

**Ep #31: Developing a Practice of Distinction with
Dr. Susan Maples**



Full Episode Transcript

With Your Host

Allison Watts, DDS

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Welcome to *Practicing with the Masters* for dentists with your host, Dr. Allison Watts. Allison believes that there are four pillars for a successful, fulfilling dental practice: clear leadership, sound business principles, well-developed communication skills, and clinical excellence. Allison enjoys helping dentists and teams excel in all of these areas. Each episode she brings you an inspiring conversation with another leading expert. If you desire to learn and grow and in the process take your practice to the next level, then this is the show for you. Now, here's your host, Dr. Allison Watts.

Allison: Welcome to *Practicing with the Masters* podcast. I'm your host, Allison Watts, and I'm dedicated to bringing you masters in the field of dentistry, leadership, and practice management to help you have a more fulfilling and successful practice and life.

Tonight we have Dr. Susan Maples. I have had the privilege of getting to talk to her on the phone a couple of times now. I feel like she's my new, fast friend. I think your bio describes you very well so I'm really just going to read this, Susan.

Dr. Susan Maples' success has always been about passion, forward thinking, and never settling for good enough. She bought her general practice upon her graduation at the age of 25. After seven successful years of general practice she decided to pursue her master's degree in business—aren't you smart? Where she developed her passion for organizational behavior, executive leadership, and target marketing.

After earning that degree, she began studying with some of the top clinicians in restorative dentistry, noted educators like Dr. Peter Dawson, Dr. Frank Spear, Dr. John Kois, Dr. Jack Turbyfil and Dr. Jimmy Eubanks. That's when it all came together: the business insights, the clinical mastery, and her inspiring realization of how it all fit together.

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Susan climbed from being an effective, busy clinician doing tooth-based dentistry to an accomplished and fulfilled restorative dentist performing at the forefront of her profession. Her insurance-dependent practice nestled in a small town in Michigan which is the center of the bullseye of economic decline in the United States...

Susan: Okay, I have to correct you, it's insurance independent which is a big difference.

Allison: That's what I meant. Did I say dependent? Oh my gosh. Sorry about that. Yes, insurance independent. Thank you for correcting me because there's a huge difference.

Her passion for sharing the secrets and philosophies behind her success continues to grow. She has become a sought-after speaker for her ability to inspire just about anyone, doctors, business executives, and team members, to reach new levels of personal fulfillment and professional success.

She is a proud member of the American Academy of Dental Practice Administration, the Michigan Dental Association, the American Dental Association, the Central District Dental Society, the American Pediatric Dental Society. She's a fellow of the American College of Dentists and RL Frazer National Study Club and the Spear Faculty Club.

Also I want to mention that in 2012 Dr. Susan Maples was named one of the top 25 women in dentistry and one of the top eight innovators, which we're going to explain that a little bit further but "disruptor" which I think means just forward thinking. She's changing the thought patterns of dentistry. Is that right, Susan?

Susan: Hopefully.

Allison: Disrupting the status quo, she's a rule breaker.

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Susan: Stirring the pot.

Allison: She's a pot stirrer. I'm so excited to have you, Susan. I'm grateful to have you. So excited with you sharing with us.

Susan: Thank you, it's good to have you as a new friend. I was laughing today because I write for a local health magazine. I've written once a month forever. I love to stir the pot in my own community and the title of the article that came out fresh of the press today was "Floss Them or Be Flaccid." It's periodontal disease and the relationship to erectile dysfunction. So that was pot stirring gesture of the month. My patients were chuckling all day reading it in the reception room. It was very cute.

Allison: Oh my gosh, that's pretty motivating.

Susan: Well there's plenty of evidence. Get rid of the Viagra and floss your teeth, buddies.

Allison: Wow. We might have some questions about that later. Although Susan gave me probably, I don't know Susan, you probably gave me six or seven topics to choose from. I chose, you guys that are on here may have seen my Facebook ad or the heading for this but I asked her to speak to us tonight about facilitating health change behavior and becoming a practice of distinction in your community. I know some of you may know Susan even better than I do. She also speaks about wellness in children and adults. If anybody's interested in questions that are not directly on target, that's okay too, right, Susan?

Susan: Or even specific questions on anything from esophageal reflux or sleep apnea or periodontal disease as it relates to all of these things, heart attack, stroke, diabetes, the bidirectional aspect of diabetes in the patient, erectile dysfunction, anything that you would like to ask in specific about smoking cessation.

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The state of where we are with any of that, I'd be happy to share.

Allison: Yeah. So I just had several things to choose from and I picked the ones that I thought would be the most universally interesting but you guys feel free to ask questions. Okay, I think then why don't we start with, I do want to make sure we get us to facilitating health change. But why don't we talk a little bit about what you mean about becoming a practicing of distinction in your community? Give us some ideas and your thoughts about that.

