. Maybe do the following: (Please write provisional answers now.
4. My best decision is to (and I will write this after some careful thought and process which will follow.)

Also, take one personal decision. What is one situation in my life that I wish were better?

Write a brief answer as you now see it.

My tentative decision is to. . .
Do something; do nothing, but I don't know what; maybe do the following (and again write a provisional or tentative answer). Then, "my best decision follows" and, again, please leave this blank until the end of the exercise.

The suggested way to begin this better system is much like many of the other behavioral prescriptions we've seen.

To make a better decision, use a better system.

I use my **head** to ask probing questions and my **heart** to find better answers. In the brief story that is narratively wound around "yes" or "no" Mr. Johnson magically ties head and heart together.

He then speaks of real need. I'm certain that wants and needs differ and we'll all spend plenty of time defining what they are.

I'm certain that in dentistry we realize we have to help people buy things they need whether they want them or not when we know they're

OMER K. REED, DDS

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buying things they want whether they need them or not, with the help of the media.

Johnson's question, "When I pursue only the real need, I'm more decisive and I make better decisions."

So, in pursuing the real need in the beginning, I get better results in the end. Pursuing means seeking and doing; seeing a vision of needed results in such lucid detail that I sense myself achieving them now and doing only what gets needed results.

Needs are essential for success and fulfillment. Wants are just distractions. I see what I merely want and I ask "What do I wish I could do?"

To see what is really needed, I ask, "Looking back on this decision, what would I like to have done?"

Notice the time frame of the questions.

What do I really need from this decision? For me? For others? Is my vision clearly focused on a needed result?

Am I saying "Yes" to only what achieves the real need and "No" to everything else? Am I pursuing the real need?

Yes___ No___ (Please check one.)

We're beginning to see here the parallel to model-building. Select objectives, measurable things that are of need. The model pursued, by many of us, inserts here things that are unachievable by ordinary means. Objectives that are unachievable by ordinary means.

Einstein said, ". . . the confusion of aims and the perfection of means are the only things that should attract mankind." How true it is.

Working back from the future is intended, if you read carefully, the difference between the questions that relate to wants and needs. We see, in clear focus, that which we need as having been accomplished.

What a remarkable piece of power!

When I get the needed information, I discover more of my options. Informed options are essential to intelligent decision-making. Informed options, when summarized, are extremely helpful in broadening our base.

Data provides information. Information provides knowledge. Knowledge provides wisdom.

Information is the collection of data. Facts. Objectives. And, of course, subjective feelings.

Information is a collection of what is and how people feel about it.

I gather the needed information for myself. I either observe it, or I verify it.

Options. First, I realize I probably

"Life is to be lived as an adventure or it's nothing. . ."
(Helen Keller)

Truth. . .
Reality. . .
Intercranial
Experiences. . .
Personal.

have several options that I've not been aware of.

I become more aware of my options as I gather the needed information.

I choose the option which fills my real need.

Do I have the information I need?

If not, who has it? Where is it? What's the best way to get it? Have I verified the information for myself?

"Truth and equality do not exist in nature.
Only freedom matters."
(Helen Keller)

As I gather the needed information, what do I discover my better options are? Am I blind to my options or have I uncovered several useful options from which to choose?

Am I informed of my options?

Yes___ No ___ (Choose one now.)

Bettering results are important in our maturation of decision-making.

To make a better decision, I ask, "Then what would probably happen? Then what. . ? Then what. . .?" until I think my choice through to better results.

Summary of better results. . .

My results are my mentors. They can teach me more than any one can. As I look at my results, I'm not too hard on myself. I did the best I knew how. Now I get better results because I focus on the real need and am informed of my options and I think things through to a better result.

To see how good my results are, I measure them against my real need.

What would the results have to be to fill the real need? If I act on my decision, what will probably happen? Then what. . . ? Then what. . . ?

What do I fear would be the worst result? What would be the best result? What would I do in the worst/best case? (Contingency plans.)

How clearly do I foresee the most likely result? For me? For others? Have I thought this through to a better result?

Yes___ No___ (Choose one now.)

On your journey toward decision-making more wisely, you are halfway there. My decisions reveal my beliefs.

Through the personal integrity I have with self, only I see the truth; ergo, I will make a better decision. My integrity, as summarized.

My poor decisions are based on illusions, I believe. My better decisions are on realities that I recognize.

When I see the truth, the decision is easy. It becomes obvious. To find the truth, I really look for it.

To discover the truth, I search for the illusion which I want to believe is true, but is not.

We see each other's mistakes more easily, so I ask others what they see and then I notice what feels true to me.

Have I looked closely enough at my past decisions to see how my poor decisions are based on illusions that I choose to believe?

Have I done a reality check by observing what is really going on around and within me? Will I avoid the pain of believing an illusion? Have I noticed the obvious? Do I clearly see the truth now?

Am I really telling myself the truth?

Yes___ No___ (Choose one now.)

My intuition is an important part of this process. My feelings often forecast my results. (Reality, truth and integrity are intercranial experiences for the individual. Thence cometh intuition, or the synapses in the gut that autonomically often make decisions as a result of the values we've formed. It seems to me that this decision-making process is highly personal and in that nature, right on!)

My intuition is summarized.

The more I use my intuition to look at how I feel, the more I protect myself from making mistakes. How I feel about how I make a decision can often forecast my results. I will not make my decision based on fear as it never brings me a better result. I may make a better decision when I am not guided by my ego, but by my better "guide". . . intuition.

Do I feel: Fearful or enthusiastic? Stressed or peaceful? Drained or energized? Clear or confused? Egotistical or guided? What would I do if I were not afraid?

Does this decision really feel right to me? As right as seeing a favorite color, or meeting a close friend, or taking a peaceful walk?

What, though impossible if it were done. . . would add meaning to my life?

If it doesn't <u>feel</u> right, it probably isn't; I need to change my decision.

Does this decision <u>really</u> feel right?

Yes___ No___ (Choose one now.)

My insight is also critical. We often get results we subconsciously believe or really deserve. We become what we think about.

My insight, as summarized.

Many people <u>think</u> they deserve better, but their actions show they do not <u>believe</u> it.

To discover what I really believe, I look at what I most often <u>do</u>.

To thine ownself. . . be true.

The key to making a better decision is to believe I deserve better and then act on that belief.

Do I look closely enough at my past decisions to discover what I

really believe I deserve? Do I see how my decisions reveal my beliefs? To see what I really believe, do I look at what I actually do? Do I believe enough in my decision to act on it soon?

Courage.

What would I do now if I acted as though I believed I deserved better?

Do my actions show me I believe I deserve better?

Yes___ No___ (Choose one now.)

Conceive. . .

There is a map, then, to better decision-making. Three practical questions should be answered.

Am I pursuing the real need?

Am I informed of my options?

Have I thought this through to a better result?

Three private questions:

Faith is . . . belief without proof and trust without reservation.

Am I really telling myself the truth?

Does this decision really feel right to me?

Trust is . . . voluntary vulnerability.

Do my actions show that I believe I deserve better?

If all the answers are "yes" I proceed. If any answer is "no" I re-think this. I ask all the questions again.

Now, would I like to change my decision?

My poor decisions are based on illusions I believe. My better decisions are based on realities I recognize.

I stop a poor decision to make a better decisions.

I use my head to ask probing questions and my heart to find better answers.

My decisions reveal my beliefs about my integrity, my intuition and my self.

Once I see my truth, I make a better decision. . . for me.

My feelings often forecast my results.

I get results I really believe I deserve.

We are each our own guide to better decision-making and we can help others discover this for themselves.

This checklist of decision-making, in my opinion, will take a bit of our naivete and unawareness and set it aside so we can be more aware of what is going on around us.

The author convinces me that in each of us resides a "guide". . . an internal mentor which each of us is given to show us our own wisdom. That guide is called "intuition." Our real challenge is to say "yes" or "no". "Yes" to reality, "No" to illusion.

If we can stay focused on real need as we select it, gather needed information, become aware of our

options, think each option through and make proper selection, we will gain a better result.

We will be more able to distinguish reality from illusion when we tell ourself the truth, trust our intuitions and act on the belief that we deserve better than what we have.

What may seem complicated at first, as we begin to use this process, it will certainly seem more clear.

When we use a better system, we make better decisions.

Why is to know not to do?

What does it take to get something into the sponge?

The system works best when you actually use it. To know about it isn't enough.

Get into the habit of using your head to ask probing questions and using your heart to discover the better answers.

Into your gut for the intuition that is essential for better synaptic application, and go for it!

We are each our own guide to better decisions and we can help others discover this for themselves.

I believe probably one of the finest tools for team integration and decision-making is at hand and the half-hour or so that it takes to devour the text of one hundred pages, and to tear out the decision-making card (map) at the back of the book and to begin to enjoy the beginning of a new habit is remarkable.

Is it a miracle? Is it magic?

Of course not. It just makes good sense.

After you've had an opportunity to enjoy it, let me know how you feel about it. Pentegrans, look forward to borrowing the video tape out of the library as it will be arriving shortly . . .

Omer

Use your head. . .

Use your heart. . .

Napili News

Two spaces remain for the Colorado River Rafting Experience, May 21-29. Seminar each day; before, during and after the float. . . pre-taxed dollars. AGD credits, $1550/person.

Napili 6 experience: South African Dental Congress in Bophuthatswana (Sun City). . . the more who travel, the less the cost. Mingle at the Congress (after Cape Town) then off to tented camps for game viewing, visit Victoria Falls, raft on the Zambesi River, game viewing in Etosha. Dates are 6 - 21 August.

The Economic Core of Model Building (Napili 4) will be presented before Model-Building (Napili 3) at the Radisson Hotel, Grand Cayman, to allow time on the open day (Wednesday) for counseling with attorneys/bankers for offshore asset protection. June 21-23 (Napili 4) June 25-27 (Napili 3). Tuition is $1250/workshop, $2200 if both are attended.

