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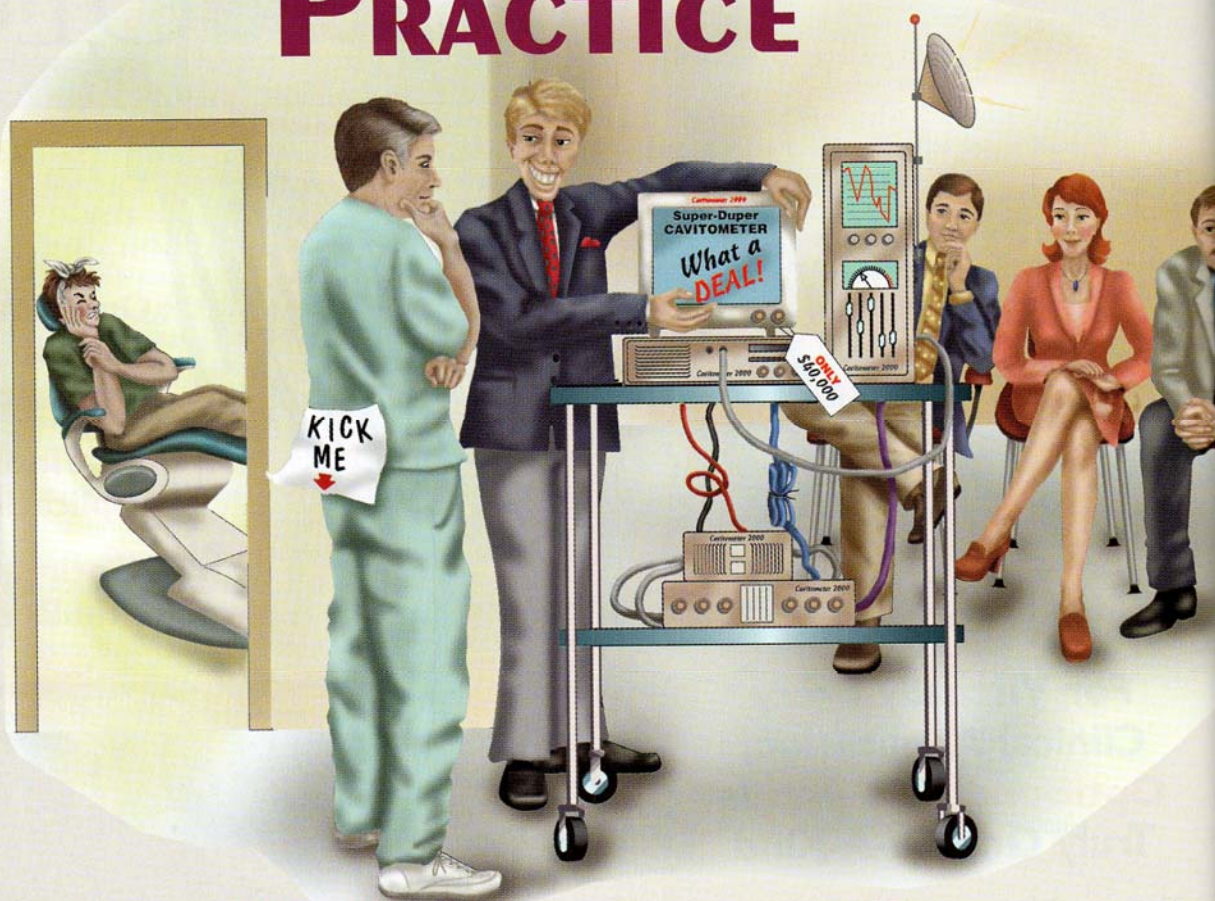
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I GUESS I HAVE A Low-Tech PRACTICE



DO WE HAVE A “KICK ME” SIGN ON OUR RUMPS?

by Jack Griffin, DMD

Look at the “Practice of the Year” articles featured in magazines. Most are basically big advertisements for “Gadgets-R-Us Dental Supply Company.” They look like the power tool bin at Home Depot. It bothers me that featured practices promote more bits and bytes rather than service and compassion. In reality, the amount of stuff you have to plug in should have no influence on a “practice of the year.” When have you seen one of these awesome offices featuring a dentist who does kick-butt gold crowns, pulpotomies on kids with no crying, or composites with great contacts?

Or how about a “Clinician of the Century” nominated because she could do an injection that couldn’t be felt using just a light touch and a regular needle? How about a trip to the podium for someone who does gold crowns that last 30 years?

