Ortho Tribune

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All relationships come down to this.
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Practice has best month yet. Find out how.
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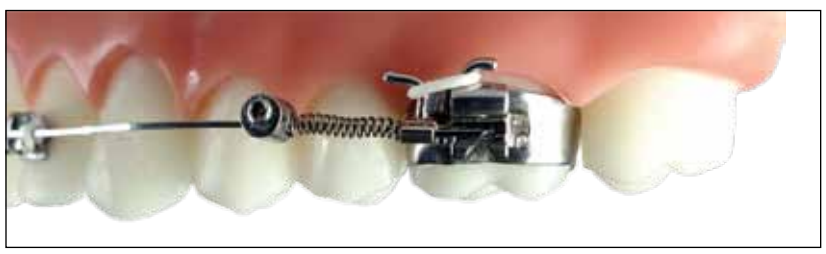
Quick-fix device for pseudo-Class III

Resolving anterior crossbites with the quick-fix device

By S. Jay Bowman, DMD, MSD



Illustrations of the quick-fix device. (Photos/Provided by Dr. S. Jay Bowman)

The early resolution of a pseudo-Class III malocclusion appears to be one of the most successful and stable orthodontic procedures. The purpose of this article is to describe a simplified yet predictable mechanism for the correction of pseudo-Class III malocclusions and, with the addition of mini screws, treatment of some Class IIs.

Pseudo-Class III malocclusion

The differentiation of pseudo-Class III from a typical Class III malocclusion is a simple yet critical distinction in orthodontic diagnosis. The classic clinical presentation of pseudo-Class III is seen in a patient who exhibits an anterior functional "shift" of the mandible, resulting from lingually inclined maxillary incisors (i.e., anterior crossbite).[1,2]

When the pseudo-Class III mandible is manipulated into a terminal hinge axis position, often the incisors will contact edge-to-edge. Consequently, the patient must move his or her lower jaw forward in order to occlude on his or her posterior teeth. This type of shift is not indicative of a true skeletal Class III relationship.

Specifically, a decreased midface length, diminished upper-arch length, retrusive upper lip, increased maxillary-mandibular anterior displacement, retroclined upper incisors and normal vertical development typically characterize pseudo-Class III patients.[1,3]

Interestingly enough, Lin[4] has reported the prevalence of Class III in a Chinese population involves one in 20 youngsters, but half of those may be characterized as pseudo-Class III. The incidence of all types of Class III malocclusions in Caucasian populations is far less frequent.

Correction of Pseudo-Class III

Hägg and co-workers[5] have stated that "interceptive orthodontics is intended to prevent a specific problem from getting worse."

Consequently, the goals for early resolution of a pseudo-Class III malocclusion are to improve the functional shift of the mandible and to increase maxillary arch length to permit proper eruption of the permanent cuspids and premolars into a Class I relationship.[6-8] Advancing and/or tipping the maxillary incisors labially can normalize the

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Communication ...

Understanding learning styles is key to working with others

By Dennis J. Tartakow, DMD, MEd, PhD
Editor in Chief

Learning how to communicate with one another is the first step in all relationships. All educational programs must adhere to basic principles of learning in order to enhance a student's educational experience.

It is important for educators and administrators to understand and recognize that not all students use the same learning modalities.

For the clinician, it may be helpful for each one of us to recognize which modality of learning serves us best.

Seven learning styles

First, and foremost, be aware that there is a minimum of seven recognized styles of learning for all individuals.

In "Frames of Mind: The Theory of Multiple Intelligences" (1993), Dr. Howard Gardner, a respected authority on higher education and learning, established another way of grouping learning styles, suggesting that there are at least seven modalities or intelligences linking our individual styles.

While Gardner's work encourages the consideration of new and creative ways to educate students, a solid grasp of core modalities apply immediately to everything we do.

Adult learners typically rely on learning modalities that process information at an unconscious level, but the adult may be consciously aware of which modes he or she prefers. Most learners retain a dominant and an auxiliary learning modality, and access information through all the senses but generally favor one.

We process by visual-sight, auditory-sound, kinesthetic-moving and tactile-touch.

Gardner suggested the following basic learning styles:

1) *Verbal and linguistic:* Sensitive to the meaning and order of words.