The People Without Perio program, September 24-26, Phoenix, is filling rapidly. Call now to reserve space.

Napili/Pentegra Spring Symposium promises to be an adventure in change, growth and learning.

The rains have favored us, the desert is "a-bloom" and gorgeous.

We enjoy hearing from you. . . and look forward to having you join us!

Marci Reed

President
Napili Seminars

THE CALF PATH (A Metaphor)

One day, through the primeval wood, a calf walked home, as good calves should; but made a trail all bent askew, a crooked trail as all calves do.

Since then 200 years have fled, and, I infer, the calf is dead. But still he left behind this trail, and thereby hangs my moral tale.

The trail was taken up next day by a lone dog that passed that way; and then a wise bell-wether sheep pursued the trail o'er vale and steep, and drew the flock behind him, too, as good bell-wethers always do.

And from that day, o'er hill and glade, through those old woods a path was made; and many men wound in and out, and dodged, and turned, and bent about and uttered words of righteous wrath because 'twas such a crooked path. But still they followed (do not laugh) the first migrations of that calf, and through this winding wood-way stalked. . . because he wobbled when he walked.

This forest path became a lane, that bent, and turned, and turned again; this crooked lane became a road, where many a poor horse, with his load, toiled on beneath the burning sun, and traveled some three miles in one. And thus a century and a half they trod the footsteps of that calf.

The years passed on in swiftness fleet, the road became a village street; and then, before men were aware, a city's crowded thoroughfare; and soon the central street was this of a renowned metropolis; and men two centuries and a half trod in the footsteps of that calf.

Each day a hundred thousand rout followed the zigzag calf about; and o'er his crooked journey went the traffic of a continent. A hundred thousand men were led by one calf near three centuries dead. They followed still his crooked way, and lost one hundred years a day; for thus such reverence is lent to a well-established precedent.

A moral lesson this might teach, were I ordained and called to preach; for men are prone to go it blind along the calf-paths of the mind, and work away from sun to sun to do what other men have done.

They follow in the beaten track and out and in, and forth and back, and still their devious course pursue, to keep the paths that others do.

But how the wise old wood-gods laugh, who saw the first primeval calf! Ah! Many things this tale might teach. . . but I am not ordained to preach.

Sent by Dr. Kenneth W. Sand, written by Sam Walter Foss

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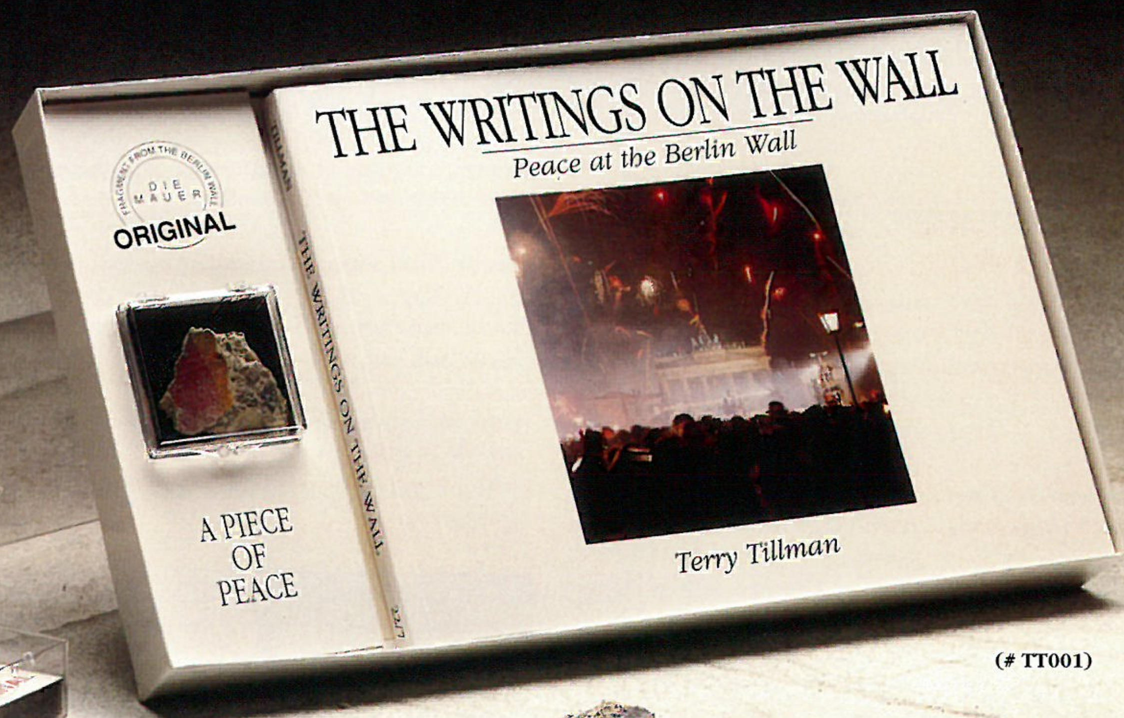
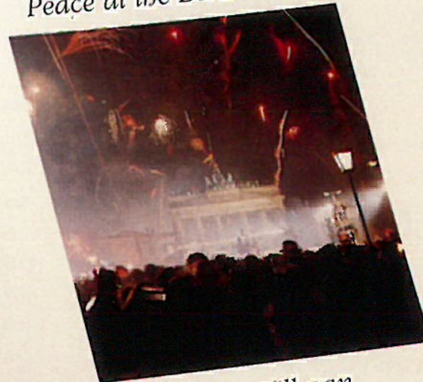
"...ranks among the year's most dramatic gift offerings."
—Los Angeles Times

THE WRITINGS ON THE WALL





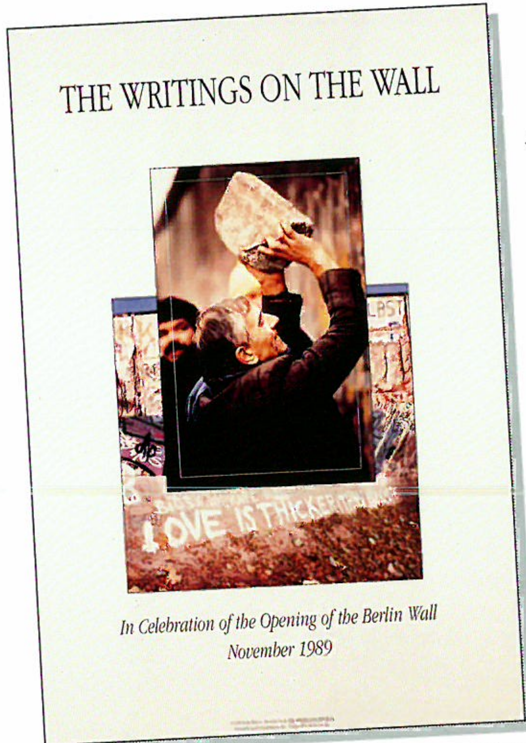
(# TT001)

(# TT003)

A moving and dramatic book—*plus* an authentic piece of the Berlin Wall

with original graffiti paint. The full-color, oversized soft cover book contains 120 stirring photographs complemented by poignant quotations.

THE WRITINGS ON THE WALL



Commerative Poster (# TT004)

A gift of hope and inspiration. A tribute to the spirit of freedom ...and a piece of history.

The Writings on the Wall Gift Package—An art quality, full-color, 10 1/2 " x 8" soft cover book of 120 stirring photographs complemented by poignant quotations, by John F. Kennedy, Martin Luther King, Jr., Mahatma Gandhi, Dwight D. Eisenhower, Napoleon, Lao Tzu, Nelson Mandela, and many others. Packaged with an authentic piece of the Berlin Wall with original graffiti paint, in its own 2" x 2" plexiglass box. Complete with a Certificate of Authenticity and a U.S. Customs Declaration of Origin. *(book and wall piece packaged in an 8 1/4" x 13 7/8" x 1 3/8" gift box)* *# TT001*

The Writings on the Wall—An art quality, full-color, 10 1/2 " x 8" soft cover book of 120 stirring photographs complemented by poignant quotations, by John F. Kennedy, Martin Luther King, Jr., Mahatma Gandhi, Dwight D. Eisenhower, Napoleon, Lao Tzu, Nelson Mandela, and many others. *(book only)* *# TT002*

Berlin Wall Piece—An authentic piece of the Berlin Wall with original graffiti paint, in its own 2" x 2" plexiglass box. Complete with a Certificate of Authenticity and a U.S. Customs Declaration of Origin. *(wall piece only)* *# TT003*

Commemorative Poster—A striking full-color poster commemorating the opening of the Berlin Wall. Quality 22" x 34" frame-able poster with photographs from the book *The Writings on the Wall.* *(poster only)* *# TT004*

This remarkable book communicates in word and picture the harsh reality that was the Berlin Wall and the historical circumstances that saw it changed from a bitter symbol of a divided world to a hopeful sign of peace. But it is about more than the Wall and its graffiti. It is about the walls in our daily lives, how these add up to a fragmented world, and how, bit by bit (peace by peace?), we can free our world. It is witness to a consciousness change from division and separation to unity, oneness, and human caring. It's about the family of man. And it is a record of the demonstration of the very real possibility of individual and world peace. The writing's on the wall.

This book is deeply moving because it is about freedom... The Writings on the Wall has done the impossible, giving the reader the uncanny feeling of actually being in Berlin as the historic event unrolled.

I was moved to tears. The juxtaposition of photographs and quotations told a magnificent story of the human spirit... The Writings on the Wall, in my view, is more than a book. It is a perpetual flame. It is a guiding myth, a story with a compelling cast of characters: citizens, soldiers, politicians, numberless and nameless artists and poets, mourners and celebrants. Like the rainbow in the story of Noah and the flood, the dismantling of the Berlin Wall is a promise and a reminder of grace.