I have my fair share of “stuff” — some of it in the basement holding Christmas decorations and the office water hose. Some of this technically orgasmic equipment can be great for the right dentist with the right practice and if it is used in the right way. But let’s not put the cart before the horse. Cameras don’t replace

LOW-TECH

The following is as “techie” as I get because patients seldom feel much of what I am doing.

- ◆ First, use a generous amount of topical, even though you don't really think it does anything because it doesn't numb deeper tissues. The point is that patients think it works and that alone is reason enough. The mind is a very powerful thing.
- ◆ Use only a 30-gauge Astra short needle for *all* injections. It has a red dot marking the bevel so that the sharp point goes away from the bone so you don't nick the pain-sensitive periosteum. This also keeps the point sharp for follow-up injections. There is no need to use a “shark harpoon.” Some guy in dental school told you that there is no perceived pain difference between 25ga and 30ga needles. They didn't tell you that the research was probably done on cadavers or 4th year dental students (which many think are the same).
- ◆ For a higher percentage of success for the mandible, aim halfway between your normal location and a Gow-Gates injection into the tissue, level with the maxillary occlusal plane adjacent to the 2nd molar. Go more superior for a more consistent numbing.
- ◆ Insert needles slowly — never bending or intentionally deflecting them. Go straight to the target. Needles that are bent after being inserted into the tissue act like scalpels and hurt more, not to mention the increased risk for tissue damage. The more tissue you hack up, the more post-op pain.
- ◆ Use prilocaine (Citanest, with half or none of the epinephrine of your lidocaine) first. The smaller amount of vasoconstrictor means it burns less going in. Prilocaine seems to be less irritating to the tissues so there is less pain during delivery.
- ◆ Use a quality brand of anesthetic because the rubber plungers like to stick to the carpule sides on some of the cheaper brands. When they stick, you have to push harder to expel the stuff. When it comes unstuck, you will have the touch of a gorilla and the patient will feel the surge.
- ◆ Administer just a few drops per second when first going in. Use a full minute if you are giving a full carpule. Any faster and you are being mean.
- ◆ When infiltrating, just place a quarter carpule or less to just numb the soft tissue, slowly injecting as you insert the needle, a few drops every millimeter you advance. Wiggle, shake, pinch, or do the Macarena to provide sensory interference at the same time. Allow one to two minutes before following the prilocaine with lidocaine. Then wait five to 10 minutes before drilling. *Nothing* is instantaneous except PDL or intraosseous injections. The only time dentists *don't* think numbness is instantaneous is when *they* are the patient!
- ◆ Numb the palate at the assumed position of the maxillary palatal root apex when doing molar endo or extractions. Push firmly with a topical-coated cotton swab for several seconds until the tissue blanches where you want the numbness. Then put in prilocaine right next to the swab. One to two minutes later, follow with lidocaine. Use the same technique for long buccal on the mandible for the same procedures.

compassion. Computers don't replace caring. Monitors don't replace humanity. Real “high-tech” dentistry is taking care of patients as real human beings with real emotions and feelings.

Technology should be considered a supplement to an organized and well-managed practice, *not* the potential “fix-it-all” for an underproducing or non-efficient practice. Spending big dollars won't solve your practice woes.

If there are “high-tech” practices, then there must be “low-tech” practices. It just figures. I have an intraoral camera and a Gameboy for my patients, so in what category am I?

Shoot, I even got rid of my dip tanks and got me one of them there eee-lectric developers. I also use a caries indicator and an apex locator; I am the “cutting edge” poster child. Nowadays, I use a curing light to make composite hard instead of making my patients stand

with their mouths wide open by the window. My patient chairs even plug in.

What category does your practice fall into and why? If you have a computer, or a panoramic, or even curing lights, are you high tech? Why do I need to spend \$90,000 on a CEREC machine or \$10,000 on a sand blaster to be a techie? (By the way, I have both.)

Dental supply guys love this “high-tech” revolution — economically speaking, of course. Think of all the cool stuff us dentists will buy if we think another dentist will be getting an “edge.” How many patients will we lose if we don't keep up? Advertising pretty much assumes that we have money and we'll buy almost anything. Look at the large percentage of dental magazine ads that push “techno-stuff.” We're being overwhelmed with the idea that if we *spend* megabucks, we'll *make* megabucks. Sure, we need new advancements; I'd hate to still be slapping in hand-mixed alloy and banging in

LOW-TECH

gold foils or drilling with a belt-driven, jackhammer-type drill. The truth is, however, that *high tech* usually costs *high dollars*, and it may not necessarily mean higher profits or higher patient satisfaction. Are we just being gullible? Do we have "Kick Me" signs on our rumps?

