Ep #36: Communication, Occlusion and Your Patient with Dr. Michael Melkers

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.

Welcome, everybody. I'm so excited to have you guys on tonight. I'm really excited to have our speaker, Dr. Melkers. Mike, if it's okay with you, I'm going to do your short bio because I want you to tell a little bit about yourself as well because I know you've had a lot of changes lately and I'd love for you to tell us that. Is that okay with you?

Mike: That would be great. I'm just excited to be here.

Allison: Cool, excited to have you. Dr. Melkers is a 1994 graduate of Marquette University Dental School. He practices general dentistry with an emphasis on comprehensive and restorative care. Dr. Melkers has presented and been published around the world on occlusion topics, communication, and restorative dentistry applicable to the everyday and someday practice.

Dr. Melkers is the founder of the Nuts & Bolts Occlusion programs, the current editor for the American Equilibration Society, and an Ad Hoc Reviewer for the *Journal of Prosthetic Dentistry*. He is a mentor for the Pankey Institute and visiting faculty at the Spear Institute. Dr. Melkers enjoys sharing real

world challenges as well as solutions in his interactive learning experiences. So welcome, Dr. Melkers.

Michael: Thank you, thanks for having me, Allison. I'm excited and honored to be here.

Allison: Yes, I'm excited to have you here. Thank you to Mary Osborne who I see just joined us. She's the one that knew that you would be a great guest on here and knew that we would hit it off.

Michael: Good, thanks, Mary.

Allison: Yeah, thanks, Mary. Why don't you tell us about the last couple of years of your life and what's been going on for you because I thought that was really cool.

Michael: Mary's ears must be burning when she jumps in just before that question. It has been a huge, huge change in the last couple of years from everything you read. I usually don't get that long of a description unless my mom is introducing me.

Today is actually my second anniversary here in Hanover at Lyme Road Dental. My wife, Jeanine, and I sold our practice just over two years ago. At the youthful, mid-40s, decided to upend our life, move cross country and completely change everything we've been doing.

We were out in Spokane and had been practicing in Washington for, gosh, when we started the conversation maybe 17 years or so. Mary Osborne called us one day and asked us if we were looking. We said not really, kind of we had been. She said, "There's this place you have to check out." We came out here and I came out and visited, here in Hanover, New Hampshire, home of Dartmouth. Just beautiful area of the country.

I met an incredible team. I met the doctor that was retiring and his partner, who strangely enough, Paul Wonsavage and I had so many mutual friends. We'd both had been through all of Pankey. We knew Mary. We knew Gary DeWood. We had been to the same meetings and evidently had never really run into each other.

So fell in love with the place within the morning, long story short. Took us a little while to get out here. We sold our practice, strangely enough, to one of our patients who had been a long-time dentist and patient of ours. Loaded up the cats in the Subaru and moved it all out to New Hampshire from Spokane, Washington.

Allison: Wow. And you're loving it.

Michael: I'm working on the movie rights. We are loving it. Honestly, it sounds silly but it took me three months to not just spontaneously start giggling on the way home from work. My commute every morning is up and down the Connecticut River and just a few miles through the country. It is just a beautiful place to live.

Allison: That's awesome, that's really cool. And you've been teaching for quite a while, right?

Michael: Gosh, I have to think back on that one a little bit. I started out just like everyone does. We were just sharing in study clubs. It was before digital dentistry. It was before digital cameras. It was before Dentaltown. It was before all the great forums that we have—yours, and Facebook, and all of that. We were just sharing with study clubs and friends.

In 2002, I was involved, and we were talking with Dave before, with the Washington AGD. We put on a meeting in Sun Valley, Idaho. When I say 2002, it was February 2002, which was right

after a big, big event that no one forgets about that happened that past September. We had speakers from all over the world show up and not too many attendees.

We had, Matt Roberts was there, Newton Fahl was there, Tom Trinkner was there. Matt was up on stage lecturing with Tom and was going through some of each of their cases. Flipped open a case and said, “You know, Tom, this is actually one of Mike’s cases. Mike, why don’t you come on up here and talk about this case with me?”

Unbeknownst to me, Matt Roberts cold called me onto the stage to present in front of a small group of people but I was thoroughly terrified. I backed up against the wall to present with a glass of ice water behind me. I was shaking so hard I think ice cubes were bouncing out of the glass into the back of my neck and all that good kind of stuff.