2) *Musical:* Sensitive to pitch, melody, rhythm and tone.

3) *Logical and mathematic:* Able to handle reasoning and recognize patterns and order.

4) *Spatial:* Perceives the world accurately and tries to re-create or transform an aspect of that world.

5) *Bodily and kinesthetic:* Able to use the body skillfully and handle objects adroitly.

6) *Interpersonal:* Understands people and relationships.

7) *Intrapersonal:* Possesses access to one's emotional life as a method to understand oneself and others.

Second, develop better communication skills and lines with other service providing individuals, i.e., fellow orthodontists, dentists, physicians, attorneys as well as a patient's nuclear family.

Third, gain a better understanding of behavior and interactions between individuals from different cultures.

Forth, extend respect, compassion, empathy and concern for the needs of others.

Fifth, create an environment to develop greater leadership skills.

Sixth, and last, be considerate of the social justice and human rights afforded to all individuals.

Learning may be defined as useful changes in behavior by reflecting upon past experience. The past leaves much to reflect upon when contemplating the future.

Today's answers will lead to tomorrow's questions. *"Tell me and I forget. Show me and I remember. Involve me and I understand,"* says one Chinese proverb (source unknown). Hindsight so often provides an individual with an unequivocal opportunity to review and reflect upon one's experiences.

According to Dr. Wayne Dyer (2004), inspiration is not reserved only for high-profile creative individuals in the arts and sciences, it is for everyone and is the force behind humanity's greatest achievements.

When the secrets to cultivating inspiration are discovered in every moment of one's life, that individual will enjoy an unimagined experience of enlightenment, abundance and extraordinary achievement in an effortlessly manner.

In summary, do to others as you would do to yourself. One of the most important goals for all orthodontic educators is to encourage students to work on becoming more sensitive to the needs of others.

A top priority for this orthodontist has always focused on developing greater understanding of an individual's behavior when alone as well as in group interaction. Sensitivity to the needs of others is of extreme importance and significance, and vital for the orthodontist: compassion, understanding, empathy and consideration are some of the salient and foremost attributes we all must strive to develop. OT

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- Dyer, W. (2004). *The power of inspiration*. W.S. Bookwell, Hay House, Inc.: Finland.
- Gardner, H. (1993). *Frames of mind: The theory of multiple intelligences*, 10th anniversary edition, New York: Basic Books.

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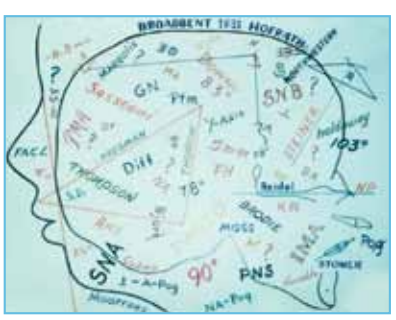

Image courtesy of Dr. Earl Broker.

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OT Editorial Advisory Board

Ackerman leaving JU

National search for new orthodontics chair to begin in November

After three years of full-time teaching at the Jacksonville University School of Orthodontics and taking over as the chair of the program earlier this year, Dr. Marc Bernard Ackerman will depart at the end of the current semester to assume the role of director of orthodontics at Children's Hospital Boston with a teaching appointment at Harvard University School of Dental Medicine, Department of Developmental Biology.

The national search for his replacement begins in November.

Ackerman served as the chair and program director of the School of Orthodontics since June. While at JU, Ackerman developed and implemented the one-year fellowship in orthodontic clinical research program.

To date, all of the fellows who successfully completed the program have matriculated to an American Dental Association-accredited residency in orthodontics and dentofacial orthopedics.

In addition to his teaching responsibilities, Ackerman completed JU's Davis College of Business executive MBA program in 2009. He was instrumental in aligning the School of Orthodontics' curriculum and clinical care model with other well-established residency programs in orthodontics.

"JU School of Orthodontics is far stronger today than when I arrived three years ago. With a continued focus on educational innovation and quality of care, the school could position itself as one of the leading residency programs in the country," Ackerman said.

Ackerman will be responsible for orthodontic clinical care, teaching and research at Children's Hospital Boston.

