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April 2005

## from Gregory Tarantola DDS



### Greetings!

**Tarantola Dental Learning** is dedicated to helping dentists and their team of staff, specialists and technicians learn and apply the principles of comprehensive, masticatory system dentistry in a relationship-based environment. That means promoting and maintaining optimal health, function and esthetics of all the components of the masticatory system, that is, the TMJs, the neuromuscular system, the dentition, the periodontium and occlusal bio-engineering. And accomplishing this in a way that is appropriate for that particular patient, that is, with their interest and active participation.

### Remember this formula for "Peace Of Mind" in your practice:

#### **NP (or EP)+E+D+TP+TS+CA=PS**

New Patient (or Existing Patient)+Examination+Diagnosis+ Treatment Planning+Treatment Sequencing+Case Acceptance=Predictable Success

Thanks to Charles W Martin, DDS, MAGD, DICOI, FIADFE  
LeadershipMastermindCoaching.com for suggesting the enhancements to the above formula for success.

#### **This month's inspirational quotes:**

**"Failure is nature's plan to prepare you for great responsibilities."**

**-Napoleon Hill, 1883-1970, American Speaker, Motivational Writer, "Think and Grow Rich"**

**"A man's errors are his portals of discovery. "**

**James Joyce, 1882-1941, Irish Writer and Poet**

## Thought For The Month

**How to be more confident and effective in our interactions with our patients.**

Like it or not, we are in sales. Not so much selling



the "products" of dentistry but rather ourselves, the value of our services, an incredible experience. It is very frustrating to have patients say no, or not follow through with what we really feel is in their best interest and can be of great benefit to them.

We will make a lot of mistakes along the way but as Napoloen Hill and James Joyce say in this month's quote, these failures prepare us for greater things...if we learn from them.

We can also learn from the wisdom and experience of others. This month's article, "Ten Sales Mistakes and How Not to Make Them" by Al Simon gives us great advice as it applies to sales in general with interesting implications to us in dentistry.

- [Go to the article.](#)

## SELF-STUDY LEARNING CDs

**Multimedia...interactive...interesting...effective**

COMPREHENSIVE, RELATIONSHIP-BASED DENTISTRY



COMFORT, FUNCTION, HEALTH AND ESTHETICS  
WITH STABILITY AND LONGEVITY  
OF THE ENTIRE MASTICATORY SYSTEM

**Look for Dr. Tarantola's article in the March issue of Dentaltown: "Defining Our Role As Dentists"**

Enjoy the peace of mind and fulfillment of practicing comprehensive-care, relationship-based, masticatory system dentistry! These **SELF-STUDY LEARNING MODULES ON CD** are a great way to learn and implement masticatory system principles and to connect with the patient so they become an appreciative partner with us.

The learning modules are very visual, the text is to-the-point outline style, and the photo table of contents is linked to every page making it extremely easy to navigate and refer back to over and over. You'll find it a GREAT value...and of course, with a money-back guarantee!

*"How often have you gone to a continuing education course and wished that you were back in your own office doing dentistry? How many times have you sat through hours upon hours of lectures only to get one pearl of information that took mere seconds to dispense? What if there was a way to get quality condensed information delivered to your door that you would be able to watch on your computer? Now, what if I told you that you could, and the answer was Tarantola Dental Learning CD-ROMs?" Dr. H.F., DDS, MBA*

***We all learn in different ways. These modules are very visual and not a lot of text to read. If you are already in a course of study, you need these CDs to complement your learning.***

***For the month of April, we will continue to include the "Management Workbook" and "Vision Workbook" with the purchase of the Complete Set or Case Study Guide.***

- [Click here to see Tarantola Dental Learning](#)
- [Click here to see the article in Dentaltown](#)
- [If the above link does not bring you to the article, click here to go the](#)

[Dentaltown's home page and navigate from there](#)

## **APRIL CLINICAL TIP**



This month we will continue with the patient whose exam and diagnosis was presented in October, which you can still view on the website. December presented the diagnostic blueprint. The patient is finished with bite splint therapy and the goals of 1. Improvement of signs and symptoms and 2. Stability of the occlusion on the splint over several months have been accomplished. She is ready to begin the definitive plan which was presented in January's Clinical Tip. Because of her involved history it was decided to stage the treatment in smaller segments. To do this, the first step had to be incorporating all occlusal parameters with composite additions and equilibration.

**So the patient is comfortable with the bite splint...now what?**

A splint is simply a reversible way to immediately give a patient a physiologic occlusion. A cause-effect diagnosis has been made, that is, there is a logical connection between their occlusal interferences and the signs and symptoms they present with. Your clinical exam and tests confirm this. The splint then allows you and the patient to assess the effect a physiologic bite splint

occlusion has on the masticatory system.

Once the goals of bite splint therapy have been accomplished, it is now time to re-evaluate with new articulated diagnostic casts and see what it will require to give the patient a physiologic occlusion. The same comfort and stability that was achieved with the splint should be achieved definitively in their mouth.