Allison: Oh my gosh. You really do need to write a movie.

Michael: That was my terrifying start. From there, it’s when digital did start to really become popular. I was invited to speak at the first Dentaltown meeting in February of 2003. People saw that. They’d seen the things at Sun Valley and just asked me, and really just, someone gave me the opportunity to share and learn and it just blossomed from there.

Allison: I have sure heard your name a lot over the years and I'm really excited to hear about the Foundations, you’ve put this together, and present it in a way that I know I've heard is really well done and easy to understand. You're helping all kinds of dentists. You said your first thought was that you would work with new dentists, right? It ended up being some of more actually people who just needed a renewed sense of their practice or they just needed some—what did you say? That needed to understand occlusion.

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Michael: That first year after Dentaltown when things exploded and people actually asked us, “Can you put on an occlusion program?” Jeanine and I talked about it, when I say Jeanine, that’s Dr. Jeanine McDonald, she’s my wife and cofounder of the Nuts & Bolts programs. We’re still teaching together after all these years and after the move to New Hampshire. It’s been wonderful for us.

We said we want to give something back. We’ve had some great mentors in just a short few years. So why don’t we do this Nuts & Bolts occlusion program and we’ll focus on getting all the young practitioners there. It will be fantastic and we’ll be able to share with them. The program sold out quickly and all the 55-year-olds showed up.

We realized that it wasn’t about age. It wasn’t about all the courses that you had been to. It was about people that were just looking to get together. They were looking for smaller, in-person programs, to learn and grow together. Those years were really amazing.

I remember one of the first programs when we got past the 55-year-olds the first couple days, is we had a program where one of the attendees I think had been out of school for maybe six weeks or two months. In the same course, we had had a practitioner that had been through every Dawson course and I think half of the Frank Spear Continuum.

Both of them were able to get something out of the program. Both of them became not only participants but it instantly became a study club environment where we weren’t just learning as Mary Osborne says and Joan Unterschuetz says, we weren’t just learning from the front of the room. The room became the course. The attendees became the instructors and co-facilitators. It was a wonderful experience.

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Allison: I'm excited to dive into this. I'd love to hear about this. Tell me about the Foundations.

Michael: The Foundations course came as an evolution of the Nuts & Bolts occlusion programs. When we started those, everything was really about occlusion. We were learning about how to make teeth fit, how to keep them from breaking, and face-bows, and appliances and all that. Everything was just technical, technical, technical.

We realized we knew how to do a lot of dentistry and we weren't getting to do a lot of dentistry. From there, I was exposed to some really neat mentors, two in particular that allowed me to get to do the dentistry that I'd been training for, that I'd been through the continuums at Pankey and had been reading Dawson since even before dental school.

Those two people, and it's very nice she's on tonight is Mary Osborne. The other is Dr. Frank Spear. I don't want to limit it just to those two because there's Lee Brady, Gary DeWood, and just countless others. But they're two of the people that helped me see the forest for the trees but not forget about the trees.

Mary taught me that there was actually a patient attached to those teeth and how to listen to the patient. Dr. Spear taught me how to take all the dental intake and all the facts and all the objective things and put it into a treatment plan. So the Foundations program really was a melding of the influences of our mentors, of communication, treatment planning, and occlusion.

I think that traditionally, we are all taught I think occlusion, occlusion, occlusion. Then once we figured out how to make things fit, then we'd go back to actually treatment planning. Then we would try to figure out now that we've made them fit,

how do we complete change them to look like something else? Then after we've gone through this long, arduous process of models and waxing and face-bows and all this, then why don't we go back to the patient and hopefully we guessed what they wanted without actually listening to them.

[Laughter]

Yeah, ouch. You have the big closet full of models that you never got to treat. Come on, Allison, fess up.

Allison: Oh yeah, I do. I have a storeroom full of them.

Michael: Oh yeah, I had a big dent on my door handle, unfortunately on the out direction of Jeanine's and mine office where we tried to force the people quote/unquote "quality or comprehensive" dentistry. I got to the point with the long story of back to Foundations is Foundations with that heavy influence from Mary of, how can we listen to find out what the patient wants? Because I came to realize that the patient goals actually are the treatment plans.

When we can turn those patient goals into actual dental treatments, then we can figure out how to make it fit so it doesn't break. So before we were traditionally taught that occlusion and treatment planning, communication, if we were even taught communication, it became the communication piece on the front side. Finding out what those goals are, those goals being the treatment plan. Then taking those goals and trying to actually figure out the methodology of the treatment plan with our dental knowledge to make it happen.