The department of dentistry provides comprehensive dental care for infants, children, adolescents and persons with special health-care needs. OT

Dr. Marc Bernard Ackerman will depart from the Jacksonville University School of Orthodontics at the end of the current semester. A national search to replace him begins in November.

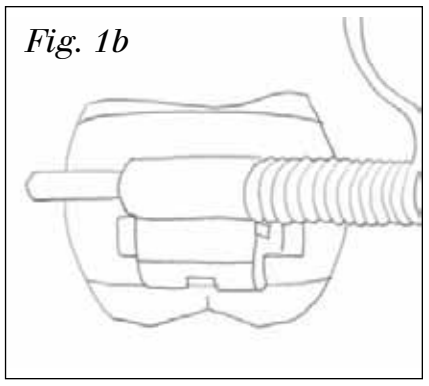
(Source: Jacksonville University School of Orthodontics)

Ethics and Legal Aspects conference planned for Feb.

The third annual Ethics and Legal Aspects of Dentistry Conference sponsored by the American College of Legal Medicine will be held Feb. 25 and 26, at the Planet Hollywood Resort in Las Vegas.

Seminars will include legal issues in dentistry and understanding the government's role and the role of dental education, a description of ethical, moral and diagnostic issues as they relate to the dental practice, evaluations of risk management considerations, issues relating to patient care and mid-level care, issues about access to care and dental health care coverage, electronic record keeping and more.

For further information and registration, visit the ACLM website at *www.aclm.org*.



Figs. 1a and 1b: Alternative methods for advancing upper incisors have included: a) compression of a rectangular super-elastic arch wire between the molars and incisors; b) so-called 'bimetric wire' with a compressed open-coil spring against a required headgear tube attachment. (Note: Excess wire distal to the tube required for advancement.)

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overjet and permit the mandible to close into a Class I relationship without the anterior shift.

Phase I treatment is defined as early treatment with the intent to change skeletodental relationships and to limit or eliminate a second phase of treatment. Unfortunately, the routine use of early (Phase I) treatment to resolve Class II (by mandibular "advancement")[9,10] or crowding (via bimaxillary expansion)[11,12] has not been supported by the referred literature.[13]

In contrast, the early resolution of Class IIIs using protraction facemasks and expansion has been demonstrated to be helpful for 70 to 75 percent of patients.[14-18] Researchers at the University of Hong Kong have shown that early correction of pseudo-Class III anterior crossbites was successful for 100 percent of 25 consecutively treated patients.[5]

This was accomplished in a short, eight-month Phase I treatment using simple mechanics ("advancing loops") with a 2 x 4 bracketed appliance. In fact, only 25 percent of the patients required a second stage of treatment upon the eruption of the remaining permanent dentition.[8]

Johnson[19] has recommended that in order to reduce treatment time in Phase I, specific goals must be set for early treatment and no procedures should be initiated in an early stage when they could be done "better" later.

Early advancement of the permanent maxillary incisors for a patient with a pseudo-Class III malocclusion can: correct the anterior crossbite and/or reduce traumatic occlusion, produce a positive overjet and improve coupling of the anterior teeth, permit proper posterior occlusion without an anterior functional shift, may reduce the risk of development of a skeletal Class III and provide some additional arch length for erupting premolars and canines. In other words, the cost/benefit ratio is highly favorable for early intervention for these types of patients and the treatment time is usually less than nine months.