The case study introduced in October has been treated with bite splint therapy and our goals have been accomplished. This month's tip illustrates the beginning of her definitive care.

- [Click here to see the APRIL CLINICAL TIP](#)

## **BRAND NEW-"THE CASE STUDY TREATMENT PLANNING GUIDE"**

***The practical, everyday application of masticatory system dentistry***



A collection of over 30 fully documented cases. History; exam; photos; casts; radiographs; diagnosis; the diagnostic blueprint to include an outline of all 10 decisions to make when blueprinting; treatment plan; treatment sequence; provisionals; the definitive case. A wide variety of cases are included.

When you have a perplexing case, you most likely will find a similar case in this collection to help you in your decision making. It shows with real life, practical cases, the application of the principles of the comprehensive approach.

There is also a new tutorial included that covers the keys to restorative success: Planning-Execution- Communication. You will find clinical tips throughout that will enhance your cause-effect understanding and how to deal with it at the planning stages.

As a bonus, the pertinent occlusal scientific literature of 2004 is summarized. 31 references and abstracts included for your review. Yearly updates including new cases and current literature will be offered .

As Steven Covey says in his book *The Eight Habit*, the road from effectiveness to significance is paved with this challenge, "Learn, Do, Teach". In other words, you not only have to LEARN it, you must DO it, that is put that knowledge into action. Then, to REALLY learn, you need to tell or teach someone else. By doing this step, you learn the material even better as you consolidate and clarify your thoughts in a way that you can convey it understandably to someone else.

This Case Study CD has a special challenge to help you implement "Learn, Do, Teach" and move from effectiveness to significance. Those who accept and complete the challenge will have their own case study published in a new, upcoming section of Tarantola Dental Learning - "Case Studies From Our Readers".

**For the month of April, we will continue to include the "Management Workbook" and "Vision Workbook" with the purchase of the Complete Set or Case Study Guide.**

- [Click here to see THE CASE STUDY TREATMENT PLANNING GUIDE](#)

### **QUESTIONS AND COMMENTS SUBMITTED FROM MARCH'S CLINICAL TIP**

*The March Clinical Tip stimulated a lot of questions and comments so this section is longer than usual.*

***Suggestion for the "Comprehensive Approach" model above.***

Your "Comprehensive Relationship-Based Dentistry" chart is missing an important ingredient, that is "Nutrition". Dr. Weston A. Price, DDS, did a large study showing a direct connection between dento- skeletal DEVELOPMENT and nutrition. You can find that information in his 1939 book, "Nutrition and Physical Degeneration". (ISBN 0-87983-816-7) Sincerely, Pentti J. Nupponen, DMD, MAGD, FIND (drnupe@hotmail.com) PS from Greg Tarantola: In Dr. Pankey's original philosophy from the 50's, the four legs of the "Total Patient Care" stool are 1. Hereditary predisposition 2. Restorative dentistry 3. Periodontal therapy and 4. Nutrition.

***What are all the negative implications of not providing a facebow when mounting diagnostic casts in splint fabrication?***

The facebow gives you the general position of the maxilla as it relates to the TMJs, that is distance from the TMJs and orientation of the occlusal plane. If a facebow is not used, the arc of closure will not be correct therefore when the closed from the vertical dimension of the jaw relation record to tooth contact, errors may be seen. Also, if the orientation is not correct, the condylar inclination setting used on the articulator would not reflect the mouth. Therefore what you determine you may need to do to the casts to get a correct occlusion may not represent the mouth. Also when you fabricate

the bite splint, you may find you need to make the splint thicker or the anterior guidance steeper to get disclusion.

**So what do you do with this patient now?? I have an "older" practice with many patients in their 60's and above, even a number in their late 80's and early 90's. This is the norm for them with cracks, shoed cusps, and, I am sad to say, missing teeth due to fractures. We have to fight them to get BW's much less mounted casts and bruxism splints, which many just won't wear even when we make them. What do you envision as your future treatment plan for this patient? Do you insist they wear a splint and have periodic equilibrations, do you crown the teeth with cracks? And finally how do you get paid for performing treatment that a lot of older patients will think is not needed.**

I am continually amazed at the power of a "co- discovery" exam whereby the patient learns and becomes interested. Get a book by Tom Freece "Question based selling". It is an eye opener. We, especially adults, don't learn by being told. Start with a full set of digital PHOTOGRAPHS, hand the patient a laser pointer and sit in front of a computer monitor to review the photos. Let the patient do the talking. Ask questions to get them talking. You can't argue with what you see. Don't talk about treatment, just talk about what you see and the implication of what is observed. I bet you will see the level of interest rise. If not, well...not everyone wants optimal care (but more than you think do with this approach). As they become more aware and interested, then you can talk about treatment specifics. And don't feel rushed to give them an answer right on the spot. Take some time to ponder and reflect.