Finally, the occlusion piece so that all these things that we want to happen so they don't break and they last as long as possible.

Allison: That's cool. So you're saying, this is in the way that we think about it and in the way that we do it.

Michael: Absolutely.

Allison: Yeah. So what do you mean when you say the patient goals become the treatment plan? You're just saying so they'll tell you, "I want white, straight teeth. I don't want to hurt anymore." Is there more to that than just simple—like when you say you weren't listening. I know you were listening. I'm thinking there's something deeper here.

Michael: I guess the depth and the profound breakthrough for me was it is that simple. If someone wants to have a nice smile, giving them a nice smile is the treatment plan. The methodology for that could be whitening, it could be changing the levels of their gums, it could be veneers, it could be braces, but the outcome that they're asking for is not based on the methodology, it's what they want to look like. It's what they want to feel like.

I remember having a patient come in and I said, "What are your…" I was fumbling along with my communication earlier on, although I fumble along quite well right now, and stumble on a daily basis. I said, "What are dental goals?" He goes, "I don't know. No one has ever asked me that."

I said, "Yeah, it's kind of a silly question, isn't it?" He goes, "Yeah, it's kind of a stupid question." I said, "Oh." I got a little self-conscious. I said, "Well what are you dental goals?" He said, "Well no one has ever asked me that." I said, "Well, I guess I'm asking." He goes, "Oh. Well, I'm never had any problems."

I said, "Well, that's good." I just waited past that uncomfortable silence and he thought about it. He said, "I'd like to eat steak when I'm 70." I said, "That's a great goal." He was maybe in his mid-40s I think at the time. I said, "Anything else?" He goes, "No, that's a pretty good goal. I like that goal." I said, "Well, why

don’t we go in the back and figure out how we can keep you eating steak until you're 70?”

All of our treatment at the point, all of our recommendations came back to his original goal of just wanting to keep what he had, keep it working, and keep him eating the steaks that he loved. I think we tend to overcomplicate and obfuscate—there’s a big nice word, to obfuscate—our patients with methodologies that they don’t understand. We try to recreate them into quote/unquote “valuing” dentistry.

When we’ve spent dozens of hours if not dozens of weeks to figure this out with Mary, with Frank Spear, Pete Dawson, or John Kois, or the Pankey Institute, yet we expect them to have the same level of appreciation and depth of understanding that we have after we've committed a good portion of our career to that education.

Allison: I like what you're saying. You're right. I do think we overcomplicate it. I can't quite put my finger on it but I know that we gather all this data and we listen to the patient for a long time and then sometimes we would completely lose sight of what it was they told us they wanted along the way.

I don’t know if you were really doing it that simply but it sounds really simple. Like, “Let’s go back to the back and see how we can keep you eating steak the rest of your life.” Then it’s just a constant conversation where you can't forget it because that’s what the whole conversation is about.

Michael: You laugh at it and I’m glad you're laughing and giggling but it was that epiphanal breakthrough. It’s like the Indigo Girls say, what made us think we should start clean slated? The hardest of all to learn was the least complicated.

Allison: Yeah.

Michael: It reminds me of treatment planning in dentistry because every time that Carl came back—and Carl is the "want to eat steak when he's 70." He'd say to Lori our hygienist, "Well, you know, I'm thinking about only coming in twice a year now because my insurance doesn't cover it." Instead of getting into some sort of insurance discussion or periodontal disease, Lori just said, "You know, Carl, if you doing that, that's really not going to help support your goal of eating steak when your 70 because if," then bringing back the goal to him saying, "because if you let your gums go or the foundation go, you're not going to be able to eat steak when you're 70."

That's my favorite one of all time is the steak when you're 70 but those conversations can become incredibly simple when they're focused on the patient's goals. They understand them. We understand them and we can act appropriately.

Allison: Yep. So if it's that simple, how do you make this into a three-day workshop?

[Laughter]

Michael: That's—oh gosh, it's getting hot in here and I'm blushing a little bit. I need to go get some water.

[Laughter]

But that's the leap…

Allison: I'm thinking this could be a really short call, Mike.

Michael: Well, that's it. Thanks for coming, everybody. Don't forget to shop at Maynard's.