—Marilyn Ferguson

Author **Terry Tillman**, an internationally recognized leader in the human potential movement, has conducted personal growth, effectiveness, motivation, and leadership seminars for over 30,000 people in 40 cities and 26 countries since 1977. He lives in Los Angeles, CA.

A portion of the proceeds from the sale of these products will go to the Institute for Individual and World Peace.

EULOGY FOR DR. CHARLES PINCUS (By Bob Hope)
September 7, 1986

Dr. Charles Leland Pincus was my dentist and my good friend. (Charlie, when I got the news on Friday that you had gone, it was the first time in 50 years that you hurt me.)

When I first met Charlie, I like him because he had every kind of degree a dentist could have, and I had a mouth that might need them all.

Not many people have the same dentist for 49 years. He'd have to be a special kind of guy. (You were, Charlie.) It's something special to have a good dentist for a good friend.

Dr. Charles Leland Pincus, born in New Rochelle, New York, in 1904. A caring, charming and uniquely talented man who became as integral a part of the Hollywood scene as Kleig Lights or limousines.

Charlie truly loved show business and everyone connected with it. He loved their warmth, their camaraderie, their sense of fun, and the fact that almost all of them needed their teeth capped didn't hurt, either.

Charlie had such a kind and gentle way with performers. The first time I ever went to him, back in 1937, to have my front teeth capped, he sat me in the chair, clipped on my bib and, as be began adjusting the light, he said, "Which one's your good side?"

I knew right then I'd found my dentist for life and that's the way it turned out.

Charlie was the dentist to the stars. Walking through his waiting room was like a trip through central casting. In a town built of legends, Charlie Pincus was definitely one in his own time! His patient list would be the envy of CAA, ICM and William Morris. He knew them all, the greats and the near greats. He was a gifted and skilled dentist, and the finest friend a man could have.

Behind that professional competence was a man with a huge heart and a great sense of humor. Charlie loved a good joke. I guess that's one of the reasons we were good friends for almost 50 years. Charlie, Frances, Dolores and I shared many great moments. There were fishing trips, the golf games, and the wonderful times we enjoyed together. We're going to miss those times, miss his laughter, his humor. Down deep, Charlie was a born performer. He was no less a giant in his chosen profession. Hall of Famer at USC and numerous awards, often invited by his colleagues to lecture all over the world on the latest trends and breakthroughs in dentistry.

No professional challenge was too great. When the best wanted the best, they went to Charlie. He flew all over the world to consult on difficult and extraordinary cases, and people used to come to him from the ends of the earth.

I was in the Ziegfield Follies in Philadelphia in 1936 and we had to close the show for two days because the star of the show, Fanny Brice, had to fly to Hollywood to see her dentist, Charlie Pincus.

A few years ago Monty Clift was in an auto crash and needed serious surgery on his mouth and the man they sent him to was Charlie Pincus. . . lucky Monty. He told me later that Charlie's genius saved his career.

And he treated all his patients with tenderness, like they were family. Charlie reveled in the laughter, the applause, and the refreshing opportunity lecturing gave him to finish a performance without saying, "Don't bite down too hard."

Charlie was a man of wit, charm and a gentle kindness that endeared him forever to everyone lucky enough to know him. I was one of the lucky ones, as were most of you. Charlie touched our lives in a way that will keep his memory vivid in our minds, always.

We all pass this way but once. But oh, how fortunate we are that Charlie's path crossed ours. Eighty-two years is a long time. . . especially when it's a productive life like Charlie's. . . when you have the love of family that Charlie enjoyed, when you have the riches of friends that he seemed to attract. Eighty-two years is a long time. But for those of us who will miss the camaraderie, the warmth, the blessed friendship of this man, it's not nearly long enough.

It's interesting, the more I keep trying to focus on Dr. Pincus and his feats of dental wizardry, on his national and international professional honors, on his illustrious patients (Edward G. Robinson, Ethel Merman, Monty Clift, Moss Hart, Robert Taylor, Buster Keaton, James Dean, George Raft and Walt Disney, to name but a few) the more I come back to Charlie, the man. Who he was is more important that what he was. He was probably the kindest man I've ever met. He never said a mean or hurtful thing about anyone, nor would he tolerate that kind of talk in his presence.

He was a gentle and caring man. He often tried to hide this sweetness and it only made it more poignant. He had an infectious enthusiasm for people and life. He was a good listener, and when he spoke he brought a kind of wisdom and point of view that was unique, and always he brought his ready laugh. It was full and rich.

You know, as I think about it, it was absolutely right that my friend, Charlie, should choose to be a dentist. The mouth is probably, next to the eyes, the most expressive part of the body. Through it we eat and are sustained, we curse out our anger, and most importantly, we express our love . . . and we smile.

Charlie is gone from us now, but each of us who were his patients and his friends carry around with us a little part of him; the skill of his hands remains in our thoughts and the warm memories of him force, in the midst of our tears, that famous Pincus smile.

(Charlie, when you get to your new office, you're going to recognize a lot of smiles you're responsible for. Friendship is a combination of esteem and love. That's you, buddy.) And one really nice property of love is that it's made to outlast our years.

The ones who will miss him the most, of course, will be his family, especially his beautiful ga, Frances, who gave him love and support in all of his endeavors.

There are some lucky people upstairs because they'll be seeing and pal-ing around with Charlie again. Many of the people he'll be running into up there are old friends and patients; folks like Jack Benny, Al Jolson, Judy Garland, Amos and Andy, Vincente Minnelli and others. Yes, when Charlie walks through the Golden Gates, he'll be met by a lot of smiles he recognizes. . . and is responsible for.

(So Charlie. . . may we always remember not only the beautiful smiles your work gave us, but all the smiles your life gave us. We'll remember you that way forever with love!)

REED'S INTERNATIONAL LETTER

Dear Friends

What do dental teams do when one of the "crew" doesn't perform up to expectation? The most common response is to remove the individual from the task, either through transfer or termination. This is usually initiated either by the person uncomfortable with the position and/or the performance level. . . or the team commonly consenting to this displacement.

The most common word in our thinking vocabulary toolbox for this event is

"TURNOVER"

In dentistry, the "life expectancy" of a team person or the percentage rate of turnover in any given year can only be estimated. . . at any rate, we're well assured that it is considerably higher than is comfortable for the industry, the people involved and/or the economics of the game.

Turnover may be seen a a handle for several concepts, among them the team replacement so common and frequent in dentistry. . .and the **conversion** experience of values in self: self-changing self, and subsequent self-behavior.

With turnover of a team person disrupting the existing productivity and initiating pruning, tuning, and training the replacement, it is estimated that the cost of the event is somewhere between $20,000 and $30,000 in any given year.

I believe this to be conservative.

The removal or replacement is not the only recourse available for the crew in response to performance or challenges in the inter-personal relationship.

Personal development is also a possibility. Though traditionally less likely than turnover, some dental teams do perceive and believe. . . and achieve, through cooperative effort this fundamental growth,

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change and learning opportunity. Through the use of constructive feedback on **behavior** and the modifying of the offending behavior, oftentimes growth and development replace turnover.

If we change the way we make decisions, handle people, press for results (indeed governance itself) in administrative process, we may alter the frequency, expense and chaos that comes through turnover.

Power of empowerment. . .

The behavioral approach is effective under the right conditions. However, in my opinion, it suffers from over-use. As leadership is replacing management, as personal power emerges situationally, as team effort is replacing the pyramidal experience of industrial management, as the term "collateralization" emerges, as we see each other as associates or indeed as "unmanageable professionals" who are "obvious opposites", we may choose other than behavioral shifts as our primary tool to intercept turnover.

Let's talk "back to basics" and change perception values; indeed, change self.

Dentistry has almost superstitiously steered clear of methods that "get personal" and yet the individual person, when taken into account, is the important asset of the team and how **self** can be altered and/or the reasons for why we behave as we do are analyzed, it may be far more effective and efficient and less chaotic (although less understood and less frequently used) than strictly changing behavior.

Peter Drucker defined efficiency as merely doing things right. . . and effectiveness as doing the right things.

When it comes to performance problems, Bob Mager's work, Analyzing Performance Problems, is an absolute **must**, a real primer. Developing the word tools to think with that come from his book, Goal Analysis would also accelerate your experience.

The value of taking the person into account and making sense of the performance problems that exist, and the resolution of those problems, is most important.

Every person's work is always a portrait of self; you are who you are. The "effectiveness" question is, "How can you be a better you?" and "How can you handle you better?"

This personal approach, in my opinion, is one that encourages exploration. This newsletter is written reflectively as 35 years of general practice have cranked around. Group practice has been profitable and rewarding. Napili seminars have now enjoyed 30 years of continuous experiential exposure to practicing dental teams and Pentegra, now in its fourth year, is hands on with over 100 practices and the people in them with remarkable exposure, for me, to change growth and learning in a personal sense.

I am going to exclude the title of dentist, hygienist, front desk,

OMER K. REED, DDS

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chairside, etc. and deal with people as persons in this newsletter because I really believe that the person, irrespective of his/her academic position or licensure, is the focus of this approach.

Some people on the dental team are so ambitious to prove themselves that they end up undercutting themselves and undermining the organization. Raw ambition for self is not a successful drive for a person on the dental team.

There are some real resistors to the personal approach to leadership and the team approach in dentistry. One is the organizational defense, which acts to keep team discussion and action on an impersonal level, and the personal defense which resists attempts by people to explore their private motives for their behavior. I believe these resistors are formidable, but they can be overcome with a strong commitment to self-development and a systematic workable method for approaching it.

I'm certain that the behavioral changes that are essential are not going to be replaced with this personal approach to altering the end point, but I strongly believe that when used in conjunction with the behavioral approach, the personal accountability approach can and will empower real and lasting change.