Great equipment won't make you good

It's amazing how many golfers think

that spending big bucks on new equipment will make them a Tiger Woods. They buy a Big Billy Super Ti 1000cc Killer driver and expect they'll get an invitation to the Masters. A great club can't fix a bad swing. It's about the same in dentistry — many practitioners think that buying new equipment will fix their practice woes and poorly run offices. If quality, peace of mind, or patient satisfaction were directly

proportional to electric stuff, we'd all have kick-butt practices just by spending a bunch of money. Then we'd sing and dance every day as we park the Porsche at the office door.

The dental tabloids suggest we need sand blasters, tooth scanners, porcelain grinders, anesthetic machines, cameras and monitors, imaging stuff we can't understand, and gizmos and gadgets galore. How can we possibly make it without lasers, computers, digital X-rays, microscopes, and our own Web page? An automated dentist can't be far behind: "Just push the remote control and watch him drill." This stuff is thrown at us as if it is *essential* for our success. Not only that, but the implication is that we can't be current, compassionate, or "cutting edge" without more electric stuff. How about another 20-year mortgage? Anyone? Is your credit line still good?

Do today's technophiles have a Caridex caries removal machine? Oh, I almost forgot — no one has them any more. The Caridex was a high-tech goodie in the late 1980s promoted to remove decay without anesthetic by using a spoon-like thing that squirted some solvent into the tooth. Cool! The problem was that it didn't work.

There are certainly some fine reasons to buy new, "high-tech" components for your practice:

- To increase efficiency, quality, or patient comfort
- To increase patient understanding of disease and needed treatment
- To give more and better service to the patients
- To increase your interest in dentistry and decrease potential "burnout"
- To help your tech portfolio go up


Nevertheless, we need to stop thinking "gadgets" and start thinking *service*. Our business goal should

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LOW-TECH

Low-tech tips:

- Try a No. 33 ½ bur on a high-speed handpiece to open the suspect grooves. The handpiece must have a smooth-running turbine with a consistent, even water spray, and a quality *white* light source so you can see just how deep you are drilling.
- Always use prismatic loupes or magnification so you can actually see what you are drilling on. This will save time, make you more accurate, and help show you when you need to stop hacking on the tooth.
- Use a dark caries indicator to show possible decay and when to stop your assault. Remember about false positives with a caries indicator (e.g. plaque, food plugs, decalcified enamel, etc.); and, don't just drill off anything that isn't white.
- Try cleaning grooves for sealants with these same No. 33 ½ burs and a good, sharp explorer. If you really feel the need to take out 100 percent of the organic plug in the grooves, drill deeper or use a microetcher unit.
- Clean out decay with a sharp No. 2 bur on a slow speed that runs smoothly enough so that you're not causing internal bleeding in the patient. Replacing the contra-angle only as often as the Hale-Bopp comet flies by isn't often enough.
- The younger the patient, the deeper you can go into the tooth without anesthetic — with just nitrous oxide. Stop (really!) when they raise their hand because they are uncomfortable, and offer them anesthetic. Don't be mad at them because they stop you.
- Try using a self-etching bonding system (e.g. Clearfil, Prompt) if you get into the dentin, so the tooth isn't sensitive to the phosphoric acid etch and subsequent rinse.
- Don't dork around. Coming in and out 50 times during a filling is unproductive and increases patient stress. Get to the point and go straight for the target. Have a mental image before you floor the pedal.

be to do everything it takes to provide excellent dentistry while making our patients as comfortable as possible. This needs to be done with your heart and not necessarily your wallet. You can't purchase anything that replaces genuine concern. The following are ways to act high-tech without buying anything that needs a manual. They are at the center of "high-tech" because they are the best way to make your practice "state-of-the-art."

Pain control

High-tech is low pain. Patients refer friends only to dentists who don't hurt them. Electric anesthetic devices like the Wand are really cool, but I believe you can do it as well by taking your time with the right techniques; it doesn't have to cost two to three dollars per injection and another mortgage before starting. Also, remember that while the rate of anesthetic flow is very important for pain perception, blind studies that compare patient feelings between different techniques are useless unless the exact same needle type, size, and shape are used. Also, the chemistry of the anesthetic should be identical.