But that's the point, that we can get into all the complicated stuff we know how to do. We can get the face-bows, we can get the appliance therapy, we can get the CR bites, we can get the wax-ups. We can plan perio prosthetic. And the leap that we go

from there is based on—as Gary DeWood's voice echoes in my head—based on their goals as we understand them.

I can say to that patient, "Based on your goals as I understand them at this initial interview, what I would recommend is we go in the back or go back to the operatory and we get a full set of x-rays and get a mounted set of study models and a photographic series so that we can see what dentistry might have to offer to help you accomplish those goals."

It backs treatment recommendations all the way back to the diagnostic level because when we walk out of that interview, if we even do one. Or we've all been there, the patient calls on the phone and they get the line, "In our practice, we only do quality dentistry and all of our patients get a thorough comprehensive exam" and so on and so forth. While that can sound great, what it also means is we're just rubber stamping everybody and everybody gets the same thing regardless of their concerns.

So that treatment plan, regardless of what it is, we can recommend those things that we do regularly do, but we give that recommendation for the models, the records, the photographs, based on their goals and we can move forward. So right from the beginning they're seeing that everything that we're doing is tied to their goals.

That we're not just saying, "Everybody gets this every time." Saying, "Based on your goals, this is what I recommend for you." It enlists the patient from the beginning on being a co-treatment planner, a co-diagnostician and it's a great way to start the relationship.

Allison: So you're actually walking through, you're doing some hands-on communication and then hands-on treatment planning. Then

teaching them occlusal principals and that kind of thing in that workshop.

Michael: Right. We back the first day of communication into even single tooth selections. A lot of people want—and I've seen it and I've been it, I've been that person that's gone down to the Pankey Institute or the Spear Center or the Chicago Mid-Winter where dental education almost became not continuing education but continuing dental entertainment because I wasn't doing any of that stuff.

I was going in, I was oohing and aahing over these amazing clinicians. But there was no way I could get anyone to do that because people don't do that in Washougal or they don't do that in Vancouver, they don't do that in Spokane.

So we walk our attendees forward with helping patients understand and being involved in single tooth choices and we move that to two teeth. And we move that to quadrant and we move that to arch. By the end of just the first day or maybe getting into the second day, they realize that their treatment planning in broad strokes at least with general ease, even complex care that they couldn't even imagine doing just a few hours before in the morning when the session started.

Allison: So, gosh, I don't even know if there's a way to walk through it on the phone but I was just thinking you could walk us through an example of that. Are they role playing?

Michael: What we start out with is we start out with a pretty safe environment is that I will role play on demand at the front of the room. I will ask questions, I'll invite responses that they can come into the discussion and we'll really start looking at cases from a benefits and consequence. We talk about what they see. We talk about the benefits of treatment. We talk about the consequences.

So we get them to really dissect their choices and their recommendations and share together between the group why they would choose that own treatment for themselves. They start to unravel and unveil how our own values influence our treatment recommendations and how even other dental professionals in the group might have completely different values even when they choose the same treatment.

That is, say you were losing, Allison, say you were losing number 30. You went in and you had a fractured root. The tooth was going to be lost. I might ask you, “Why would that be a concern for you?”

Allison: You want me to answer?

Michael: Yeah. If you lost 30, why would that be a concern for you? Or if your root was fractured, why would that suck for you?

Allison: I don’t want to lose any teeth. I want to have my teeth for the rest of my life. So that would be a concern for me.

Michael: We would just ask, “Why would losing that tooth be a concern?”

Allison: Because I think that our real teeth are better than anything else.

Michael: Cool.

Allison: If they're healthy, obviously.

Michael: There you go. Someone might answer, “Because I couldn’t eat steak.” Someone might answer, “Well, I would worry about what the replacement would be and whether it would be like real teeth.” Another person might answer, “I'd be really concerned about expense.” Or, “I would be concerned that I would feel old.”

We start to unravel not the whats, not the methodology, but the motivation of concern, of why they would be concerned with

this. Because we would say, “Well based on your concerns of worrying about being able to eat or how it will look or we can answer…” Sorry, I’m getting a little scattered. “We can answer what their concerns would be rather than what our own values would be.”

We start to teach the attendees how to connect what the patients—not only what their goals are—what their concerns, what their motivators are, as we move forward from just that one tooth, that number 30, to two teeth. Maybe where we’re choosing between crown lengthening and implants. Crown lengthening and root canals or implants. What would be their motivators to pursue each of those? We escalate these cases up further and further through one tooth to two teeth to quadrants to full, large cases.