Personal development is subjective and not a panacea for performance problems, but I believe can be applied, in a healthy way, to all team persons and need not be reserved only for trouble spots but can also appreciably accelerate success in an environment with few performance problems. I believe the idea of personal development is the real paradigm shift for mature adults in our profession as a result of the field being dominated by the behavioral approach in modification and, without question, also the major resistor of believing that adult, mature persons have "arrived" and are unchangeable. As a matter of fact, I would like to propose the premise that two major resistors stand in the way of even considering personal change or growth as a viable premise. Most look more favorably on changing the behavior of people, and the behavioral performance patterns of people, rather than approaching growth in the personal decision-making and values department of life.

Ambition for self is not a successful drive for a person on the dental team.

Resistor one is the **myth** that change is probably not going to happen much, if at all. As Pankey said, ". . . you can change people, but not much." Second, if they do change, since they're probably more good than bad, the real worry is that they will be worse if they are able to change (change deleterious to performance, productivity and the effort of the organization); they will not be as able, motivated, committed, useful, etc. as a result of basic change.

Two major resistors stand in the way of personal change.

During the Pentegra experience, we attempt to get a complete

picture of the person coming for membership by not confining our-selves to the work setting, but also interviewing and visiting with family members, visiting outside the office, having unusual access to the life and value psychology of the incoming member and the members of his team. This perspective is seeing the person through a window seldom used; one that often escapes scrutiny; one that only happens if reasonable privacy is assured to the persons participating.

Leadership and its development is very personal.

Anonymity and/or private comment at the initial feedback stage in analyzing performance problems and determining what personal values changes will be essential may be necessary before any sharing can occur.

Milton Erickson, famous for his counseling psychology, pushed for achieved change in the person. . . not just the behavior. Neuro-linguistic programming is a process that has emerged from his work.

To change the superficial structure of behavior doesn't provide a lasting or real change.

I believe that leadership and its development is very personal. When observed in the dental team as is exhibited by any one of the members of that team, we find that the basic character of the individual emerging as a leader is the primary power of leadership.

Many of us, as dentists, have escaped the economic and behavioral sciences in sufficient quantity to be a liability to the team and ofttimes the areas of leadership in these two sciences must come from others on the team, properly selected.

To really comprehend leadership, we cannot confine ourselves to the observable behavior of the individual as much strong organizational science would recommend, but must delve below the surface and look at the profound effect of the basic character of the individual as it emerges in leadership.

It is the "basic character" of the individual that inspires the willingness to follow.

I recommend that we seek outside help, if necessary, to go "below the surface" as I believe adults can change their basic nature as well as changing their behavior, though the latter is a more common approach. When attempts to alleviate performance problems are restricted to behavior models, the results are often disappointing because the troublesome behaviors may be stubbornly rooted in the person's character. The nature of the person emerges in the behavioral pattern; to change the superficial structure of the behavior doesn't provide a lasting or a real change at all.

I can tell you that at least a dozen Pentegra members (this means dentist, hygienist and others on the team) have managed character shifts for themselves as I've observed them closely over these past three or four years. As a result, their performance improves noticeably. Not only that, but they feel happier, healthier and have more peace of mind than previously. They are commendable

for the internal nature of this alteration of values and personal character, as it's something no one can do for another, it's from within the person. It requires a will to change, grow and learn and an ability to survive the chaos that is likely to accompany change, growth and learning.

This most meaningful event, as I've observed, is celebrated by all those interfacing with the individual. . . a true testimony to change.

The "paradigm pioneer" characteristic of faith, trust and courage is also essential. If a person is to assist and/or be primarily responsible for self-change, then self-awareness must be gained. . . and that alone is a challenge.

Most frequently this requires the help of others around us in love and kindness. A pattern of feedback monitoring is essential to modification. Many times the particular character of the person gets in the way of self-awareness and as you proceed through this newsletter, you may begin to think that it's psychiatric/psychologic beyond the norm of ordinary communication and best be left to professionals in those areas.

This may well be, but, in my opinion, only in pathologic states. This discussion belongs in the hands of each of us on the cutting edge, in the trenches, at the level of the action of the dental team.

I realize that the elevated situation (that sometimes we feel we're in as dentists, hygienists or persons) impedes the flow of constructive criticism and precludes our being open to flaws that could well be corrected or deleted in our personal lives.

What this really boils down to is, with the help of others and a concerted effort on the part of self, we have the opportunity and responsibility of recognizing, ourselves, those major factors that synaptically make us tick (the "drivers" in our gut) and re-organizing those factors in a constructive way for the purpose of team function and a lifestyle that is enhanced with additional quantities of happiness, health, wealth, wisdom and peace of mind.

Along with the work of major authors (such as Tom Peters) in observing the international phenomenon of personal power emerging, the corporate pyramidal structure diminishing, flat organizations gobbling steep ones all over the place, etc. . . . it seems that this is an appropriate time for us to seriously consider the investment of self in self for the purpose of personal improvement. The end point of this process is a change in personal values, behavioral patterns, an easing of team tension, an increase in productivity and net gain, a setting aside of the myth that we can't change and the worry that if we do change, we'll lose our effectiveness. . .indeed, a change to the degree that we plunge wholeheartedly into the process of getting to know. . . and the changing of self.

A pattern of feedback monitoring is essential to modification.

We have the opportunity and responsibility of recognizing those major factors that make us tick.

As you begin this process, you will not so much study it but will learn, grow and change with it. Of course, this newsletter will not capture it for you but will point toward opportunities for further study and profitable change for the person who cares enough to invest self in the process.

The real measure of change. . . can you change yourself?

It's fine to tell others to change and to expect, outside of self, to find the reasons for failure. The real measure of change is "can you change yourself?" The cartoon of the day shows a lady going into the bookstore asking for a book on "Self-Improvement for Others." Our bookstores are jammed with wellness, health and self-help books from nutrition to physiology to the mind games. It's an exciting time to consider the ambitious project of inventory, personal growth and the development of balance that's essential for leadership.

The transition from tenseness. . . to equanimity, peace.

"Toughminded leadership" is a term that probably has some semantic meaning for almost everyone. (Those who have access to the Pentegra library will recall the video by Joe Batten and the audio tape that is popular in the motivational field by him on the same subject.) I'm certain that the drive to mastery is over-developed as a specialized role in the heart, mind and "gut" of recognized leaders. Many of us have a near pathologic need to demonstrate self-worth and those identified with true leadership in times of trial are often seen as being unbalanced persons, properly and appreciatively placed in the situation for the moment. Serious imbalances in every day life and team performance can be major sources of performance problems. Those who are led and/or driven to leadership positions from time to time, (or even always), can improve our peace of mind quotients and improve our leadership by redressing the imbalances.

Metaphor and parable as introduced by Milton Erickson have long-since been effectively used for communication and as behavioral indicators. Such metaphors as "when you get to the end of your rope tie a knot and hang on" indicate helplessness and hopelessness that's oftentimes a part of how we feel in the frustrating arena of the dental environment.

Personal development can tone down the excessive, expansive drives of some of us. Through the transition from tenseness, self-responsibility and worry, to equanimity, peace. . . perhaps most wonderful of all, a shift of inner equilibrium. We can simply relax and throw down the rope. We don't need to tie a knot and hang on. We can set it aside and stand there and look at it if we choose to do so, a different metaphor. . . a diferent self-instruction. There are all sorts of choices that must be considered. A lopsidedness is often necessary in leadership, in team function. Situational leadership should be an "ad hocracy," it should be brief, and unsustained. . . useful situationally and then set aside and done so without apology or guilt.

A person who becomes a more balanced leader in team function is,

in reality, simply less unbalanced by these definitions and we move away from extreme imbalance as a lifestyle.

Let's look again at the nature of our belief in regard to personal change. Most of us doubt, with great disbelief, that adults (particularly adults in decision-making positions) can change. Many times we believe they "got there" because of who they are and what they are and to change that would bring about a tremendous worry, an anxiety that the change might be for the worst and, coupling this worry with this doubt, lethally, subconsciously, sets people against personal change.

It's been my experience that many people in the dental setting ardently desire that dentists and other emerging leaders on the team make needed adjustments to their behavior. This type of change is conceivable assuming the person somehow gets the message that an adjustment in behavior is needed.

There are very few people, however, who seriously entertain the possibility that a leader, a person exhibiting leadership on the dental team, can change who he or she is. This type of shift seems improbable to most. How can people use their basic character to alter their basic character? I'm certain many are also pessimistic about the possibility of personal development as an avenue for more effective leadership, problem resolution and improvement in team function.

I observe this belief to be warranted in the case where necessary extreme change is unlikely. People who respond aggressively and defensively are usually attempting to defend their identity. These extremes are usually dealt with by turnover of team persons and the expense we experience becomes real.

There are few people who entertain the possibility that a leader can change.

One of the things I'd like to include as you're thinking about this, and I've perhaps given you a number of venues in which to think, is the venue of the dentist's wife coming into the practice, or being in the practice, and her leaving the practice.

Here, again, we have a personality interface that alters the cultural nature of the team, challenges the governance philosophy of the team and effects the function of team-building. When a wife is on the team, things will be different than if she is not on the team. . . sometimes better, sometimes worse. It's certainly one of the interfacing factors that must be considered as I talk about the myth of change and the worry of the effect of that change in regard to the person interfacing as a member of the team.

Things will be different when the spouse of the dentist is on the team.

"Who you are is where you were when." Morris Massey's work shows us that the impacting of events in life, on our early person, prevails in our adult lives. Recent newsletters have talked about self-image, self-esteem, where they come from, how they work and how we may even choose to go

Concepts of self come about early in our experience.

Many of us may be unaware of the early expereinces that led us to our point of view of the world.

back to an event that has imposed great structure on us and re-structure its reality to some degree, fully realizing that our perception of that event at the time of its occurring may not have been complete enough for us to continue to carry into our adult lives the impact we perceived at that moment in such a directive and permanent way.

Our perception of events that impose constructions we've adopted to organize and synaptically govern our life experience can be changed. This may require professional guidance and outside help, so be it.