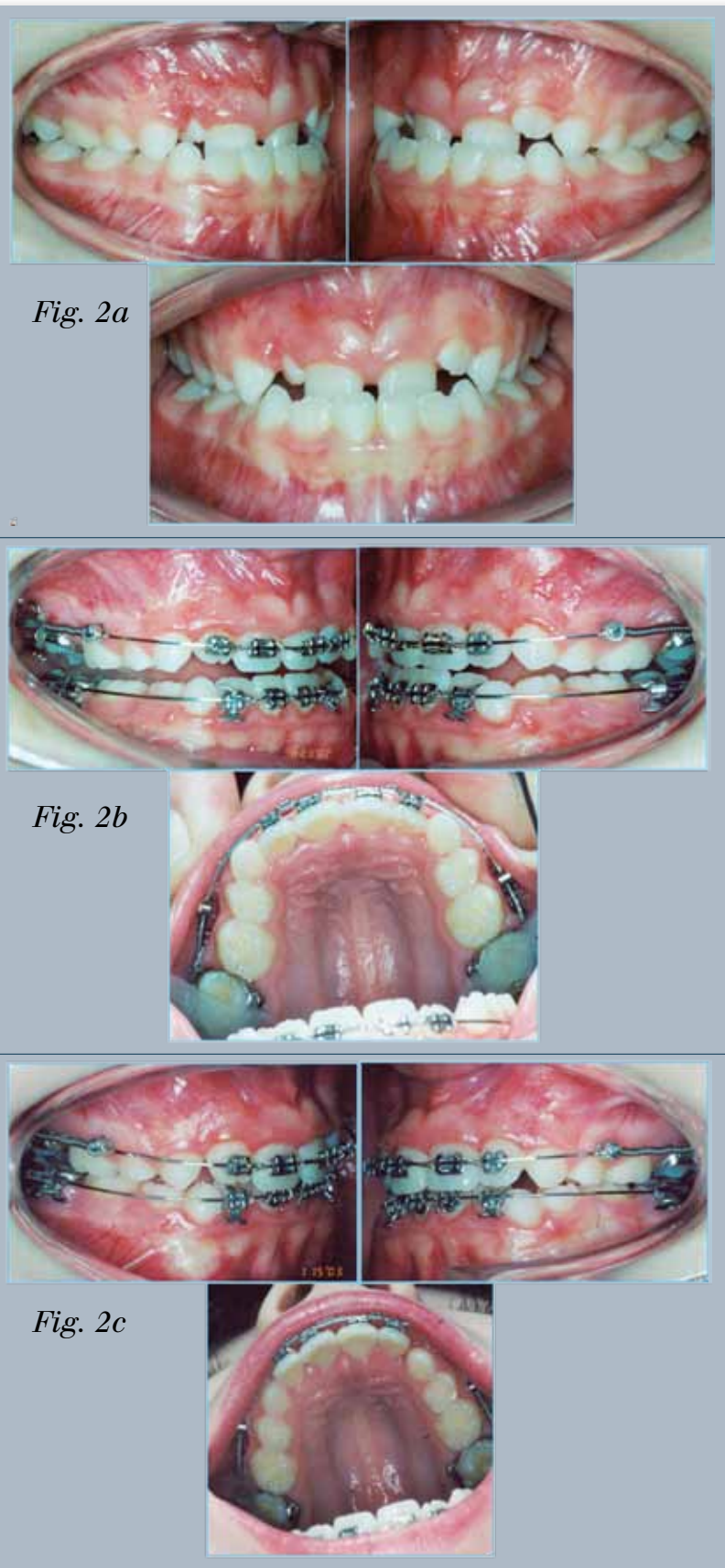

Fig. 2a–2c: Nine-year-old female with anterior crossbite and associated functional shift. Upper and lower 2 x 4 appliances were placed for leveling and alignment. Patient was noncompliant with Class III elastics. Quick Fix appliance advanced the upper incisors into favorable overjet in three months without dependence upon patient cooperation.

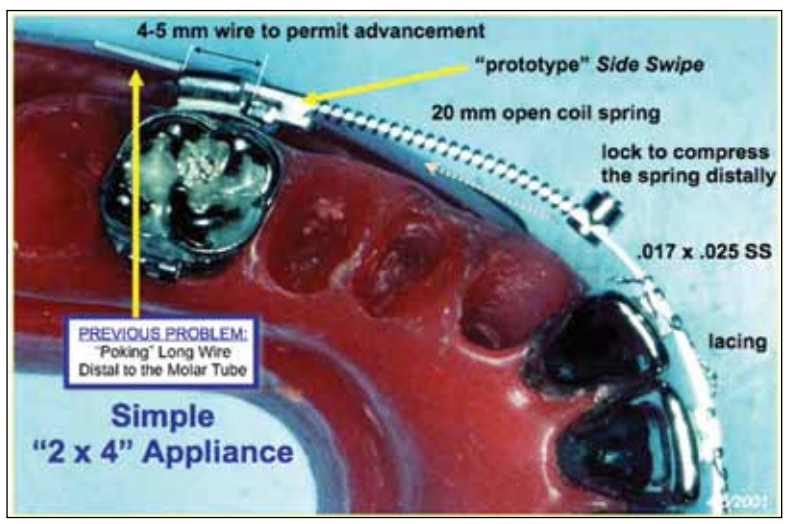

Fig. 3a

Quick Fix Device

The Quick Fix* device is based on a typical 2 x 4 edgewise appliance and was designed for effective and efficient advancement of the maxillary incisors.[24]

The appliance consists of a rectangular stainless-steel arch wire, open coil springs, arch locks and Side Swipe auxiliaries.