We start to then connect that with the facially-generated treatment planning, or the Hanau Quint. All those things that we’ve learned over the years but using those treatment planning tools based on their goals as we understand them. We get to figure out how people want their teeth to look, how they want them to function, and get a treatment plan together. Then finally, we take them to the occlusion piece is how do we make them fit? How do we make them last?

So over the course of the three days, we learn to listen. We learn to use the information that we’ve heard. We put it into a treatment plan. We also during those three days, we do face-bows, we make appliances, we mount the casts, and then we go back at the end to some of the more complex cases and tie all the pieces together.

Allison: I love that. That’s awesome.

Michael: And I agree, it’s a little hard to explain on the phone.

Allison: It is.

Michael: I'm sitting here doing puppet fingers and pacing around my office.

[Laughter]

Allison: But what you're talking about is, I think, and I know Mary talks about it, the trying to tap into those values. I have found it really easy to sit and have the conversation and do what I think is a decent job of listening and gathering the information. Then I think not-so-decent of a job at then taking it from that consult room in and out and woven in through our conversations.

I mean, I think some of the time I remember what they said and I think about it and sometimes I think I just get lost in my own little world. Maybe I'm doing a better job than I think I am but I do think that's an interesting conversation about the patient's values and concerns versus our values.

Michael: I think you do a better job at it than you're giving yourself credit for. In fact, I know you do.

Allison: Yeah, I probably do but I'm just thinking that it's interesting, we're kind of taught like you said, what would you do if it was your mouth? We're sort of taught to treatment plan, at least I think for me, that was kind of a gift that I have is treatment planning for a patient the way I would want treatment planned for myself. I still think patients would want that, but they would want it with us keeping their goals in mind, right?

Michael: Exactly.

Allison: Okay.

Michael: I think what you bring up is a great point. We all hear this comment, "What would you do, that you're the doctor?"

Allison: Right.

Michael: Patients ask that all the time. It doesn't matter whether we're doing one crown and they were just given a choice between gold or tooth colored. Whether it's the implant versus the crown, lengthening, and the root canal. Whatever the case may be, they might become so overloaded or they just want our counsel and they say, "Tell me what you would do. You're the doctor."

I used to hate that question. I felt, probably earlier on in my career, I felt insecure that I didn't have the right answer. Later on as I got more into communication, I almost hated the question because I'm like, "No, you don't want to know what I want to do. I want you to know what you want to do." Then there came this moment of clarity that I don't want to tell them what I would do. I want to tell them why I would do it.

Allison: Why, yep.

Michael: So if a patient says to me, "Dr. Melkers, I know you're trying to get me to choose between gold and porcelain, what would you do? You're the doctor." I might say to them, "Listen, Allison, I'd be happy to share with you what I would do but first let me tell you why I would do it. The most important thing to me is conservation and longevity. Whatever I want and have done for my own dental treatment, I want it to last a long time and I want it to be as conservative in reduction of my tooth structure as possible. For that reason, my treatment choice would be gold on that tooth."

Or, if I said, "The most important thing for me is that whatever I put in there, you can't tell that it was done. So in my case, I would choose a tooth-colored restoration because when I'm done, I don't want anyone to know I had any work done."

So bringing our own values I don't think is wrong. I don't think it's a mistake. I don't think sharing our recommendations of what we would choose for treatment is wrong. I think that we miss out in sharing our values and our passion with our patients of why we would choose those things.

Allison: Beautiful. I love that distinction. I actually remember having a conversation with a patient not too long ago. We were not seeing eye to eye. He actually, we parted ways. But he called me for advice after he had already left. There was a whole story and it's not important.

I told him, I said, "I'm not going to tell you what I think because we don't have—you've already told me, we don't have the same values." So in some way, I think I've done this before but I love what you're saying and I don't think I've ever been that clear. I didn't realize that's what I was doing until you just said that. You know what I mean? Like I didn't even realize that I did that. But yeah, that's a beautiful distinction.

Michael: Thank you.

Allison: I think you're right. We do lose out on an opportunity for I think even for maybe them to clarify some by sharing that. I don't know how you could turn it around. Maybe Mary has an idea of how you could share that with them and then turn it into their—just turn it back around to them, right?