Susan: From a marketing perspective, I think most people are interested in having new patients and the right new patients or patients that serve us well, where we can be at our best both in terms of serving predictably, profitably, and enjoyably. How do we do that? I think if you look back at the history of dentistry, we were a cottage industry where we were duplicates of one another and it wasn't really clear from one person to another what was the difference.

As market differentiation and all aspects of consumerism has grown, in other words, we have lots of choices now where we choose to buy whatever we buy. We have seen a big change in dentistry, especially in the last ten years in terms of where people seek care from low and medium and high-end markets to niche practices, boutique practices, and things like that. So what we put forward hopefully stands out.

Let me just sort of create a picture. For marketing in a general practice, it's sort of like a bunch of fish swimming in the sea in the communities around and they have to choose. How do you let your colors fluoresce so that you stand out among the rest? Or if I can say it a little bit differently, let me just say that if you're trying to stand for something so that you attract the

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target market that you can serve profitably, predictably, and enjoyably, then how do we attract those people?

How do we continue to serve them well knowing that statistically it takes five times the cost to attract a new patient as to hang on to an hold one. Yet we're much more interested in securing new patients than satisfying our existing customers. When they leave, we don't tend to follow that up.

The flip side of that is if you wanted a niche practice where you are creating an opportunity to serve your community in a way that other people aren't, so that's what the definition of a niche is. A niche is finding a way to serve where your competitors are clearly underserving. Focusing all of your efforts into marketing the practice around that.

Right now, for us, this piece on helping people get healthier is clearly underserved in medicine and in dentistry. So it's fun for us and it's an area clearly underserved. We're creating a practice of distinction around that. You can do it in areas where—let's say it's cosmetics, where everybody and their brother has a sign that says "cosmetic dentistry." Let's say you wanted to do it around that.

There are clearly ways that you can create a practice distinction around an area that is not a niche, it's just one of your offerings that you think you do really well, predictably, enjoyably, and profitably by bringing into the fold your target patients and asking them to help you improve the practice in ways that would appeal to them. Then thereby attract more of their friends.

I just said two very different things. One is target marketing, where we become a practice of distinction around an area that we just really enjoy and do well and are able to profit from. The other is a niche practice. I was just taking to Kent Smith out of

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Dallas who has a niche practice in sleep dentistry, sleepdallas.com or dallassleep.com. All he does is short-term orthodontics and sleep. He is very successful at it. We were just talking about niches.

In a world of hurt, where we're dealing with a very unhealthy world, sleep dentistry, being able to able it to diagnose sleep apnea and treat sleep apnea through oral appliances is a huge and growing market. Since he's doing it very well and not a lot of his competitors are doing it well, he's able to create a niche. So I said a lot there.

Allison: Let me ask a real quick question. So are you saying a niche is something that no one else or not many other people are doing? Then the target marketing is basically where it may be something that other people are doing but you choose to market that particular thing because you want to do more of it or because you think you do it really well. But there may be plenty of other people doing it.

Susan: Right. That's pretty good. When we have a general practice, and let's say that we sit down with our team members and have a pow wow or a team meeting and say, "Who is it we're serving best?" We come up with names. Let's say we came up with six or seven names of people we absolutely love seeing. They've accepted our treatment plan. They trust us. We've served them well. They've finished very happily. They recommend us to other people. They have lots of intent to be long-term loyal customers for us.

I use the word customers instead of patients because we're talking about business principles here. Let's say we identify them by name. Then we're able to sit down and say, "What is that we have done that fits our service mix that we've enjoyed

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doing with them? What is it that their behavior shows that has served us well?"

If we can identify those people and find some commonalities, we can also look for commonalities in demographics and find out socialgraphics. We call it the psychographics but I call it socialgraphics, like what kind of belief systems do they have? What kind of attitudes do they have? How do they treat us? If we can identify some of those commonalties and we can begin to recognize what is the makeup of our ideal target market?

We can invite those very people we named and others like them to come into the fold and we put them on our sort of patient board of directors. In other words, we ask them to partner with us to figure out how to improve the practice and attract more people like them. By doing that, we do two things. We compliment them because we let them know that they're the kind of patient we most adore and appreciate. Then we also really put them to work for us.

So instead of marketing efforts such as expensive advertising campaigns or things we're sort of unclear whether it's worth it to do this or that advertisement, this is a slam dunk because it's very inexpensive. But we are asking their opinion to help us change the practice to better serve them which can have a little bit of cost to it. We basically ask them to help us grow the practice with more people like them. That's target marketing.

Allison: Yeah, I like that what you're saying. I want you to talk more about that. I don't want it to take the whole time. Is that a really long conversation to get a little bit more in detail about that? Did you call them board of directors?

Susan: I talk about when I teach target marketing I have like 21 different strategic target market activities that I bring forward. One of them is a patient board of directors. I was sort of using

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that as a sort of euphemism for the entire aspect of it. But what I mean is that you're bringing them into help guide the practice to become a practice that would serve them better.

Let me give you an example. An example is a patient focus group where you would bring in those patients and ask four or five questions over a dinner. Ask them to help you solve the dilemma that's right before you, whether it is the process of an advanced restoration that they've just gone through or setting up a new program or we're interested in changing computer systems and we want you to look at what does this website look like? Whatever it is you're posing as an area where you need help.