Look for Part II of this article to appear in an upcoming edition of Ortho Tribune.

Previous advancement methods

In the past, a variety of appliances and orthodontic mechanics have been used to correct anterior crossbites in the transitional dentition.

This has included the use of inclined planes (both fixed and removable), chin-cups[20], Smart Wire fixed reverse labial bow[21], protraction facemasks[14–18], removable appliances with advancement springs and functional appliances.

One of the most common techniques is to use a simple edgewise appliance (tubes on the molars and brackets on the incisors) to advance the incisors into a normal overjet. The force to advance these teeth can be produced by bending "advancing"[5–8] or bulbous loops.

Another method involves compressing a rectangular super-elastic wire between the molar tube and incisor brackets (permitting the additional arch length to deflect away from the line of action), but this mechanism limits some control and may result in impingement of cheek mucosal tissues (Fig. 1a).

As an alternative, an open coil spring on a more rigid wire can be compressed against the molar tube to

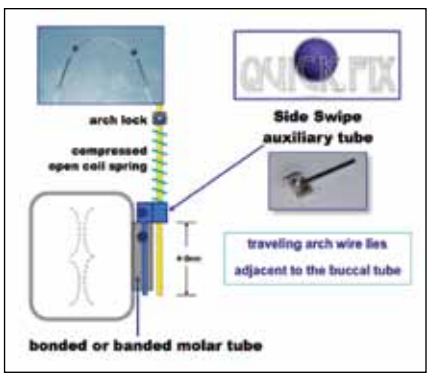

Fig. 3b

Figs. 3a, 3b: a) Sliding arch wire advancement of the incisors typically requires four to five millimeters of additional arch wire length extending distal to the molar or headgear tube that will 'poke' a patient's cheeks. b) Resolution of this problem was achieved by the development of the Side Swipe Auxiliary that permitted cutting the wire 'flush' to the molar tube while still providing the necessary 'travel' length for adequate incisor advancement.

push the incisors labially (Fig. 2). Most often, four to five millimeters of wire must travel through the molar edgewise or headgear tube (e.g., bimetric arch[22,23]; Fig. 1b) and that additional length of "traveling" wire may also create significant soft-tissue trauma and discomfort. An alternative was sorely needed.

Development of the Side Swipe Auxiliary

The intent of the so-called Side Swipe* Auxiliary was to eliminate painful cheek poking from the four to five millimeter extension of wire distal to the molar tubes (mentioned previously), yet still provide a sufficient length of traveling arch wire to track forward through molar tubes as the incisors are advanced (Fig. 3).[24]

The original construction of the Side Swipe involved a segment of .0175" x .025" stainless-steel wire inserted through the shorter of the two tubes in a dual-tube rectangular auxiliary (a modification of the "auxiliary attachment"[25]). Next, a tube with a soldered hook was placed onto the wire and was either "crimped" or spot-welded in place (Fig. 4a). This concept was later simplified and miniaturized into its current state (Fig. 4b; American Orthodontics, Sheboygan, Wis.). Application of the Quick Fix device will be described in Part 2 in our next issue. OT

(Editor's notes: Bowman has a financial interest in the Quick Fix Kit. A complete list of references will appear with Part 2 of this article.)

Figs. 4a and 4b: a) Development of the Side Swipe began with a segment of .017" x .025" stainless-steel wire inserted into a dual tube auxiliary and followed by a crimpable hook. b) This evolved into the current pre-formed auxiliary tube.