Drill substitute

I have used two types of air abrasion machines in my office. I leased a relatively expensive one (a \$9,000 unit), and bought a relatively inexpensive one for \$2,000. They both clean grooves and incipient lesions well. Now, the one I bought sits in the closet near the unused amalgam. It's not that it didn't work, it's that we could do basically

the same thing with a No. 33 ½ inverted cone bur and a slow hand. If either instrument stays in the enamel, there is no pain, even without anesthetic. With a handpiece, we don't need to clean abrasive dust out of and off of every surface within two miles of the office, worry about breathing it, or risk messing up the suction system. I took a great course from a skilled teacher, and the potential for these air abrasion machines makes sense. The reality for me, however, is that a slow hand with an ultra small bur — a No. 2 round bur on a slow speed — and some caries indicator gives me as much pain-free, no-anesthetic dentistry as I produced with the "blaster."

Fluoride has made enamel so hard, decay has to basically go to the pulp before a tooth will break. It amazes me how often we see what appear to be surface lesions that go several millimeters into the tooth after breaking through the enamel. The air abrasion unit went through the enamel as well as the bur, but could not remove the decayed dentin predictably or without pain. Then, the sharp No. 2 round bur on a slow speed is often needed no matter which way you go through the enamel, and it seemed that anesthetic was needed at roughly the same frequency with or without using the air abrasion unit. The twin disadvantages of mess making and inconsistencies outweighed any clinical advantage we had — even *with* the giant elephant-nosed sand sucker machine.

Treatment acceptance

If intraoral cameras are high-tech, then I'm stylin'! I

Really low-tech stuff that works

☆ Have the hygienist examine the teeth during the prophylaxis and mention to the patient, "Dr. Hacker will probably talk to you about a crown for that broken tooth." The hygienist should tell the dentist about her discussion with the patient — either in a private meeting with the dentist, a note in the chart read by the dentist before entering the room, or a note on the tray cover that the dentist looks at before doing the exam.

☆ The staff is almost perceived as an unbiased second opinion. Don't forget those models you have in the closet. Teach the staff how to discuss treatment in a professional manner with the patients while you are off doing other teeth or sitting in the library. They are very believable and can convince patients as well or better than you can.

☆ If a two-dimensional video is good, then a three-dimensional model must be a whole dimension better! Of course, there is no bad way to help the patient understand the needed treatment as long as we don't try replacing people with gadgets.

☆ Brush and floss your own teeth. It's amazing how many dentists have bad breath. Have a few Altoids or Velamints during the day. Patients probably won't accept your treatment if they can't stand smelling you talk to them.

☆ Trim your nose hairs and clean the blood splatter off of your glasses between patients. If you are a slob, your patients may think your work will be the same.

☆ Have an office that looks like quality work is produced there. You don't need to build a new office, just get rid of the brown, three-color, sculptured shag carpeting that didn't even look good in 1975 when you put it in. Brighten things up and get rid of the clutter. Take the moose head down in the reception area and put up pictures of your children. Repaint and wallpaper at least every three to five years.

☆ Give your patients options, then "guide them" to making the choice you want them to pick. In other words, they can be encouraged to choose your preferred method but are involved in the decision. For example, offer the crown as well as the four-surface composite while giving the advantages and disadvantages of both. Let them decide while being influenced — not forced — by the office inkling.

have them in all hygiene rooms and most of the others as well. I've had them for several years, but I believe my case acceptance rate was just as high *before* I bought them. I had 24" by 36" dry-erase boards in each operatory and drew pictures of many procedures for the patients — crude, but effective. I believe just taking the time to explain things to patients builds rapport and helps you gain their trust. That is what "sells" cases.

If there is one techie item to throw money at, however, the intraoral camera is it. The key to remember is that cameras, DVD players, CD ROMs, and 50" TV screens are merely *supplements* and are not *substitutes* for caring and knowledgeable staff members. You will not be able to lay off a staff member when you buy a CAESY. Patients don't want to be locked in a dark 8' by 10' room for 15 minutes with a VCR explaining why crowns are better than fillings. They want to ask real people real questions and get real answers. Show them the pictures and tapes, but take the time to listen to their concerns and properly address them.

Restorative options

When was there a "practice of the year" that featured awesome gold crowns on molars? How about 25-year-old amalgams that have tertiary anatomy and are so shiny you can see your face in them? A high-tech office is one that does consistent restorations that are functional, comfortable, long-lasting, and affordable to our patients. *Service* is the name of our profession. *If our patients cannot afford us, we provide no service.*

Think about it: How many times have you had a posterior PFM or all-porcelain crown fracture porcelain off? Be honest. How does that compare with the number of full gold ones you've seen break? At least 90 percent of the crowns we use are porcelain, but how is it that the *choice of material* is what makes them high-tech (or not)? It's preparation design, marginal adaptation, comfort, and perception of value by the patient that makes a procedure high-tech.