For instance, my target market is, we really have two targets right now. One is men or women from the ages of 55 to 75 who value health and restoration. We're not differentiating men from women in this standpoint but no one on my team is in that demographic. So I can't ask my team member's opinions on how to serve this segment of the population best. I have to ask them.

When we get people like that on the phone that are calling or coming in for a new patient, we certainly recognize that they're really different from us and they're in our target market. We sort of say, "We really want your help in giving us feedback on how we're doing and what we could be doing better." So we're always begging for complaints so to speak. We're begging for not just positive pats on the back but what else is possible. What can we do differently? So that's that.

In the aspect of setting ourselves as a practice of distinction right now, one of our targets for instance is physicians for referrals. So we're looking for likeminded physicians with values similar to ours and we're asking them, "How could we serve you

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better?” We have physician focus groups where we say, “What kind of letters do you want? Or how do we get this information to you? How do we work together? How do we create co-referral relationships which we’ve never had with physicians?”

So it doesn’t have to be patients. If you're an orthodontist for instance, you might gather your select clients who are referring dentists. Or you might gather the moms who are the choosers in the family. It can be whoever your target is. Does that make sense?

Allison: Totally. Nice. So where can we find if we wanted to know what your 21 ideas for doing that? Do you have something on your website? Or do you have a place...?

Susan: I really don’t. I generally just lecture on it and I've never even written an article about all those different things. One of the things, I mean you could certainly call and interview any of my team members. These are constant engagements for us. We weave them into the culture of what we’re doing.

So we’re garnering feedback if someone leaves the practice for any reason, we do an exit interview and learn from them. I don’t mean anyone, I’m talking about our target patients. Regardless of if they’re relocating to Florida, we’ll call and say, “Would you help with a retrospective look at what it’s been like to be here and what might we possibly...?” We have a whole bunch. We can do another call on this sometime. That would be great.

Allison: That’s what I was thinking. Okay, yeah, that is really cool. I've heard, something Bob Frazer talked about.

Susan: Yeah, select client group.

Allison: Yeah, select client group. Which we I think did once but it’s definitely not an ongoing part of our culture. So I really like that.

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- Susan: You know a lot of people have done some surveys. I think surveys are all right. In business circles they're statistically flawed and we don't need to go into that but if you're going to do surveys I would select the people every day at your huddle who you want to answer the survey to gain really juicy data rather than just sending it out to the masses in your practice.
- Allison: Right, because you want the data from the people that you really want more of.
- Susan: That's exactly right. And what we know is that if the people we're more likely to please will be more, especially on that very high end of the pleasing scale, the wow scale, the high end of the satisfaction scale, they're much more likely to remain loyal and dedicated to us. Knowing that we can't please everyone, let's figure out who we want to please and how we want to do it.
- Allison: Cool. Okay, I like that. I think it's different enough. I've never heard anybody talk about this, Susan. I think it's very different. Gosh, even just the point that you made which sounds really silly I think and I know it in the back of my mind that it's not just important to get new patients but it's important to serve our existing patients and follow up with them and satisfy them, I think that you're so right that we tend to kind of forget about those people and move on to the next person that we're looking for.
- Susan: What's interesting about that is indifference is really the killer. Most people will leave a business because they feel you don't care enough because they're mad at you but they just feel like they're invisible. That you're just indifferent to them. It's interesting, you've heard it said that love and hate are the same side of a coin and the opposite side of the coin is indifference. It is, "We don't care." When they leave, they silently slip away and

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we do nothing to respond to that. It's affirmation that we're indifferent, you know? It's real proof that we don't care.

So oftentimes when people leave, if you call and say, "Oh my gosh, what could we do?" Or not even putting them on the spot but just saying, "I recognize that you're leaving and I'm just hoping you can help us learn how we might improve because you're the last kind of person we'd want to lose. Our door will always be open to you. But in the meantime, if you could make any suggestion at all, we're all ears."

Oftentimes patients all of a sudden feel cared for. You can actually raise their esteem of you and even if they've decided to leave for now or for a while or forever, they will speak more highly of you in the community if you cared about them in the end than if you just let them go.

Allison: Right, totally. Cool.

Heather: Hi.

Allison: Hi.

Heather: Susan, I have a question. Do you find it more difficult to target men since you only have a squad of women helping you in the office?

Susan: I don't. Actually, I think there's more difference within a gender than between genders, Heather. I don't try to make that distinction but if I had to generalize, I'd say that men like to and want to be cared for by a nurturing group whether it's a man or a woman at the helm. What I notice is that during the time when everyone was trying to increase their practices with more cosmetic dentistry, they targeted women because women typically purchase a lot more in hair, clothing, makeup, and jewelry than men do. So we thought that was our low hanging fruit.