About the author

Dr. Bowman is a diplomate of the American Board of Orthodontics, a member of the Edward H. Angle Society of Orthodontists, a fellow of both the American and International College of Dentists and the Pierre Fauchard Acadmey International Honor Organization, a charter member of the World Federation of Orthodontists and is a regent of the American Association of Orthodontists Foundation. He developed and teaches the Straightwire course at the University of Michigan, is an adjunct associate professor at Saint Louis University and is a clinical assistant professor at Case Western Reserve University. He received the Angle Research Award in 2000 and the Alumni Merit Award from Saint Louis University in 2005.

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Makeover update: gaining momentum

This is the fourth part in the Levin Group Total Ortho Success Practice Makeover series

Levin Group Total Ortho Success™ Practice MAKEOVER

By Jennifer Van Gramins & Cheri Bleyer

The month of August couldn't have been better for Dr. Michelle Gonzalez, our 2010 Levin Group Total Ortho Success winner. In fact, it was the best month the San Rafael, Calif., orthodontic practice had ever achieved in terms of production, which was up 15 percent compared to 2009.

"It's exciting to see our efforts paying off to make over the practice," Gonzalez said.

Gonzalez and her team arrived at our Phoenix-based Levin Advanced Learning Institute for Phase II of their management-consulting program. During their two days at the institute, they received training by our expert orthodontic consultants on the following subjects:

- The importance of the treatment coordinator (TC)
- The TC's role and responsibilities
- Superior case presentation
- "WOW" customer service
- New patient experience

Outside the office learning, whether participating in consulting or attending a seminar, often provides the orthodontist and team a new perspective of what is possible in the practice. As Levin Group CEO Dr. Roger P. Levin often says, "Stepping away from the practice allows orthodontists and teams to see the big picture."

The consulting experience

Phase II focuses on what orthodontists and their teams can do to make their practices the No. 1 choice for orthodontic treatment by prospective patients and parents. In this era of increased "shopping," practices need to update critical systems such as customer service, case presentation and the entire new patient experience.

A well-trained treatment coordinator can be a real asset to orthodontic practices. This key employee handles most of the orthodontic consult process, allowing the orthodontist to spend more time on patient care. A 90 percent start rate for new patient consults is typical for Levin Group orthodontic clients.

During the Phase II breakout sessions and classroom discussions, Gonzalez and her team interacted with other orthodontists and team members from across the country who were also there for training. Beyond the classroom time, orthodontists and their teams can compare notes with other offices about what works, what doesn't work and what can be improved upon.

"It was an extremely positive two days. My team and I are more motivated than ever to accomplish our goals this year," Gonzalez said.

A new schedule

After completing procedural time studies earlier in the year, Gonzalez and her team created a new scheduling template that more accurately reflects the time clinical staff need for a variety of appointments, including consultation, records, checks and emergencies.

The new schedule is based on Levin Group Power Cell Scheduling™ principles, such as:

- Schedule orthodontist and assistant time separately.
- Reserve longer and more productive procedures for the morning.
- Move shorter appointments near the end of the day
- Schedule new patient consults within seven to 10 days after prospective patient calls or is referred.

The goal of Power Cell Scheduling is to maximize productivity and production through increased capacity and efficiency, while at the same time, create a more organized day and reduce stress. A practice with an inefficient schedule will never reach its full potential.

As part of the new schedule, Gonzalez will be adding early morning hours on one day and evening hours on another day.

"We are in a service business, and patient convenience is critical to practice success. We believe this small change in our schedule can be a big benefit to our patients," Gonzalez said.

Consistent marketing

Since the spring when Practice Coordinator (or what Levin Group calls a professional relations coordinator) LeAnn came aboard, the practice has marketed steadily to its entire referral base, including dentists who had never referred or who had stopped referring.

The results have been outstanding: more referrals from current referrers, an expanded referral base and more new patients. The record production of August is a testament to the referral marketing program's success.

"Building strong relationships with referring dentists requires consistent communication," said Gonzalez. Before hiring LeAnn, Gonzalez had done most of the marketing, which was often haphazard due to her busy schedule treating patients. Delegating tasks to qualified team members is the best way to get the most out of an orthodontist's limited time.

As Levin says, "Orthodontists should spend 98 percent of their time on patient care. This is what they were trained to do and this is where they are most effective for patients and the practice."

Dr. Michelle Gonzalez, center, with Levin Group senior consultants Cheri Bleyer and Jen Van Gramins. (Photo/Bruce Cook Photography, San Rafael, Calif.)