So what about the case study patient? He needs definitive occlusal therapy, periodontal therapy and definitive restorations on the affected teeth and a bite splint as a bruxism protection device. What if he does not want this? Well if he doesn't, my first question would be if I educated, motivated and got him interested well enough. That does not just mean "telling". As stated earlier, it means "co- discovering". They have to understand where they are before they can understand where they can go. What if after all that, he just isn't interested? Well then you (and the patient) have a decision to make. Do you want to stay in a crisis care mode (which is what it will be)? Then be ready to accept the frustrations it entails. If the patient understands their condition and still won't wear a splint, then there just isn't much you can do to help the patient.

**Additional diagnostic comments from a reader**

This patient has significant perio issue also. I see significant recession in multiple sites and incomplete passive eruption on the lingual and palatal. If this case is to be treated properly and definitively it will need crown lengthening in the posteriors and root coverage grafting. You're right, there's a lot going on here.

**I truly appreciate your thorough evaluation and impeccable photos to describe the findings. The comments I have with "Just a 5 minute check" issue is that although it is good to discover these issues in people's mouths with a thorough exam, rarely do they want to do anything about these findings. Whether due to lack of understanding, motivation, financial issues or some other obscure issue that is difficult to pinpoint. Some things have to be said about people's perception of urgency, motivation and appreciation for recommended therapies. Many of us who have been to the Pankey Institute and have studied the philosophies and techniques know how to**

**recognize these things, what many of us don't know is how, and more importantly, when to confront and motivate our patients. An example would be if a 20 year old college student had this mouth and came to see us out of our ad in the yellow pages, would we even try to say something knowing that the patient will be disappointed? This is why many of us do the 5 minute exam. Despite my education of Dr. Pankey's philosophy, I find that timing for comprehensive examinations is more critical then anything else I have learned. I find that a 20 to 30 year old is best taken care of with a simple cleaning, a slap on the back and an invitation for a comprehensive exam if we find the mouth we see in your photos. With a simple question such as: "Look John, I see some things that concern me in your mouth. I see cracks, wear and other issues. I really think it would be best if you come in another time for a deep and thorough exam involving more than just a check up of cavities. What do you think?" and give them the power of the choice. At this point, our only goal is to motivate the patient to appreciate the comprehensive exam. Once we are convinced that they are truly ready for it, give them the comprehensive exam and detailed analysis report. Believe it or not, it is possible to "WOW" a patient in 10 minutes. The point of this comment is simple, all the clinical findings, photos, doppler, and the occlusal analysis mean nothing if the patient does not understand it, appreciate it or value it. Actually, it could irritate the patient if not done according to the patient's understanding level.**

On one hand I see your point but on the other hand I see the "5 minute exam" as the nemesis of dentistry. When I was planning my current office, the architect spent more time getting to know me, my desires and expectations than the orthopedic surgeon that recently operated on my thumb spent examining me!! What's wrong with this picture? The complete exam is not just for those we think need dentistry, it is for everyone, even the young patient, because it establishes a baseline for future comparison diagnoses. For one thing, studies have shown that over 50% of teenagers have signs of TMJ changes. I wonder how much of the dentistry I do could have been avoided if a complete exam was done by their former dentist long ago. What you do today, you will do more of tomorrow. If you do a lot of 5 minute exams today, you will do more tomorrow, unless you proactively change. The 5 minute exam leads to some minor restorative work. That may deteriorate and then a crown is done. The same thing happens elsewhere in the mouth. Where does it end and change. After they have been coming to you for years and are used to the "5 minute approach" it is harder for you and them to change. It is a whole vision/strategic plan thing. The entire office must have a comprehensive mindset. The person answering the phone must believe it and be able to converse with new patients about it. This way, "pre qualified" patients will get to your time for the exam. Why would a patient object and be offended by only talking about what you see together in their mouth? Not about dentistry or solutions you might suggest, but simply what you see. Discover a concern they have and "stay with it". Be interested, ask more questions to understand everything about it and let that be the segway for the rest of the exam. As the months go by, you will be amazed how you will be doing more complete exams (and dentistry). Those patients refer others. The face and reputation of your practice evolves. You find you don't need the Yellow Page ad. And you also realize that you don't have to (and simply can't) be all things to all people. The term "suitability" I feels pertains as much to the dentist, the leader of the practice, as it does the patient.

### ***PLEASE TAKE THIS 5 MINUTE SURVEY***

***It has been one year since launching Tarantola Dental Learning. If you would please take less than 5 minutes of your time to complete this survey, it***

**would be very appreciated. Our goal is to make the information more useful and beneficial for the dental profession.**

*The response to the survey was wonderful. Thank you all for you input, comments and suggestions. For those that did not take the survey but would like to, please feel free to respond.*

- [CLICK HERE FOR THE SURVEY](#)

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