We live in a time when tooth conservation is paramount, so conservative air abrasion or slight drilling is *de rigueur*. Yet, often at the same offices, they are whacking off many square millimeters of enamel so that porcelain can be stuck on teeth to lighten the shade or do minor tooth reshaping. *This is contradictory in nature.*

I can't believe the cases I see in some of the "aesthetic" magazines. Why do so many good-looking teeth have to be ground down to nubs so porcelain can be stuck to them? Are we conservative for needed fillings and then aggressive when we do cosmetic stuff? Even though it often has a fee that is two to four times higher, porcelain can be overvalued if it is treatment-

planned incorrectly or done sloppily. More introspective stuff:

☺ Never think of cash flow or production when recommending treatment. This sounds obvious, but does the fee ever creep into your mind when treatment planning? Be honest. Let your convictions lead your persuasion of the patient toward treatment needed.

☺ If you do a crown that costs three or four times the cost of a filling, make sure that you give three or four times more effort, technique, concentration, and service for that fee. If you can't, give patients their money's worth for the least expensive procedure. We all have bad days when not every prep is an "A+," but honestly assess the value your patients are receiving from you.

☺ Remember, a bad crown or veneer is worse than a bad filling. We generally destroy more tooth structure doing crowns. Repairing them later will cost the patient even more tooth; a filling is generally more conservative and reduces tooth structure losses. Certainly, the crown or bonded porcelain should last longer and be a greater service if done well; if not, the patient wastes his money and we waste our time.

☺ Whatever material and technique you use, do it as well as you possibly can. Sometimes I feel sick when I see a filling I did only two or three years ago — it looks like a blind guy did it. Look at the notes in the chart and evaluate the materials, curing lights, treatment room, or even the assistant used for that restoration so you can make changes. I consistently ask the hygienist at recall appointments what materials we used and on what date it was done. That way, when I see something particularly good or bad, we will know why it worked so well or make adjustments if it didn't.

Caries detection

Decay pretty much has to go to the pulp in order for the enamel to break. However, we often allow decay to go undetected because of laziness. Now, we think an electronic caries detector — like the DIAGNOdent — will make us catch it all. Certainly, anything we can do to correct disease when it is small is an advantage for the patient. Again, let's get really competent at diagnosing before trying to cover up our sloppiness with new stuff.

♦ Do scheduled maintenance weekly on your developer and pour in fresh chemicals. Doing processor maintenance only as often as you change your car oil isn't enough. We often can't see smaller lesions because our films are rank.

♦ Faster speed film is great for lowering radiation, but if the quality of film is so poor that we can't detect

beginning disease, we are radiating the patient for no reason — that in itself is over-exposure.

♦ Teach the staff how to take quality films so that overlap, distortion, and faulty developing are minimized. Often we get a poor-quality film and are too busy or too lazy to wait for a new one to be taken. If the staff knows how to detect a poor-quality film, they can take another one before you see it so it won't keep you waiting. This may even allow them time to hide the evidence by throwing away the bad films so they are more likely to get that new raise.

♦ Once inside the tooth, liquid caries indicator (e.g. Sable Seek, Snoop, etc.) should routinely be used. Certainly, there are false positives like decalcification, porous dentin, or even plaque. But it is very high tech to remove the decay with your favorite spoon, drill, or weed-eater and then use the caries indicator to see the areas you missed. It's amazing how often I would have left decay under the cavo-surface margin or in some innocent-looking nook or cranny.

♦ Use explorers that actually have points on them (how techie!). We often have explorers that couldn't pop a balloon because they are so dull. Try using a CH3 or pig-tail explorer instead of your 20-year-old ones and you'll see just how many grooves you never got into before. Explorers can miss decay; they can even give a false positive if they get "stuck" in a deep groove. However, they are still an awesome way to reinforce what you suspect

from visual inspection and radiographic interpretation.

The good, the bad, and the cutting edge

Clearly, different equipment and techniques work better for some dentists than for others. But again, some dentists think they need a marketing edge, so they buy some expensive, "state-of-the-art" toys. Remember, your attitude and compassion determine what kind of dentist you are — not the size of the mortgage on the toys. A lousy dentist with lots of high-tech is still a lousy dentist — with a big debt.

Some awesome practitioners routinely use many of these gadgets to do terrific dentistry. But it is ridiculous to imply that these dentists are "high-tech," while others who do great quality restorations with older, less expensive, time-tested tools aren't "cutting edge." Being high-tech is doing consistent work in a compassionate manner. Now *that's* cutting edge. I've got to get back to work, I'm thinking about buying one of those caries detectors ...

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