Conclusion

Practice success is often about seemingly obvious things: making prospective patients feel welcome, communicating regularly with referring dentists and documenting systems in writing. But doing all these "minor" tasks using systems and targets often leads to huge gains in practice performance and productivity. Witness Gonzalez's record production in August, up 15 percent from the previous year!

Breakthrough performance doesn't happen overnight, but it does occur when the right systems are in place.

"My practice is now on a path to greater success," Gonzalez said. "With continued focus and Levin Group's help, we will get there." OT

Orthodontists interested in getting their own Levin Group Total Ortho Success Practice Makeover can now apply online to win this life-changing opportunity at www.levingrouportho.com. *Find Levin Group on Facebook and follow them on Twitter (@levin_group).*

OT About the authors

Cheri Bleyer, Levin Group senior consultant
Bleyer joined Levin Group in 2003 as a Levin Group orthodontic management and marketing consultant. As a senior consultant, Bleyer has played a key role in the development of Levin Group's ever-expanding marketing program, and she regularly lectures at the Levin Advanced Learning Institute.

Jen Van Gramins, Levin Group senior consultant
Van Gramins has spent the last four years working as a Levin Group orthodontic management consultant. Prior to that, she managed medical and dental practices for 12 years. She served as practice manager for the Oral Health Clinic at Loyola University Medical Center in Maywood, Ill.

Cheri Bleyer, left, and Jen Van Gramins

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Free yourself of the 'grind'

By Sally McKenzie, CEO

Adopt a winning strategy to re-gain control of your orthodontic practice. (Photo/stock.xchng)

Are you settling for mediocrity? Is your practice merely getting by? Do you feel surrounded by complacency? So there's no excitement or enthusiasm, you say? It's not that the team is outwardly negative or difficult, it's just that "average" has become simply good enough in their minds. Is it possible that new ideas seldom emerge because they are shot down as quickly as they surface?

Are issues with systems perpetually on the backburner, kept there by the proliferation of excuses explaining why the changes won't work, can't work or would simply be too much work to fix?

So there you stand having lost control of the practice you once loved. It's become the daily grind and at times it seems that you tick away the hours at the mercy of those who seemingly care to do nothing more than simply get by.

As familiarity breeds contempt, complacency breeds mediocrity. If teams are not challenged to continuously improve, when the push is on to do things differently the shift can be unnecessarily traumatic because the staff feel threatened, so they resist it. They've settled into their "way" of doing things and don't understand why what seems to have worked perfectly fine in the past is suddenly called into question.

Sounds like a major issue with the team, right? Wrong. What we have in circumstances such as this is more likely to be a major issue with the leadership. The team mirrors the leadership of the practice.

Look carefully at your team: Does each member reflect your commitment to excellence? Is every staff member open to change? Are you willing to challenge them to make changes?

In addition, are you willing to invest the time to educate them on why change is necessary?

Or do you shun better, more efficient systems and procedures because Mary Jane has been there since the beginning of time and you decided long ago that it's not worth it to challenge her negative attitude and poor performance?

Have you been rationalizing your fear of addressing the problem by telling yourself that she handles all the insurance, or she knows all the patients or whatever the excuse?

If you've chosen to ignore the problem, you've abdicated your responsibility as the leader. You can count Mary Jane as one of your concrete blocks — dead weight tethering your practice to average performance.

Being the leader takes courage to examine systems, processes and staff. Change those things that don't work, but, most importantly, challenge everyone — not just yourself — to continuously improve.

Your team members are taking their cues from you. If you have a "Mary Jane" and she is unwilling to change or do things differently, she is the shining example for the rest of the team to follow suit.

Employees are expert "boss watchers." They are quietly watching as you look the other way, make excuses and allow employees such as Mary Jane to run the show.

The irony is that most employees want to excel and they want to be challenged. Yet they look to the orthodontist to be the leader and address Mary Jane's unacceptable attitude and poor performance.

Yes, I know it's not easy, but it's mandatory. Read on.

Reluctant leaders

Orthodontists, by virtue of their position as CEO of the practice, are the leaders, but often they don't take to that role naturally, and frequently they do not have leadership experience to prepare them for the responsibility.