Beliefs about ourselves and other people, the world, concepts of self as workable responses developed in our behavior come about early in our experience. Primary early experiences may be not relevant for present circumstances, yet we individually resist change in concept because we learned "too well", initially. The extent to which we as adults "realize" the self-defeating constructions we may have inherited early in life will indicate the measure of pain we will suffer in changing them as they result from the amount of pain we experienced at the time we learned them.

Many of us may be unaware of the early experiences that led us to adopt a beleaguered point of view of the world and/or be unwilling to let others around us know of them. Many of us take those early pains that were intense and park them deeply, out of our way, and develop systems powerfully defending a recurrence of similar experience.

This produces a rigidness to changing self and we unwittingly sacrifice the good cause of continued growth and change of self for the defense of "our nature."

Many who set out to change fail to do so. This reinforces our unwillingness to try. Many times, we "set up" to change and fail. A recent article pointed clearly, to me, that if we continue to focus on the end point, we'll be unlikely to achieve it. If we understand the process and invest ourselves heavily therein, our opportunity is enhanced.

Intervention must, in its strength, be related to the strength of the initial experience if change is to be real. Significant emotional events (S.E.E., an acronym) are essential for the change of personage. Informal conversation and feedback, simple systems of dialogue may not lead to a shift in character. Profound personal change is possible and if a person is beyond the reach of normal dialogue, vigorous intervention of a powerful nature will be essential. As I observe life around me and people of significance, the "significant emotional event" may not occur by design, but may appear as a tribulation of mid-life, mid-career, marital or health challenges, difficulty with adolescent children, death of a family member/loved one, disaffection with life dominated by work (better known as burn-out). . . such hardships do not normally happen by design. But they can be

"significant emotional events" that assist in change of the person.

If a team person is placed in a stiffly challenging task, with the intention to provoke evolution personally and professionally, we may produce the significant emotional event necessary for that individual to review self, internally, . . . and to change.

Another way to say this is that the intervention that's essential is a deeply introspective self-development. When it happens, the credit is due the person who achieves it.

This self-development, introspection may be precipitated by a dose of constructive criticism, forcing an issue that if left alone may sooner or later grow to crisis proportion, thus synthetically precipitating a concern and a desire for the change of the person.

Forcing the issue can be seen as a way of anticipating a natural crisis of adult life. Pentegra provides a self-questioning opportunity with a grid of professionals, including psychiatrists, psychologists, qualified plan management, asset protection, estate planning individuals, etc. in sufficient quantity to stimulate a willingness to undergo the self-questioning that is integral to personal change.

To examine one's basic motives is anxiety-provoking. When one does so, a semantic response is usually felt, such as is described by "gut-grabbing", "rumbling in the stomach", or peeking into the darkness of inner self where things are buried as described in the Johari Window (ask for a back issue, it is a dynamic tool for self-analysis). When one is asked to "bring the whole self to the table", many times the person has trouble responding. When one is asked the question "Who are you?" oftentimes the only answer comes in the form of what that person does. ("I'm a dentist." "I'm a wife." ". . . a mother." ". . .a hygienist.") When one is asked "What makes you tick?" the question isn't as easily answered.

When one faces significant emotional events, oftentimes feelings are pushed into deep recesses and never dealt with. . . and to shine a light on that part of self is not done without expense. Ambivalent as many are about delving into the inner self, the <u>need to know</u> can prevail over the <u>fear of knowing</u>.

One Pentegra member, who is now recognized by team and by those coming for care, and by spouse, as being kind, loving and caring instead of arrogant, defensive, managerial is practicing with much success. Not long ago, he said to me that for the first time in his life he's started looking at his feelings. "I had a fear of facing up to what I was doing in order to obtain a feeling of personal worth. I achieved the necessary willingness to strip away the social veneer and the illusion, even though what I might have found there would not be nice to look at."

Introspection may be precipitated by a dose of criticism.

Feelings are pushed into recesses. . . to shine a light on that part of self is expensive. . .

The "need to know" can prevail.

co-workers and family and drops a heavy load of feedback on me constructive?

Am I, as a recipient, in powerful awareness of my readiness to receive such input?

Am I ready to face up to constructive criticism from co-workers, family and self?

Am I truly open to commitment to my own growth and development?

Is it sociologically desirable for me as a person to see myself as part of a team?

Growth and development . . . an arduous journey.

It's one thing to give lip service to growth and development, quite another to embark on an arduous journey, a process of self-discovery and self-development.

Many of us are heroes of quests of accomplishment. . . such as surviving college and professional school curriculum and/or establishing business and practice, and/or selecting ourselves into team roles of various types.

I really believe it's no less heroic to go on a quest to become a better person and a better leader.

Are we ready to take charge of our own development?

All the people on the team have an important role to play, but ultimately the individual must take responsibility for his/her growth.
No one, no matter how expert in helping, can do this for another. Anyone who over-relies, consciously or otherwise, on experts or those outside of self, squanders the chance to grow.

Remember, this is all being placed in this newsletter in regard to the subject of **turnover**. . . the personal enhancement of the individual in team position being an option rather than searching out and selecting a new unknown to take the place of the departing team person.

"Better to deal with the devil you know than the one you do not."

Speaking of the team, there's hardly anything more demoralizing than to individually make the choice to change, grow and learn, and then to find that one's fellow team persons resist or depress the occurrence of that change.

Not every change will be welcomed with open arms and a person, as alterations take place in basics, may present an entirely different interface as a team person.

It is always more positive when appreciable support for adjustment or change is experienced by those around us.

A program that is extensive (such as Pentegra provides for dental teams) must be selected by that team through an informed decision.

The steps and the sequence of steps that take place over the preliminary period (during a triad experience in Phoenix) and the subsequent monitoring that is ongoing with the

entire team has provided me an opportunity to observe the emotions and the growth and change results of received feedback.

What is the experience of actually making changes, outwardly and inwardly?

The best way to prepare for the emotional impact of a program of personal change is to talk to a participant who has experienced it.

One of the **major opportunities for networking with the Napili/Pentegra participant, member prior to making a decision to join in such an ambitious journey is easily accomplished**.

For a team to locate veterans of this experience is simple.

Give me a call, I'll give you some names and telephone numbers.

Your research is totally appropriate prior to decision-making and will enhance your decision.

First-hand reports from participants make such a decision much more clear.

To take a look at the people on the team who will be working with you is imperative and programs similar to the personal and practical change that can occur in people on the dental team is seriously effected by who the professionals are and what their reputation is for helping people improve and grow. Organized teams of consultants have come and gone, with bankruptcy both financially and emotionally. (A safe way to exit the market.)

The personal risk one runs through exposure is only remedied by the assured privacy of, and the total control of the data that is returned to the participants of the team when outside help is procured.

Research is appropriate prior to decision-making.

Psychological safety is necessary to concentrate on the development of the task and, much like the privileged communication of the professional in medicine, dentistry, psychiatry, law, I believe these options are best left in the hands of those participating in change.

Crisis management may be the trigger that precipitates a thorough review of self and team.

When "all hell breaks through" in life, it may be the dictator of adding the constructive stressor, that of self-inspection.

The effects on team and productivity is so impacting. . .

The benefit of going through intensive self-assessment and to have a feedback loop which allows growth to be monitored throughout the remainder of life is appreciated by those who have experienced it.

The effects on the team and the productivity at the net level is so impacting that it far outweighs the surprises/traumas of the process.

I'm certain that whoever the person on the team is that inevitably chooses to proceed with personal change, temporary pain

will be felt in having one's short comings pointed out, no lasting harm is likely to be done if the person is certain and precautions are taken.

People with psychological problems or severe stress must seek primary personal professional assistance outside of a typical team program such as Pentegra.

Individuals on the Napili/Pentegrateam are effective in helping growth, change and learning take place.

You, as a member of the team, and the entire team, must be assured safe passage by the impeccable record of those who have preceded you through a team program and/or personal program of self-awareness and change.

I'm certain that the technical equipment essential and the caring accountability of the individuals on the Napili/Pentegra team have proven to be substantially effective in helping growth, change and learning take place.

Continuity in the feedback is important as any model of human change that is assembled must have a plan, action, monitoring and modifying.

The congruence of change must take place across all boundaries.

It is unfair to dump a lot of sensitive feedback into someone's lap and then leave.

Obviously, people wanting personal change must voluntarily participate in whatever program that is selected for accelerating this change.

(All members of the team who come into the Pentegra game are offered a personal financial program at no additional cost.)

The feedback loops that are closed by personal interview effectively assist each member of the team in selecting the degree to which personal change is of value.

So, as a review, let me conclude by saying that if a person chooses to study self and/or be assisted from without in the study of self, learning, change and growth can take place within the individual that will alter behavior far more realistically and permanently than if behavior alone is changed.

One will collect, through one's research, a study of individual qualities in multiple settings (home, office, public, sport, free time) and the individual choosing to change must monitor those changes in comparison to superiors, peers, subordinates and/or teammates in a way that produces relevancy.

Some of the most powerful changes that I've been able to observe in people on the dental team have come about when the inter-relationship of the person has been challenged with change, not only with the people on the dental team but with parents, siblings, long-standing friends and people in their social environment.

The congruence of change, then, must personally take place across all boundaries if the preferred changes in behavior will have any degree of permanence.

I realize that, in reading this letter, the qualitative subjective comments being made will provide a tough job of finding order, or a pattern, emerging in my intent.

Perhaps in re-reading it, a pattern will emerge clearly as one looks into self and observes the link, between personal character and leadership behavior.

I hope, also, a link will be seen between the person's character and the question of continuing development.

As one observes self and collects data and information, patterns will emerge that will be helpful.

At any rate, the content of the letter is intended to assure you that the myth that change cannot take place at all and/or the doubt that if you change you'll be better can be set aside. . .