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What we noticed when we did a look back with our practices, we did more advanced restorative, high-end, and cosmetic work on men. I found it interesting and I didn't know if all practices were like that. But typically most dentists who were targeting cosmetic patients were targeting women in the 40-year-old range. We were really noticing that we just did a lot more with men. I never really quite understood it but the answer is I don't.

When our office was featured in *Woman's Magazine*. The greater Lansing *Woman's Magazine*. We were on the cover as a team of women. When the article was written, I was so embarrassed because the very first paragraph said, "We walk through a sea of men in the reception room waiting to get into these women." I was so embarrassed because it sounded like we were just serving all men.

But the fact is, it has been men, women, and children are attracted to what we're doing well which is caring for the individual. That's really the operative point of it. People want to be heard and listened to. I have heard some of the best speakers in restorative dentistry in the world say things like—and I won't name names. "We don't even offer bite splints to men because men won't wear bite splints. They don't care about preserving teeth." I'm like what? Are you kidding me? Who's saying this? So things like that.

We try very hard not to be assuming or sexist or label men with men's behavior and women with women's behavior or talk about men are from Mars and women are from Venus. We try very hard to focus on the individual person and not make those even in our mind, those sexual references or gender references I should say.

Allison: Cool. Do you have more, Heather?

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Heather: No, I think that's about it, just talking about target marketing and how you can go about targeting a specific group. I remember being in your office and it's all women and how she said sometimes she has like women patients that are between the ages of 55 and 75, she has to ask them what they like or what they should change. I know that she also couldn't ask her staff how to target men.

Allison: Great. Thank you for the question. We have another question from...

Kate: It's Kate, Allison.

Allison: I thought it was Kate. Okay. I haven't talked to you in a while.

Kate: I know, hi.

Allison: Hi.

Kate: Actually, mine was just thought provoking. I like where this doctor is going with all this. I wanted to carry it to a different level for you to think about, to extend your learning. I'm a hygienist. I'm actually trying to branch out into hospitals more and be more of a liaison between my favorite dentists that I think are quality. Like having a friend in the dental field that will guide you right and take people that need surgery and then guide them over to select offices. But on that note, I still dabble in private practice.

With the economy, hygienists who have been greatly affected with hiring and competition and whatnot, I wanted to mention that I feel like these are great practices that should not just be reserved for lost patients, but lost staff. Because I feel like even in the economy now with let's say not getting a job for example, with years of experience, which I know many hygienists like that. They can't even get feedback.

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I feel like as professionals, if we're wanting patients to give us feedback when they leave a practice, we're not even giving respect to people as to why they don't get a job or why they're leaving a job or why they're fired. I feel like it should be taken so we're not hypocrites to the next level and treat our own coworkers, find out why their lost. Do you know what I mean?

Susan: I couldn't agree more. I don't have people that leave, I mean it just really doesn't happen for me. I'm so fortunate. But I think that feedback is challenging. I think it's also you know when you are investing in checking someone out as an employee and having them in our office, we have to have 100 percent consensus. It's an excruciating thing to hire somebody.

Someone's really invested that much to just say to them, "You're not our person." Is just not acceptable. So I agree with you 100 percent. I think it's very helpful for us to tell the truth without judgment and blame and to encourage people to grow in the areas that might help them be more—I don't know how you would say it—I guess salable to other practices. So that's a very good point.

Allison: And to give them, your potential employee, feedback but also to ask them for feedback?

Susan: Yeah. It's interesting when you do performance evaluations or growth conferences as we like to call it with people. Letting them evaluate themselves objectively and you sort of siding up with them to help them evaluate themselves is a little more effective than telling them what they did right or wrong. They are often harder on themselves than we are. But we also do 360 evaluations. What that means is 360 degrees, we have every person in the office weigh in on that person in seven or eight different areas that reflect our value system.

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Our values are basically delineated and then we get to sort of weigh in on how they're doing. Then I as the leader compile that information anonymously and help them get feedback from their own team members which has been very helpful. It's obviously a long time stalwart team that's able to do that with some maturity and they agree that they want this.

This isn't just a big tattletale session. We're helping each other grow. But I think it's important for each of us. Sometimes it's hard for the dentist to get the feedback since they're the one writing the check and who wants to tell the dentist they're doing something wrong? So the more approachable you are, the more you state what your good intentions are, and allow people to help you see where the gap is between your intentions and your actual impact is quite interesting. Inviting feedback from your own team about yourself.

One of the strategic activities we did which of the 22 or 21 I was talking about is that we do mystery patient visits where we let a mystery patient come in and evaluate us at a team individually and what they're interactions are with us and with the practice and how they experience us. They're always a mystery patient that's hired anonymous to us in our target market, which is another way of getting feedback for individuals. So thank you for the question.

Kate: I love it. Thank you very much.

Allison: Thanks, Kate. So, Susan, how do you get an anonymous patient?

Susan: Mystery patient? I'll ask one of our board of directors or one of our patients who have bought in. We select some people that we really think give way more than they take in our practice and we put them on our board of directors. I would go to our board of directors and I would ask a couple of them if they can think of

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someone in our target market who might be willing to come to us and pay the full fee of the first examination and have it be reimbursed to them with a payment.