Orthodontists are trained to be excellent clinicians and they are. They are not, however, trained to have the necessary communication or business skills to lead teams and steer clear of complacency.

However, dramatic leadership improvement can occur under the right circumstances if the orthodontist truly wants a practice that reflects the level of excellent care he or she provides.

In order to improve leadership skills and avoid settling into a state of mediocrity and ultimately the loss of power and control over the practice, orthodontists must take three essential steps:

- Change your definition of leadership.
- Change your behaviors as leaders.
- Change your expectations of the desired outcomes.

The leadership definition for small businesses is quite different than it is for large companies. The vision is to make a good living. The plan is to work hard every day delivering the best service and quality to patients.

The required communications skills consist of knowing what you want your staff to do and telling them.

The leader must explain to the staff what is expected of them, how their performance will be measured and how that performance will be rewarded. In exchange, the followers will get paid and appropriately recognized. Rather than allowing your practice to sink under the weight of mediocre minions, choose to build and lead a team of star players.

Focus initially on the following manageable steps. You will see improvement almost immediately. Those who are valuable to the future success of the practice will emerge as will those who aren't.

Get the right people into the right jobs

Some employees are perfectly at ease asking for payment, while others feel as if they were making some extraordinarily difficult

demand of the patient. In the Mary Jane example above, she may be an excellent employee who is in the absolute wrong position. I highly recommend personality testing to place your team members in positions in which they can excel, not just get by.

The Keirsey Temperament Sorter Test, found at *www.keirsey.com*, is an excellent tool to use for this process.

Tell it like it is

Develop job descriptions for each position. Specify the skills necessary for the position. Outline the specific duties and responsibilities. Include the job title, summary of the position and its responsibilities and a list of duties. This is an ideal tool to explain to employees exactly what is expected of them.

Train

I've watched this mind boggling scene hundreds of times: orthodontists allowing untrained team members to handle tens of thousands of dollars in practice revenues. Nothing creates distrust, generates conflict or causes more internal problems than team members who are not trained.

They feel insecure and vulnerable because they've been tossed into a situation in which they are expected to perform duties and are largely guessing at how those responsibilities are to be carried out. This is a recipe for failure.

Think about it, would you hand them the instrument tray, a couple of handpieces and say, "Have at it, let's see what you can do." Of course not! Team members must be given the training to succeed and expected to meet specific performance standards.

Encourage the best

In addition to job descriptions and clear and specific goals, your team will also want to know how you will measure their success. When the time comes to evaluate your team, that too should follow specific guidelines; it's not just a matter of assessing whether your assistant is a nice person. It is about evaluating how well she/he is able to carry out her/his responsibilities.

Used effectively, you'll find that employee performance measurements and reviews can provide critical information that will be essential in your efforts to make major decisions regarding patients, financial concerns, management systems, productivity and staff throughout your career.

Moreover, performance measurements and a credible system for employee review consistently yield a more effective and higher-performing team member. The fact is that when we understand the rules of the game and how we can win, life and work are a lot more fun and rewarding.

Celebrate

Inspire the team with a practice vision and goals and recognize the progress you make together in achieving those goals.

Take time to pat yourselves on the back for the accomplishments that you achieve. Create incentives for staff to use their skills and training to develop plans to continuously improve patient services, boost treatment acceptance and build a better practice and reward them for their efforts.

If you create a structured environment with clear expectations and a plan for total team success, the Mary Janes and the rest of the crew will likely rise to the occasion.

Thus, you will no longer be suffering through the daily grind. Rather, you will be leading a happy and successful team that is not only open to change and continuous improvement, it is actively pursuing it every day. OT

OT About the author

Sally McKenzie, certified management consultant, is a nationally known lecturer and author. She is CEO of McKenzie Management, which provides management services to dentistry and has since 1980.

McKenzie Management offers a full line of educational and management products, which are available on its website, *www.mckenziemgmt.com.* In addition, the company offers a vast array of practice enrichment programs and team training. McKenzie is the editor of the e-Management newsletter and The Dentist's Network newsletter sent complimentary to practices nationwide. To subscribe, visit *www.mckenziemgmt.com* and *www.thedentistsnetwork.net.* McKenzie welcomes specific practice questions and can be reached toll-free at (877) 777-6151 or at *sallymck@mckenziemgmt.com.*