. . . and that altering one's personal characteristics by intent from within as we continue to struggle to change our behavior will enhance our health, wealth, wisdom, happiness and peace of mind.

Personal growth is an alternative that definitely provides an opportunity for strong reduction in turnover in the dental team.

Through proper selection and reward systems and the continued revolution of growth, change and learning in persons, we may perpetuate the family in the dental office and extend the hand of loving kindness to those coming to us for care.

The myth than change cannot take place can be dispelled.

Napili News

Omer and I recently attended the California Dental Meeting in Anaheim. . .one of the best dental meetings in the country (in my opinion). The speakers are always challenging and the exhibits are extremely well-presented.

*We're especially excited about the interest shown in the Sopha Bio-concepts' CAD/CAM, the Duret system. Omer's CAD/CAM will be delivered/installed within the next ten days. We are offering a two-day workshop discussing the particulars of **how to** qualify for purchase, and then **how to** be certain the machine pays for itself, and then **how to** use the system, hands on. June 12-13, Phoenix, $470/person.*

*We were thrilled to see that the **Rowpar** booth was crowded at all times; the ClO_2 toothpaste and oral rinse (RetarDENT and RetarDEX) samples were beautifully presented and all samples "disappeared" . . . into the hands of the curious.*

***Please note the "Privacy" addenda, and make your plans to join us in the Cayman Islands June 21-27 for the Economic Core of Model-building (Napili 4, emphasizing offshore and asset protection) and Napili 3, Model-building workshop,** Radisson Hotel, special rates.*

Case Presentation (Napili 5) Toronto, June 14-15.

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

WE LIKE TO GET THESE LETTERS. . .

"Dear Pentegra Crew: In August, 1989, after having been a Pentegran but a few months, Omer asked me if I would write a testimonial regarding the positive personal benefits of Pentegra services. Omer had never asked me for anything before, and I owe him **so much** because of my previous **Napili** experiences. Embarrassed, I begged off. I awkwardly explained that I had not received the tremendous surge from Pentegra as I had in the previous year and a half from Napili and I felt uncertain and uncomfortable in writing this requested letter at this time. Without missing a breath, Omer graciously let me off the hook by answering, "I understand, whenever you're ready." How correct he was in his confidence. Now, two years and eight months later, not only am I ready, but my satisfaction with and dedication to this idea called **Pentegra** is so strong that I appreciatively pay my continuum fee a year in advance.

"Pentegra is its people. First and foremost, Omer. . . always present like "Big Daddy" to guide, to encourage, to counsel, to brain pick, and befriend. However, I have used Omer's talents sparingly through Pentegra because his greatest impact on me was through Napili 2, 3, 4, 5 and 14. (For further information, request a calendar and specifics.) The two inner core professionals with whom I've worked most closely are Kelly and Neal (the Rocket), and two outer core professionals, Mike Sullivan and John Goodson.

"To have phone calls returned within a responsible period of time, to have follow-through on action items, to have conference calls on a periodic basis with people who know about and care about my life and my family is refreshing, comforting and priceless! Specifically, Kelly and Neal have worked with me on transition, computerizing my practice, eliminating the front desk, throwing out the amalgamator, completing my estate plan, implementing a practice continuation program, and re-designing my insurance portfolio. This does not include the tremendous energizing effect my wife, my team and I receive from the Symposiums and Omer's mind-expanding **For Members Only** tapes.

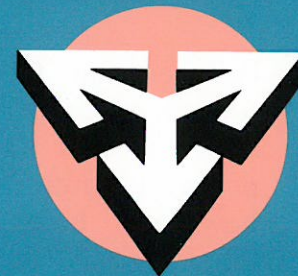
"My brief contacts with Wick, Lou, Irma, Linda and Kevin have always been pleasant and helpful. The genuine philosophy of giving more than is contracted for is the foundation on which Pentegra is built.

"May God grant you all many years!

Your friend, JJS"

"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."

THE NAPILI PHILOSOPHY IN PRACTICE



REED'S QUARTERLY

A SUPPLEMENT TO REED'S INTERNATIONAL LETTER

June 1992

IN THIS ISSUE

Maslow's Theory of Man's Felt Needs
Results of Survey Regrding CE Programs
Nurturing Your Creativity

In Abraham Mazlow's work, **Personality and Motivation**, he clearly points out his observations of man's behavior in a way that is easily understood, and with careful practice, extremely useful.

One of the big problems man (please read this as *homo sapiens*) has in his life is that he doesn't think. . . much! When he does gain some information, to convert something he knows into something he does is extremely difficult. (Oct. 89 Newsletter, "Why Is To Know Not to Do. . . or to Be") The mere presentation of Mazlow's work and the addition of this to one's knowledge does not necessarily mean that one has learned in that learning, by present-day definition, is not changing what you know, it's changing what you do.

One often hears the complaint "You can't change human nature." An obvious answer is that human nature doesn't need to be changed. What we do need to change is not nature. . . but behavior.

Mazlow's **hierarchy of needs** is a model of our nature and it hasn't changed much from the time of Socrates, Plato, or Christ.

The primary needs man has, according to Mazlow, are pyramidal.

The first level of the pyramid symbolizes the **physiologic** needs. . . . air, water, food and sleep (and perhaps in that order).

If these needs are not satisfied, they will motivate behavior. Once these needs are satisfied, they drop out of the conscious level of his existence. As soon as one of them becomes needed, it again modifies man's personal behavior.

The second level, above the physiologic needs level, is the need for **security.** When one's security is threatened (such as his job becoming less than stable, or his finances being threatened, or his home, or uncertainty about the future) he will immediately tend to these needs or drives.

Pain or the threat of pain severely undermines any security one may feel and is then a powerful motivator. (Pain, however, belongs in the physiological level as the experience of pain. . . live, throbbing pain, is indeed physiologic and not security threatening.)

Mazlow's third level need in the hierarchy, or the pyramid, is **social**. . . the need for acceptance, approval and love.

Most of us, recalling our adolescence, can remember how powerful this force can be. In dentistry, as we relate to the laboratory or cosmetic dentistry, the improving of the person coming for care's appearance is undoubtedly involved with his social motivation.

Elimination of bad breath falls into this area. . . the very fact that the person is in our office may well be triggered by his social motivation, his need for acceptability.

The dentist who is unable to answer the question "Why?" when it is applied to the person's being in the office should stop and think. If the person coming for care tells us he wants his teeth "checked". . . he should seldom be believed.
The question, "What's your next most important reason for being here?" is an interesting one to ask in that, when answered, we can begin to realize the emotional drive that brings the person to the dental office.

This is important for us in that the persons who come to us for care are not "dragged off the street" by our crew but actually present themselves into our office for care. . . an interesting phenomenon/compliment.

Level Four in the pyramid is the need for **esteem**. It can take place in one of two ways: our self-respect or our self-esteem and the esteem of others.
Again, referring to the Johari Window, this is quite understandable. We need to be competent, as individuals, in realizing our competence. We need to have an independence or a freedom, to recognize and achieve that which we establish as objectives, to feel an adequacy.

Respect from others includes such things as recognition, attention, appreciation. The inter-relationships that are included in our offices, laboratories, families, crew members and persons coming for care are often motivated by their esteem needs.

Most frequently, adding money to the salary will not be the magic wand that "carrots" the person on or "sticks" him into higher planes of activity or productivity. Often the person coming for care has an unsatisfied esteem need. Often our crew can, through its perceptivity, be of great assistance to this need.

Mazlow is perhaps most famous for his comments on the highest level in the pyramid, that which he calls **self-actualization**, defined as a person's need to fulfill that which he was created capable of being. He is motivated at this top level at any stage in his life when all the succeeding, lower, levels are satiated.

One never reaches one's full potential because one's horizons continue to expand so the self-actualization needs are always present providing constant motivation. Motivation without re-stimulation occurs because of the constancy of the horizon.

This is a pyramid, not a chronologic enumeration of needs. And, as in the case of a pyramid, the lower blocks are supportive to the upper. Mazlow clearly states that lower needs preempt higher needs as motivators.

The person who is lacking in the basic physiologic needs will seek "food" first and will not move into the other areas, will not be moved by them, until the basic need is first fulfilled. The other needs are still exerting pressures upon him, but his behavior will not be effected by them until the lower need is restored.

We are not motivated exclusively at one level at a time, but

many times it is an admixture; the basic force is greatest as it relates to the lowest needs that are unsatisfied.

Think about this as relates to crew, to family, to the laboratory technician, and to the other businesses with which you're associated. As soon as a basic need is satisfied, according to Mazlow, another higher need emerges. These emerging needs then dominate the organism until they are satiated.

When these are satisfied, then newer and higher needs emerge, etc. Man is a need-gratifying animal and as soon as one need is satisfied another emerges.

As another author states, "Man's wishes and wants always exceed his income, his needs seldom do."

When thoroughly understood, our selection of objectives and even our movement through the "sea of life" can be less painful and more direct.

One of the things that is important in applying the basic premises of Mazlow's work is to carefully observe and evaluate the level at which the person coming for care is operating.

To identify for the person a need that is on a level presently satisfied (this being a lower need level than the one on which the person is presently operating) it will become a predominant motivator until it is satisfied. These factors should be remembered when the person comes into the office.

A highly skilled engineer. . . who lives in a fine neighborhood, drives a Mark IV to his office, is president of his own company. . .cannot be appealed to on any one of the levels most apparent when he is suffering from a periapical abscess because the frank pain has moved him to the level of the physiological. Pain must be relieved before he can hear anything as social- or esteem-oriented as the fact that plaque causes his disease. As long as he has pain, his ear lids are closed.

In our office, the emergency patient is relieved of pain, bleeding or swelling. We say little or nothing at all. If we must speak, we ask questions. On a subsequent visit, when the pain has been relieved, this person can more easily be assisted in motivation by appealing to him at one of the more appropriate levels.