Michael: I think third-person removal is a great way. You could say, "Well, I would choose it for this. There are some other patients that think that getting the treatment done as quickly possible…" You can make up whatever three choices or two other choices that might not be yours or motivations that might not be yours. It seems everything comes down to a few. It comes down to pain. It comes down to esthetics. It comes down to conservation of tooth structure. It comes down to function.

People want something to not hurt, they want it to look good, they want it to feel good. They want to be able to chew with it. They want to be healthy. Which of those is their priority, we're not sure. I think that the third-person removal, throwing out a couple of fishing lures between a few choices that might be appropriate are a great way to invite them into the conversation.

Allison: Lovely. Very nice, Mike.

Michael: Thank you.

Allison: Yeah. What else should we be talking about? Is there a piece that we should be covering that we're not?

Michael: You know, Allison, you and I had a neat chat the other day. I was thinking about that a lot because we're both so young, only having graduated in the mid-90s. You know, how in the heck did 20 years creep up on me this year? I don't even know. I'm not even quite sure how that happened. You know, things that you wish you had done differently or things that you wish you could go back to the younger you and share.

Allison: Yeah. I mean, I was asking when you have dentists come to these courses, what are they really asking for too? What are the questions that they're asking? For me, I just wanted to do the best dentistry possible and make as few mistakes along the way.

I think what you're saying is the key to that. I mean, finding out what your patients want is a huge thing because they're not going to—it's less likely to get you in trouble in the long run. You're more likely to have very happy patients. But I did, I asked you what questions you've had—I don't even remember the exact question I asked.

Michael: I'm sitting here smiling and listening to what you rolled there from. You rolled between patients coming to us and not

knowing what to ask or what's possible. But you also asked how do we know what our students, what our attendees need to know.

Allison: Yes.

Michael: We ask them.

Allison: Right.

Michael: It's so funny, where we try to guess and we try to think, "What do they need to learn? What do the patients want?" We try to be these omniscient clairvoyants. Where all we have to do is step back and ask.

Allison: Right.

Michael: When we start our programs, we do an intake. We do an in-person intake. Giving away a few of the secrets of the program, but one of the first things we do is because we have such a small program, usually 6 to 12 attendees at our Nuts & Bolts or Foundations programs, we say, "What brought you here today? What can we help you with?" It's really the same questions that we might ask our patients.

Slowly, through the process of the group interview people find commonality. They hear answers that are different than theirs and they open their mind to them. It really becomes that café conversation and that group learning experience that moves us forward. Really what those three days turn into that the attendees realize is three days of a new patient experience.

They show up expecting to learn a few things or pick up a new pearl or two, or establish a new dentist. Slowly they get exposed, but not force fed, what's possible for them. I think that's the Barkley quote, I'm actually looking at the book *Successful Preventive Dental Practices*.

I think the quote goes something like, patients come to us not knowing what's possible for them in dentistry. They come to us with us—we should unmute Mary so she could pop that quote up for me—they come to us with a lifetime of unsatisfactory dental conditions. So much so that they don't know what's possible.

So we have to expose them to what's possible. I balance that quote with the Albert Schweitzer quote which is, "Patients carry their own best doctor inside." They come to us not knowing that fact. We're at our best when we give the doctor that resides inside each patient the chance to go to work. I think if we give the attendees the chance to allow the instructor and the mentor inside of them a chance to go to work, we all learn and grow together.

Allison: Yeah, I totally agree. I'm glad you took that question, where you took it. I actually was asking you what they ask. Like, what do they say when you ask that question? When you say, "What brought you here today?" The dentists, are they saying they want to learn occlusion? I'm genuinely asking you what do they say.

Michael: They're all over the board.

Allison: Are there like three, kind of like the patients, like where there's just a few things or, they're all over the board, okay.

Michael: They're all over the board but there's a consistency within them. Some will just say, "I just want to come here, learn occlusion. I don't know how to use a face-bow. I don't know how to make an appliance." Others will say, "I know how to use those things but I have no idea how to treatment plan. I see all this stuff and it is so overwhelming I don't even know where to start."

Others will share that they've tried to treatment plan or they've tried to treat or they've heard these horror stories about people that have and then things break. They get so nervous and scared about these failures, whether they've experienced them or they've heard them, that they say, "I'd really like to learn how to keep things from breaking." Or even better, "I'd like to know when it's going to happen before it happens." Now, we can't teach omniscience but we can teach them warning signs and triaging. Omniscience is the advanced course, that's coming out next week.