We might pay them \$500 to evaluate us and fill out a fairly extensive questionnaire that I would devise in terms of giving us feedback from the very first phone call through the drive up, entering the building, the smell of the place. How the wait was. What happened as a part of this. How the whole evaluation went including the treatment plan presentation, financial options, and all of that. So that's how we do it.

Then we would know that the person would be calling for an appointment anywhere within the next few months and we would be kind of self-conscious about is this the person? Who might that be? So you'd get a little bit of healthy self-consciousness about you and wondering am I being evaluated today. It's kind of cool. We've provided them for lots and lots of people over the years. People paid me for a service to do that for others but we found that we can get them ourselves by working with our select clients.

Allison: That is a great idea.

Susan: Almost always they become patients, by the way.

Allison: Yeah, I was thinking that. They get their exam and get paid and then I was just thinking I'm sure they would want to become patients. So I really do want to get to facilitating health change behavior.

Susan: Me too.

Allison: Okay, I was thinking we'll go ahead and shift gears. I do want to mention again, if anybody has a question, just push *2 and I'll see your hand raised and I'll call on you. Rich Green and all

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those—are you familiar with Rich and some of the Pankey guys that talk about behavior change?

Susan: No.

Allison: I just think this is an interesting conversation because you know we educate our patients and we tell them what they need to do and we think we're making a difference. Then really and truly we're not making a difference unless they actually change their behavior.

Susan: Right, yeah. Very, very challenging because none of us like to be told what to do. We know that but we do it anyway because that's the way we were taught. Adult learning doesn't happen that way. We don't learn based on someone telling us what to do. We learn when we can weave it into what we already know and figure out whether it works for us and decide whether or not we can make a shift.

First of all, I can just say, I believe in my heart of hearts that America is getting sicker and sicker. I mean as a country we're toast in some ways. The cost of healthcare, we're on the brink or the beginning of a healthcare crisis and it will be amazingly expensive and amazingly sad to see. By 2050, a third of us will be diabetic.

Sleep apnea is probably the biggest thing on the horizon. It's all related—it's not all related—much of it is related to obesity. But obesity aside, our diets in the United States are just awful. Tainted by grocery stores, 80 percent of the food on the shelf put up by ten food conglomerates. 85 percent of it is sugar-laden which is our business anyway by the way.

We ought to be sickened by this and if we're not mad about that, I mean to operate our handpiece all day filling teeth thinking we're making a difference in the world is absurd. It's

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absurd. We've got a healthcare crisis and we own part of this. We have the only six-month preventative relationships in all of healthcare. We have some skin in this game. We've watched people get sicker and less healthy and less sharp and less energetic and more disease and more cancer and all of this at least on my time.

To me, it is not only our privilege but our responsibility to help in that. I feel really strongly about it. So if you don't, you guys should hang up right now. Just kidding. But in terms of facilitating health change behavior, we cannot do it with the fervent approach that I just did which is "shame on us, shame on you." We have to do it in terms of jumping in, first of all, recognizing that everybody inherently wants to be healthy and they want their kids to be healthy. I don't care who you are.

They don't necessarily know what they need to do and if they did know they don't really know how to make that shift. But part of our job is to jump in where they are. To get to know where they are, what they've tried, what their attitudes are and what one piece we might be able to help them with that particular day.

We don't know that until we get curious. So the biggest shift that we have to make is just one of total curiosity. In our hygiene handoff, we have five steps. We've added a sixth over the years which is the hygienist will tell me what the patient's current health goals are. You just say to the patient, "What health goals might you be working on right now?" Once in a while they'll say nothing. "I'm actually really proud of where I am" or "I'm really doing well." Then you could say, "Tell me why that is and what's working for you."

But most everyone has an answer to that and almost everyone on this phone has an answer to that. What are you working on

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right now? What are you thinking about? What are you challenged by? What are you frustrated by? What would be ideal for you if you could do it? That's a way of getting on the same page in short order.

We have so many ways in our practice that we can help facilitate health change behavior, screen for, advocate for, refer for, treat for, that there's no way we can do this in a linear order like you would do an esthetic checkpoint list. We can't do everything for everyone at every visit. So what we have to do is be much more personalized in our approach.

If the patient is for instance demonstrating periodontal disease, there's a lot we can do with that. We can look at why is this a chronic problem for this person? What is it about the slow healing rate we need to look at? What is it about the toxins they're consuming that maybe it's tobacco cessation. What is it about the lack of discipline that they're showing in their last approach to this? Where are we with this particular person this day?

I can tell you, a lot of our patients are interested in losing weight. If you ask their motivation for that, it's very different for each person and where they've been with it. People are so confused about the different diets available. You kind of have to say—don't, “Here's my diet and here's what I think you should do” but “what have you tried? What's worked for you and what have you noticed?” The onus is on us to become constant learners in this area of oral and systemic health.