If a crew person has a financial need, even though it is temporary, your attempting to aid her motivation by granting her a prestigious position will be ineffective until the economic need is gratified.

The security of their various levels as just illustrated must be recognized by the person who's in charge of the relationship and applied sensibly if, indeed, a meaningful relationship is going to be maintained.

Once these needs have been satiated, the persons with whom we're dealing (in our example) will most frequently open their "Window Number Two" and will want to know how the recently satiated need can be prevented in the future.

A person having the traditional apprehension due to fear of pain, fear of the needle, fear of the drill (which is still common) must be dealt with at that level prior to appealing to his sense of rightness and any one of the superior levels.

A principle abstracted out of Mazlow's philosophy then could well be stated as follows:

Unsatisfied lower needs must be satiated before an evaluation of the patient's normal motivational level can be made.

After the need of the person coming for care has been identified and mutually discussed in "Window Number One" the gratification of that need must be accomplished. Said most simply, if a person can listen loudly enough to hear the <u>felt need</u> of his fellow man, he indeed has a powerful key to the motivation of that person.

It is unique that most of us in dentistry never really assess <u>why</u>

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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the person coming for care comes to see us and, therefore, we lose the powerful tool to assisting that person.

Listen for the felt need of the person, and resolve that felt need.

A particular philosophy that is familiar to most of us at this point is the plaque control phase of disease control. (It is, unfortunately, rare that preventive therapy and home care instructions are offered.) More dramatic and recognizable improvement takes place in the early stages of change. The patient immediately feels rewarded. The bleeding stops, the security need is met. The mouth tastes better, smells better, and the spouse mentions an improvement. A social need is gratified. (The emergence of ClO_2 toothpaste and oral rinse, retarDENT/retarDEX, will now also gratify those needs.)

An absolute change in the person's feeling about his mouth, supported by the enthusiastic approval of the preventive therapist, the hygienist and the dentist also gratifies the person's esteem need. We can see this person becoming free of the lower needs and, in relationship to his being in charge of the relationship, now understanding that he can be the one who's responsible for health. The dentist cannot overcome what the patient will not do for himself. This is an important factor in our understanding of motivation.

In review, four procedures have been recommended. First, always start your communication with another person in Window One. Second, equally important, enter Window Two only on invitation. Third, recognize and identify for the person coming for care a need that is on a level which the patient really felt was a satisfied level. The recognition of this need becomes important. . .needs must be gratified. . .it becomes a motivational force. Fourth, identify temporarily unsatisfied lower needs that people have upon entering the human equation with you before proceeding with the evaluation of the normal operational level of motivation for the person.

Most important, a self-awareness can be generated by the information that comes from the Johari and Mazlow models which is invaluable to us in assessing our own strengths and weaknesses. "*It would be a great gift if we could see ourselves as others see us*". . . but at least we can see ourselves against an objective framework and, in part, detect our own errors before they become dissatisfyingly obvious to others in our environment. We don't want the people who come into our practice to become patients, we want them to be real persons coming for care because a great untapped source of dental manpower in our communities exists within those persons in our practices and in our environments who can be motivated.

NURTURING YOUR CREATIVITY

Either you have it or you don't? No way. Fine turn your habits to bring out your best.

By Jeffrey P. Davidson
Inside Guide, October/November 1991

Eric Lowe supervised a staff or 18 in the credit and finance division of a large Dallas-based department store chain. He noticed that when the temperature in his office was a bit on the high side he wasn't able to think as clearly as he'd like to. Eric also felt quite certain that he did his best creative thinking very early in the morning before everyone else came in and that a good cup of coffee or even diet cola helped. Often he walked over and sat in the upholstered chair in his office but subsequently concluded that while it was comfortable he really didn't get much accomplished there.

What factors help you nurture your creativity? Have you ever considered:

→ What kind of weather most people report aids their creative thinking process?
→ How you can determine what time of day is best for you to undertake a creative challenge?
→ What other factors stimulate or hinder the creative thought process?

Control your environment. Many supervisors, just like Eric,, start the day with a burst of energy, hoping for a flash of inspiration and a little time to themselves to think. While it's not always possible to control your work environment just as you'd like to, there are many elements that should be addressed immediately. Poor lighting or poor ventilation cramp anyone's style. Excessive noise, too little working space or extreme temperatures will also hamper your creative capabilities.

What's the weather? Did you realize that most people do some of their best creative thinking when the weather outside is rainy, snowy, overcast or stormy? The reasons for this aren't exactly clear, but a nice day filled with bright sunshine seems to be a foil to the creative thinking process.

While you can't schedule a rainy day in advance, it does make good sense to take advantage of what nature has to offer. If you're one of those people who do think creatively when the weather is frightful, why not "go with the flow"? Look over that long-term plan that's been sitting in your upper drawer for the past several weeks. OR, schedule your staff for a brainstorming session to overcome current problems.

What time is it? Most individuals find that their highest period of creativity is early in the morning, while a significant number find their peak period in midmorning or late at night. A far lesser number find their most creative time in the evening.

If you're not sure what time of day you are at your creative best, monitor yourself over a one- or two-week period. This can be done by keeping a time log of what activities you undertake and when and also by noting your energy level an enthusiasm throughout the various parts of each day.

As a result of keeping this log you may be surprised to find that you should perhaps schedule meetings, write reports, or undertake professional reading at a different time than you've been doing.

Maybe these help. Other factors may help your personal creativity. Among them:

☼ wearing comfortable clothes
☼ having extra space on your desk

- using your favorite writing instrument
- readjusting the height of your seat
- altering the firmness or softness of your seat
- experimenting with the type, size and color of paper you write on.

These could hinder. While there's no hard evidence, it is possible that these factors hinder your creative though process. Consider:

- the ring of your phone
- the color of your office walls
- the presence or absence of background sounds
- the feeling of impending interruptions
- the feeling that just sitting and thinking does not look productive
- too little sleep
- too much sleep
- heavy breads and pastas for lunch
- missing breakfast
- scheduling too tightly
- fear of criticism

Look around your office and those that surround you. Are there factors you can identify that inhibit your creativity? If so, determine whether you can effectively remove or diminish them.

Worth fighting for. If you're like most supervisors you've undoubtedly experienced days or weeks on end when you hardly had a moment to think, let alone to undertake highly creative thinking. This is a serious mistake and one that should not continue to be given "back burner" status. As a supervisor, your ability to effectively schedule yourself and your staff for greatest output depends upon your ability to nurture your creativity.

Igniter Phrases. . . that encourage your staff and get things started include the following:

» I agree!
» That's good!
» Good job!
» I made a mistake, I'm sorry.
» Let's go!
» That's interesting. . .
» Things are beginning to pop.
» I couldn't do that well myself.
» That's a great idea!
» I'm glad you brought that up.
» That's an interesting idea.
» Good work!
» You're on the right track.
» That's fine!
» That's a winner!
» I have faith in you.
» I appreciate what you've done.
» See, you can do it!
» Let's get right on it.
» Let's start a new trend.
» Great!
» I know it will work.
» Go ahead, try it.
» I like that!
» Good for you!

Killer Phrases. . . that destroy ideas and chloroform creativity include the following:

» A swell idea, but. . .
» We've never done it that way.
» It won't work.
» We haven't the time.
» It's not in the budget.
» Too expensive.
» We've tried that before.
» Not ready for it yet.
» Too academic.
» Too hard to administer.
» Too much paperwork.
» Too early.
» It's not good enough.
» It's against our policy.
» Who do you think you are?
» You haven't considered. . .
» It needs more study.
» Don't be ridiculous.
» Let's not step on their toes.
» Too modern.
» Too old-fashioned.
» Let's discuss it at some other time.
» You don't understand our problem.
» Why start anything now?
» We're too big (too small) for that.

REED'S INTERNATIONAL LETTER

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During the last 150 years, perio research has been focusing primarily on etiology to fulfill Koch's criteria for identifying the etiology of an infectious disease. Early, the efforts to identify a source for periodontitis failed and alternative explanations began to leak out.

Non-specific plaque hypotheses as well as non-bacterial etiologies were suggested. Then more recently with the advances in microbiological culturing techniques, specificity became a part of the quest for etiology in regard to perio. A

MEMO: Dr. Perry A. Ratcliff

FROM: Omer K. Reed

number of pathogens have been proposed, but (as I understand it) their role in periodontal disease remains somewhat confusing.

You suggest that there have been problems associated with the search for these agents. First, the technical difficulty, as you've explained it to me, in obtaining bacterial samples, retrieving bacterial plaque from the base of an active site without contaminating it or having it be oxidized on the way to the culture medium has been extremely difficult.

If this is accomplished, we find some 300-500 species and to sort out and identify which role each plays, if any, is an incredible challenge.

As I listen to you, I realize that to determine which sites are active and with which specific type of periodontal disease they're active is also a challenge. . .and that organisms related to destructive periodontal disease may be as few as ten.

You've made it obvious to me that there's more than one type of periodontal disease and that the discrimination of what the pathogens are may be extremely important in differential diagnosis and selecting treatment;

Inaccurate conclusions can probably be made by testing, bacteriologically, of sites that are in remission and interpreting them as we would pathogenic sites. It may even be that some of the suspected bacteria result from the disease entity and certainly a lot of the destruction comes as a result of the body's response to the disease *of* rather than *from* the causes of periodontitis. Periodontal disease, therefore, may be a disease associated with bacteria, not "caused" by bacteria.

Environmental changes at any given site that are caused by a pathogen may create an environment that favors previously undetected bacteria. These opportunistic species may be recovered from the site and assumed to be the cause of the disease, creating confusion in what is already a multi-factorial situation. We have often talked about the ***seed and the soil*** and consider the many problems of naming the pathogens as well as evaluating the host resistance and/or of the immune system.