Allison: Okay, I wondering.

Michael: Yeah, I'm working on that one a little bit. So those tend to be consistent but they also evolve even within the course. We write the goals up on sticky notes and on those big Post-its and we allow people and we invite people to change their goals or modify their goals. Really, just the same way we allow and invite patients to modify their own goals.

When we try—when I say we, I mean me—when I try to force feed patients everything that first visit, you remember, it's the AACD 20000 photographic series, full mouth x-rays, full mouth probings, two sets of study models, CR records, five other things that you can figure out to do to them within two hours. Lo and behold, because you just gave them such a comprehensive experience they can't but help but say yes to everything you're going to recommend.

Allison: Right.

Michael: Yeah, right. That's kind of how I started. I realized, I can't teach like that either. If I try to tell people what they need to know without them having the value of why they need to know it, they don't listen. And I didn't listen. I didn't listen when I tried to open

a practice that was based on those two-hour exams on every single patient whether they needed it or not.

But slowly, when they do feel safe in the room and come forward and ask those questions and get a little piece of that knowledge and get interested and integrated into the process, they tend to ask more questions and become more involved. That's where after about a day I stop talking and they start asking all the questions. They start interacting with each other, providing the answers.

I don't want to give them all the answers because, one, I can't. But I don't want to tell them how to think but I'd like to teach them how they do think and some helpful tips on how to organize their thoughts so that they can be impactful with their patients.

Allison: So the value of why they need to know.

Michael: I'm sorry, I missed what you said, Allison.

Allison: No, I had a question and I just lost it. You said something like, you were talking about the value of why they need to know and I had a question around that and I don't even remember what it is anymore. I love what you're saying about that it's just the same as a patient. So they come in and they're able to ask questions and you… I don't even know what my train of thought was.

Michael: That's okay, this is payback for my jetlag when you and I were on the phone the other day.

Allison: You know what? I'm having sympathy pains for you.

Michael: You're having sympathy lag.

Allison: I am. I only went to L.A. last week.

Ep #36: Communication, Occlusion and Your Patient with Dr. Michael Melkers

Michael: Because we are both at the same youthful level, do you remember when occlusion became really, really popular again? It was just after you and I both graduated. There was something that happened back then within the industry. There was a product that was launched.

Allison: Oh, I'm thinking it was the myomonitor?

Michael: It was Empress.

Allison: Oh, Empress, yes, okay, gotcha.

Michael: We started doing things to people's smiles that we had never done before with materials we had never done.

Allison: You're right.

Michael: We had porcelain-fused metal crowns but now we had gorgeous porcelain that we were changing shape and rotation and length on patients. It looked beautiful and we were addressing their smile needs. Then a couple years later, things started breaking. When things started breaking, Pankey became popular, more than it ever had. Dawson did. Spear did. And LVI adopted an occlusal philosophy.

It wasn't even within the industry that occlusion became popular and important until we saw failure. That's one reason why we can't teach occlusion in school. It's not because we can't. It's because students won't understand it and they won't appreciate it. Because in school, unless we forgot to do bonding agent or even then, it's probably fine.

Unless we forgot to condense the amalgam, we're really not going to see much in the way of failure within our two year or two and a half years of clinical. You finish those two years, you get out, then the next group of students get to fix the last group of patients. That's why we have so many professional patients

in dental school, because it was failure after failure. But we never got to see those. And we never got to experience them until we had been in one practice and we did our own dentistry and then we sat there for a few years.

Whether it was five years for some or whether it was two years for others or whether it was ten years, there was a timeline where we started to see some catastrophic failures of our own dentistry. That's when people start looking for answers because they have need. The same way our patients started looking for solutions once they see things that threaten them. Once they understand consequences. Or, once they're exposed to the benefits of treatment.

Beyond the day-to-day dentistry of a tooth is broke, fix it. Every six months, go get your teeth cleaned. When we move into the complex or comprehensive dentistry, past that day-to-day stuff, people are just not going to say yes to treatment until they know how it affects them. They're not going to do it because we have rapport or they like us or we're a nice office. They're going to do it because it means something to them and what's in it for them as far as their treatment goes.

Allison: Right, yeah. We've tried over the years too to have like a reason to return at the bottom, where everybody in the office is using that. Kind of like what you said, I love what you said about the guy with the steak and your hygienist even tying back into his why, of why he's doing whatever he's doing. He's doing it so that he can eat steak when he's 70. So that's right back to what you said at the very beginning, just make it about them and what they want.