Everything that we know now that we didn't know ten years ago, you know the traveling oral microbiome, the bugs that live in pockets and periapical lesions that are able to travel through our bloodstream and burrow into the endothelium of vessels and create heart attacks and stroke. The bidirectional effects of

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diabetes, esophageal reflux and its negative effects on the oral cavity as well as esophageal cancer. Erosion, increased bruxism. All of that.

All of this is stuff we didn't know when we were in dental school. We didn't know that caries was transmissible or that it's a disease process. Why one could get cavities and the other kid in the family didn't. We didn't really understand it. We didn't really understand that polishing teeth on kids was actually somewhat harmful to their teeth and we shouldn't be doing it.

So all of this has been eye-opening for us but to get fervent about what we know and just tell someone doesn't work. We kind of know that but we seem to do it anyway. I think just the whole aspect of, again, staying curious, hanging back a little bit, waiting for the patient to be interested in one more piece of information that might help them.

Then the big kahuna here is they actually have to articulate. The way our brains work is if you can move it to the prefrontal cortex where they can actually think and speak out loud what they're willing to do or change or try, that's what will be effective. So someone nodding their head at you, shaking their head, "Yes, I understand" does not change behavior. It's affirmation of what you're saying. It might be like, "Shut up, lady, because I've got to go to the..." or whatever.

So seriously, a lot of it is we tend to think when we're talking and someone is nodding or smiling at us that it's getting through to them. We can say to them, "So after we've talked now for a little while, what is it that you think your next step might be?" Or, "What is it you might be willing to try?" Or, "What makes sense to you about what you've heard?" So getting them to actually say and articulate a change that they might be willing to make.

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Then maybe one more step after that which would be asking for a commitment to be their accountability partner. We have a few things in our office, one of them is like a little card that says, "Because I said I would." They write it down and give it to us and we send it back to them in the mail.

Another one is Georgette today made a calendar for a child who's getting braces and she had them in the learning lab. We do self-care with patients. Instead of polishing their teeth we have them clean their own teeth in the lighted magnified mirror with a disclosing solution and then do science experiments related to that.

So she made a calendar with them. She gave this child the calendar. She said, "She's agreed to write down every day that she's brushed twice a day." This is with braces, "and every day that she uses her Christmas tree brush" which is the little proxy brush. "When she's collected 21 days where she's done that and she gave her like a month-long calendar, the day that she's got 21 days, she's to send it back to me and I have a surprise for her."

So I asked Georgette what the surprise was. She said, "I'm sending her new spin brush." So she's partnering with the patient, this is a 13-year-old, but you know the idea that after the patient said she thought she could that, that she would go one step further and create accountability for that or text her or do something more significant to help her stay on track for change.

Allison: Wow. That's wonderful.

Susan: Pretty cool stuff.

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Allison: Yeah. I want to ask you a question but we do have another question. I'll highlight my note or something so I can remember but I think this is Carrie.

Carrie: Yeah, hi, I'm Carrie. I'm out in Las Vegas.

Susan: Hi, Carrie.

Carrie: Hi. You mentioned sleep apnea and diabetes and high blood pressure and those are all very common things, and smoking. I'm curious as to what you're seeing out in the field on nutrition and specifically autoimmune issues. I'm seeing a lot of that within my practice.

Susan: Yep. Me too. Today I had two. Chronic fatigue and one was an autoimmune issue that I could not quick quite figure out. In relationship to diet you're asking?

Carrie: Diet and I'm seeing lots of people with canker sores and I think gluten, Sjogren's syndrome, rheumatoid, and all of these terrible things.

Susan: So what we're recommending is to try—I believe that the body has an innate ability to heal and in fact every cell of our body is trying to heal until our dying breath. And yet, we don't put our body in a state to allow that to happen. So my thought is if we want to be in optimal health, we have to try to put our body in a state where it's able to heal itself.

I believe that pharmacology makes customers not healthy patients. I tell patients every drug goes to every cell of your body which means while it might be doing some good in some aspect, it's toxifying or acting at some detriment to others. So the goal is not to be on more medications.

The other thing about medication as we realize is that if you prescribe—I'm really involved in diabetes research right now.

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I'm working with a medical school on this diabetes detection at dental offices. I'm going through lots of diabetes stuff. What I notice is that when people are on a well-controlled, everybody wants the best pill for it.

Believe me, the pharmaceutical companies want to sell the best pill. But the minute you do that and you control the sugar through the glucose or A1C through a medication, the patient accepts less responsibility for their diet. They believe they can go on doing exactly what they did that burned out the beta cells to begin with in the pancreas and continue along that same path.

So part of it is, how do we inspire patients not to lean on medications and indeed to maybe get rid of some medications through food as medicine and controlling their diet? I personally believe that we ought to focus on an anti-inflammatory diet that helps people heal. What that is is different for every person.

What that is is trying to get somebody clean enough—so if you can imagine you have a cut in your skin. The cut gets inflamed immediately because we call up all these helper cells and they inflame the area and they bring in white blood cells. Then you get this red, puffy, sore area until it heals. It takes a while, like ten days.