I know your respect for Socransky (and others) in regard to identifying actinobacillus actinomycetemcomitans, p.gingivalis, B.forsythus and others, who also implies that the pathogens must be present for the disease to occur, but that other factors play a role. He also observes that organisms may be present without the destructive

disease occurring so the detection of the pathogen at a site does not always mean active disease.

In further listening to you, and remembering your ten-year study with 1,000 people documented, and the number of teeth that they lost being statistically miraculous, I realize the enormous debt so many of us owe to you in regard to that which you've done to keep those of us in general dentistry acutely pointed toward the ever-changing world of periodontics.

Socransky, in the Journal of Periodontology (April, 1992), makes comments about the current concepts of the bacterial etiology of destructive periodontal disease. You have directed us to the literature and our discipline is ever-changing. In our struggle to understand the entire problem, we have an ever-changing host whose susceptibility is not a constant and whose susceptibility can be somewhat identified through interview, medical history, medical testing and our understanding of genetics, diabetes, tobacco and drug use, and, of course, now AIDS and the other related viral issues.

Your relating to us the impaired neutrophil in regard to the genetic diabetic and/or other immune-compromised person is a concept that must be borne in mind and transferred to the co-therapist we call the patient.

We know that there are no organisms in the mouth that are beneficial to the host in a direct way, but many could act to prevent and minimize tissue damage by passively occupying a niche which would otherwise be colonized by pathogens or may be affecting the pathogen's ability to grow or function or produce virulence factors. This passive role may not be one that would justify our attempting to preserve any of them and, as you have told us, debridement alone is dramatically sufficient in five out of six people who properly experience it.

This means that somewhere between 15-20% of the population will not benefit and will continue to experience detachment and perhaps even tooth loss.

Surgery as an option is great, but we can't cut the bugs' heads off with a Bard-Parker fast enough (or even with a curette) to make a great deal of difference, and since many people will refuse surgery, even though it's appropriate, antibiotics have come into their own, haven't they? Certainly, in combination with debridement, it seems you're guiding us in the right direction with the proper use of antibiotics.

In Canada, several months after completing a three-week doxycycline regimen, people in the University of Toronto study showed no further loss of attachment, no abscess formation. . . and a control group, which underwent the same initial scaling, planing, prophylaxis and hygiene instructions, but did not have the antibiotic, continued to exhibit active disease.

Interestingly, the six pathogens screened for the study were as abundant at the end of those seven months as they had been at the baseline, suggesting, possibly, that the dynamics of the doxycycline somehow blocked collagenase activity, thus protecting the degradation of connective tissue. A long-term absence of active disease, despite the re-population of pockets, suggests to the Canadian researchers that at least part of the antibiotic affect lay beyond the elimination of reducing the pathogens.

Perhaps this collagenase theory is supported by the Columbia University research team as they

report on the tissue regeneration. In examining the effects of tetracycline in that tetracycline apparently also has the ability to inhibit the activity of collagenase. The University of Michigan researchers (which you've named) conclude that to be effective all an antibiotic has to do is reduce the periodontopathic species to a level with the body's immune system and inflammatory responses, helped by periodic debridement, can take over.

Their studies with short metronidazole regimen plus debridement properly placed against one of placebo plus debridement discovered two-three years later that the surgical needs, including extractions, with the metronidazole group were five teeth per person less than those of the placebo group. They connected this to the initial site's specific spirochete reductions that were attributed to the antibiotic.

I'm excited and pleased that the research you've done with the $Cl0_2$ products in their effective antimicrobial, antiviral and, even more important, their effect against the thrush-producing candida, as this certainly helps the negative side effects most effective antimicrobials often produce. As Churchill said after the Battle of El Alemein:

> *"This is not the end of anything, this is not even the beginning of the end, this is just the end of the beginning."*

Certainly antibiotics with more specific antimicrobial activity and less toxicity will be developed along with the precise targeting of optimal delivery systems, fast in-office diagnostic tests and a more specific relationship to the organisms. As these advances continue, the etiology of periodontal disease will be better understood and the era of anti-infective therapy for the disease will continue.

Along with this, the psychoneuroimmunology of the co-therapist, the work done by Selye in regard to stress, and the remarkable complexity of periodontal disease, etiologically, will be respected.

At the People Without Perio courses that we've enjoyed, with your assistance over the years, I'm constantly amazed at the demand for the simplistic cookbook approach and the negative disappointment when "reference texting" instead of "cookbooking" is provided. Nevertheless, something as simple and yet as universe-containing as a pocket is, is probably best explained by your students as they have been asked to do their research paper on the etiology of and the pathogenicity/therapy of the healing and repair that must then take place in the perio lesion we call a pocket.

The specificity of care must be so intensely personalized that any universal formula that "shotguns" the periodontal diseases we recognize (although a reasonable pre-diagnostic approach for some) lacks the application of personal concern and personal skills provided by thinking therapists and, in my opinion, would take the fun out of the challenge you've brought to us in the last years of your coaching in regard to this ever-changing world.

This is a short summation following the last People Without Perio course, and preceding the new accelerating hygiene department format which we've assembled for **Napili Seminars 1993**, (ACT III - The Hygiene Act). . .and ***a sincere thank you for constantly challenging us!***

NEWS & Views

The Case Presentation **Finale**, was one of the best ever! As always, participants are the reason. . .two gentlemen from Bahrain enriched our days, along with a Swede, Sven Leffler, who delighted all of us with his charm, three Canadians, some Texans, New Mexicans, East Coasters, Midwesterners and delightful team persons also added valid dialogue to our sessions.

Contrary to Valley Dental Group's new receptionist (the front desk is back). . . Omer is not retired! He is still a "wet glove" dentist, he enjoys his Pentegra consultancy, and Napili workshops are "frosting on the cake." To speak with Omer on the telephone, please use this number, 602-852-0956.

Note the 1993 calendar. It will please us to have some new Napiliites from our **Letter** subscribers. **ACT I: Back to the Future**, Palm Springs **Westin Mission Hills** hotel, January 7-8. We do not have a block of rooms reserved as your choice of hotel/resort/tariff will be important in your decision to join us with your spouse and your team.

Cliff Lodge at Snowbird (Utah) for the ski seminar, February 10-14. Please reserve **NOW** as snows have begun, rooms are filling.

England in March? British Dental Association. . . deductible. RSVP

SECOND THING WE DO IS KILL ALL THOSE ECONOMISTS!

So, who's to blame for the nation's economic funk? How about lawyers? That what Stephen Magee, a finance professor, argues. According to his calculations, the average lawyer drains a million/year from the country's output of goods and services. And can that add up: The 500,000 U. S. lawyers sap the economy of a half trillion dollars, or 10% of the country's gross national product, he maintains.

Professor Magee contends the crux of the problem is redistribution of wealth created by "litigation-specific economic predation." (Read that the loss of money to a person armed with an attorney.) This, he says, is different from "crime", the loss of money to a person armed with a weapon. . . in few material respects. Costs of such predation, he maintains, include time wasted fighting spurious claims; loss of potential engineers, doctors and executives to the legal profession; and discouragement of innovation because of excessive product-liability litigation.

Magee apparently isn't worried about a lawsuit. He divulged his thesis t\with two co-authors in a book, "Black Hole Tariffs and Endogenous Policy Theory" and will refine it in another tome, "The Negative Effect of Lawyers on the U. S. Economy."

To support his theory, he offers a statistical study of 34 countries that compares the number of lawyers in each with that country's GNP for the last 20 years, revealing that GNP growth is better in countries with fewer lawyers/capita than in those where lawyers proliferate.

Lawyers, naturally, dismiss Magee's conclusions as *ex parte,* i.e., one-sided. *Res ipsa loquitor*, they plead, the thing speaks for itself. "In the past people have resolved disputes by killing one another in duels," says a Chicago-based securities lawyer. "Is it wiser to have them defending themselves with guns than with lawyers? Besides, litigation is the product of legislation and laws are created by Congress. In other words, this system is the will of the people."

Prima facie, before further examination, that might appear true, allows Magee. Yet deeper analysis, he contends, disproves this defense of the legal profession: Some 62% of U. S. Senators and 42% of U. S. representatives are lawyers."

(by Jeffrey Taylor, sent by M.S., New York. . . Thanks.)

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 lifestylė 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 <u>must</u>. 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. <u>Collection Percentage</u>: 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. <u>Receivables Ratio</u>: Total receivables rising above 12–15% of the annual production for any length of time can result in a growing collections problem.

3. <u>Current Receivables Ratio</u>: 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

OMER K. REED, DDS

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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!

New patients accepted on a screened referral basis. . .

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. If this number is greater than the number of new patients accepted in the last year, marketing or referral base enhancement is called for.

7. Uncompleted Case Index. 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.

8. Production per Hour: 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 provider's available hours next year will give the cost per hour of productive 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.

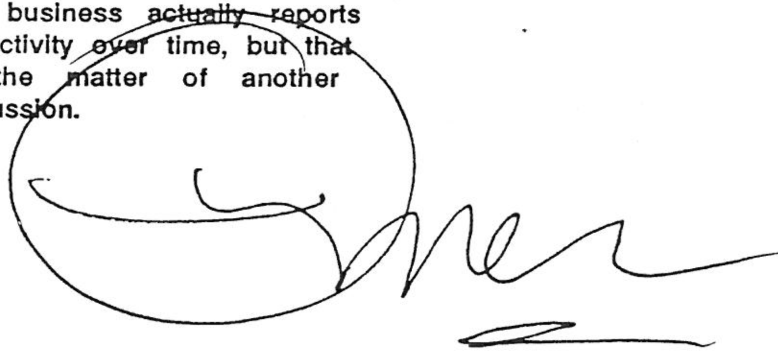
Team concern for growth is not stymied.

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.

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.

Pentegra can do!



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

		COLLECTIONS FOR----> 1987	$340,736	NO ASSOCIATE PLANNED	
ADDITIONAL DEBT		1988	$387,200	AS REQUESTED ON	
COST		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										
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%