If we can get people off everything that might be causing them distress for ten days and then start to add some things back one at a time. Because what we do is adapt as human beings. But when you heal and then you add something back, you get a more definitive reaction if that makes sense. You get a stronger reaction. Like all of a sudden I realized I was gluten sensitive when I went for that first bite of pizza after three weeks of no gluten. Boom, I had a stomach ache.

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So not everyone is gluten sensitive. People say, “Oh, if I get rid of gluten I’ll lose weight.” Well that’s not the best approach. The best approach maybe is to get clean of those things that might be irritating you by eliminating sugar, dairy, maybe wheat, alcohol. Let’s see, what else? Maybe animal flesh or heavy fats. Then eliminating that for a time period so that you're on really whole grains, vegetables, fruits, and plant-based proteins like legumes and nuts or something like that. Not peanuts because those are some sensitivities there.

If you can do that for a period of time, even ten days, so you can allow your body to heal and then add some things back to figure out what it is that’s really causing you this level of distress. Typically the foods we crave the most are the ones that are destroying us. So oftentimes what people will choose first might be dairy, ice cream, and all of a sudden get gut inflammation, diarrhea, or constipation or pain or irritability or lack of sleep. So I don't know, that was kind of an in-depth answer to your question.

There is a book out called *The Daniel Plan* which is written by Rick Warren who is the *Purpose Driven Life* guy from Saddleback Church and this is all on health. It happens to be a sort of a Christian background but the book is written with Mark Hyman and two prominent physicians. It takes you through this whole Daniel cleanse and we’re reading it as a team.

We've gone through a cleanse a couple of times with a facilitated nutrition coach and our team to help everyone. So I've lived it with these women to see, okay, everybody knows now what it is that is a trigger for their body. It doesn't mean you can't ever have that. It just means you're going to pay the price for it and you know it. But you want to live your life in such a way that you're not paying the price every day, you know? How was that as an answer? I don't even know.

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Carrie: Yes, thank you, you validated a lot for me. Thank you.

Susan: You bet. I think the biggest thing that we can focus on in terms of our patients and not everybody is going to be talking to patients about an anti-inflammatory diet but I will tell you that one thing we can all talk about is sugar. Sugar was never meant to be put into our bodies in its purest form the way it is. It was in nature, again, it's locked with fiber.

It's in fruits and it was protected by bees in its purest form and it was hard to get. In fruits and in vegetables that are high in sugar, like corn and cane sugar and beets and carrots and things like that, it's very hard to eat and it's hard to digest. Therefore the insulin spike is mitigated by the fiber. Fiber is like sponge, it absorbs water. It passes through our gut very slowly and the insulin spike doesn't happen all at once like drinking a shot of Coca-Cola. So metabolically it acts differently if we're eating it with fiber.

One of the things I think we can do is really push for our patient's reduction in refined sugar. Mostly liquid sugar. This is fair game. This is low hanging fruit for us because the caries rate from this stuff is also through the roof. So we have every right to talk about this both in terms of diabetes and caries. Diabetes affects periodontal disease in a huge way.

For us to be not understanding, for us not to understand that constant, chronic sugar intake causes insulin resistance, which means our body doesn't recognize the insulin, the pancreas doesn't shut off and keeps kicking out insulin and we're not seeing that it's causing diabetes and pancreatic cancer and all of these metabolic issues, leptin resistance and insulin resistance, this is a major, major problem. I think it's something we can talk about with our patients is just taking a look at how much sugar is in what you're eating.

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Read the packaging. 5 grams of sugar per teaspoon. So a Yoplait yogurt has about as much sugar as a Coca-Cola. Breakfast cereals, they're supposed to be healthy snacks and they're just not. So we have to be really helpful to our patients in terms of understand that there's a reason why sugar made the cover of *National Geographic* this year. It's morbid what we have done to our diet in terms of sugar. For instance, in 1800 we were consuming between 18 and 22 teaspoons of sugar in a year. That's where we are in a day now on average.

Allison: Wow.

Susan: Yeah, that's a lot. Our bodies cannot adapt to this. We are actually affecting our genetic code. This is the first generation of young people who are not expected to live as long as their parents did. Our job doesn't necessarily help people live longer than we did, it's to have a better quality of life. You think about the fact that a third of our kids in Michigan are obese and 85 percent of them will be morbidly obese by the age of 30.

So they are now managing comorbid factors of obesity. That affects everything. Their work life. Their home life. Their relationships. Their ability to parent. To be in and out of the hospital with depression and hypertension and diabetes and sleep apnea and esophageal reflux. These are all obesity-related illnesses that can be avoided if we can help, especially help kids, and put them in the driver seat for a preferred future.

Allison: Wow. So you're saying in Michigan 35 percent of the kids...

Susan: 30 percent, yep.

Allison: 30 percent of the kids are considered obese.

Susan: Are overweight. 17 percent are obese and 85 percent of the 30 percent are on target to be morbidly obese by the age of 30.

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Allison: Wow.

Susan: Yeah. It's an issue. I can tell you that teenage boys today are consuming 266 calories more than they did only ten years ago. A lot of this is because of high fructose corn syrup being added to everything. We have become leptin resistant which means our bodies are kicking out a hormone that helps us control our satiation or create satiation and our bodies are ignoring it.

The food industry, if you read any of these commentaries on the food industry, they know it and they've got us right where they want us because the government does not hold them accountable for any of this. They add it because they want to increase their market share.

Allison: Yep. It makes me very angry.

Susan: I know. It should. We have to drive as a people, as a community, we have to drive policy to support the change we want to see. We can't have the government do that for us. We have to rise up and say, "We want the government to do this." If the government imposes changes without us, then we just won't buy it. We have to rise up as a people and say, "We need to be mad enough to force policy." We need to choose law makers that are going to act on our behalf.

Allison: I knew I liked it you. Amen, sister. It feels like such a big undertaking.

Susan: It does.

Allison: It sounds hard.

Susan: But I do envision a time and I've been talking a lot with Ron Inge about this who's been visiting us. We've been talking about the future. I do envision a time when we will be paid for

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facilitating health change behavior. We'll be paid for doing screening checkpoints for health.

I think that right now there isn't a lot of healthcare in our country. It's a lot of sick care. Seven minutes a visit and it's a pill for a problem and patients are out of your hair. That is not the way I want to work and it's not the way most of the people on this call want to work but I do believe that that's the way it's going and that's what we think is going to be normal.

For us to turn that around means that we all need to be involved in that change and that means that we're going to have to integrate dentistry with medicine as much as we don't always like it. It doesn't feel good to be paid to do some of this medical screening and prevention. We can as a profession lead the way in healthcare. I believe we can and I think the day is coming when they will turn to us to do much of the primary diagnostics. Not all of it, but a lot of it.

Delta Dental of Michigan is positioning, if you look on YouTube, they're positioning the public to understand that dentists can look in your mouth and diagnose 122 diseases. Now most dentists would be like, "What? Are you kidding me?"

But the fact of the matter is we are going to be in a position through salivary diagnostics, through simple finger stick blood chemistry, through observation and questions and verbal screening tools to be able to help patients understand their health, what's possible for them, guide them, refer them, advocate for them, partner with them, and thereby earn their trust in all kinds of ways.

It takes a whole team. Obviously it's not what I do all day long. It's mostly my team doing this but I do plenty of it. I love it and there is nothing more gratifying. I don't care if you put 20 veneers on a patient and watch them cry when they hold a

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mirror. You save a person's life and there is nothing more gratifying than that. I think I've used up all my time.

Allison: You did. I just have a quick question. I think it's quick. Where are you going to learn about this? Like where do you read? Who do you go to and where do you learn about all this?

Susan: Well that's a good question. I'm an addict for learning. So I'm going to everything. Right now I'm writing a book with Witt Wilkerson called *Open Wide: A Transformational Guide to the Whole Health Dental Practice*. We're taking on every single chapter of what I'm talking about. So it's a big book. We have 24 nationally recognized leaders contributing to this. It should be really a nice resource.

There are other sources. For instance, Ron Inge is on the other line tonight has something called the Institute for Oral Health. That's on the west coast in Palm Springs in I think it's October. The American Academy of Oral Systemic Health, AAOSH is in St. Louis is in September.

Witt Wilkerson has started the Dental Institute for Systemic Health in Nashville. We're doing, I think it is a five seminar series. The Dawson Academy is sponsoring some of this. Kent Smith teaches a great sleep course. Dineen and Bill offer a preceptor course with physicians to really understand better the link between periodontal disease and heart disease. So there are areas, there are niches in that and there are areas that are sort of more encompassing. I don't think there is a terrific all-around institute of reference for it.

Again, AAOSH, American Academy of Oral Systemic Health to me has been very heavily leaning and has been leaning in the direction of the periodontal aspect of all of this which really I think is just some of it. We will see because this is going to

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blossom before our eyes. At the top of our profession, everyone I know recognizes this is the next big boon in dentistry.

It's really fun when you get involved in it and start to see real changes in people and them coming in and reporting, it happens every day for us now, reporting over and over the impact we've made and what they've changed and how good it feels. And you've got a friend for life. So it's really fun. Then you really start to build patient referrals based on that. So I love it.

We've been practicing, we started, I don't know, 15 years ago with smoking cessation but our children's hands-on learning lab where we do whole health science experiments with every child with every visit and selfscreen.net which you guys can look online to see those. Handsonlearninglab.com and selfscreen.net are things we're using every day with every patient. So a lot of fun.

Allison: Well thank you, Susan. You definitely are a pot stirrer.

Susan: I hope so.

Thanks for listening to *Practicing with the Masters* for dentists, with your host, Dr. Allison Watts. For more about how Allison Watts and Transformational Practices can help you create a successful and fulfilling practice and life, visit transformationalpractices.com.