Michael: Absolutely. We even wrote those things in our charts before. Pain can be different because that can be an acute motivator. But if a patient is motivated like you by health and keeping body

parts or if they're motivated by function or if they're motivated by esthetics, those values tend to carry through to their decisions in all parts of their mouth and all phases of their treatment. We just wrote it in pencil in some small place inside the chart. It helped us attach that.

Where we carried that forward was if someone had a broken tooth or a cracked tooth or even splint therapy, we stopped calling splint therapy, splint therapy, and we started calling it palliative orthotic therapy, or “get me out of pain” orthotic treatment, or “help me open my mouth wide enough so I can eat a burger” orthotic therapy.

Allison: That’s brilliant.

Michael: It sounds funny but when the patient really understands what is in it for them, they tend to say yes more. Because they're the person that gave you the reason that they want treatment if we can just open up our ears and keep our mouths closed a little bit more and listen.

Allison: I love that for an orthotic, Mike, because oh my gosh, I forget why I was doing it. I mean, you know, you get six or seven appointments down the road and the patient is like, “I’m doing great. I feel really good.” I’m thinking, oh my gosh, what was it? I have to go back and look at my notes. I love that. I think that would have to help the staff as well.

Michael: Oh, yeah.

Allison: The “get me out of pain” orthotic or the “I want to open my mouth.” Yeah, that’s actually really brilliant. You should market that too.

Michael: I appreciate that but it’s for people to share. It’s for people to be more successful at implementing. Orthotic therapy right now I'd say in this economy more than any other thing that we can offer

our patients is probably the best preventive dentistry we can offer. We can call it a “protective appliance” or we can call it a “holding pattern appliance.”

“We’ve gotten you out of pain and I know you're concerned about your worn teeth but Jimmy’s in college and you just bought the boat and the economy tanked, so why don’t we keep you in a holding pattern, protective orthotic therapy, until you get your feet back under you? Then we can talk about what might be possible for improving your smile.”

Allison: Nice, wow.

Michael: I’m going to run out of sound bites at some point, Allison.

Allison: That’s cool. Good verbiage. I do want to ask you a question. I want to go back to something you were talking about with your—do you just have the one course?

Michael: It seems like we have one course and we have an infinite amount of courses because everything is focused around melding communication, treatment planning, and occlusion. That’s our Foundations course. We certainly do standalone communications, standalone occlusion, and standalone treatment planning courses, but the other two elements always seem to seep in there. So if we’re at a communications program, we might be using occlusion or treatment planning as the vehicle to talk about. So they always tend to intertwine and flex and flow.

But yeah, we do custom programs. We did different ones for the CDA, the ADA, and the AGD. But our heart and soul and our favorites are always the study clubs, whether it’s the Spear study clubs or the Seattle study clubs or just a group of people getting together like they do in our office. We have a commitment study club where we have some dentists from

around New England that meet every few months. Whatever they want to talk about, we just roll with.

Allison: Okay. Yeah, that was kind of my question. So it's more in the setting of a study club. Is that true? Or you have both? You have the course and the study club. Are the courses more—is it like a study club?

Michael: We have our big room lectures that we do at any of the bigger meetings. We have our Foundations program which is not a study club but meant to be a core program that is the melding of the communication, treatment planning, and occlusion where people do face-bows and bites and splints and treatment plan and communicate.

Then beyond those, we tend to encourage formations of study clubs so that people can support their learning outside of our courses and with their friends, with their colleagues. Then we tend to do advanced courses where we might focus just on orthotics that weekend. Or we might focus on waxing anterior cases up in the lab.

Before I was a dentist I was also a laboratory technician for my father. I keep my lab skills up. Like I told you before, before we even got on the phone, I was in the back waxing up a full mouth worn dentition case. So we flex, we flow. That's one of the huge advantages we have of being such a small teaching entity. We focus on the small groups and their specific needs.

Allison: Okay, that's nice. So where can we find out more about your lectures and where they're being held?

Michael: You can find me in a few places. MichaelMelkers.com, which is just my name. Doesn't matter whether you do caps or not, all lowercase is fine. MichaelMelkers.com is my speaker website that I try to keep up. I'm on Facebook at Dr. Melkers Seminars

and various groups on Facebook. You'll also find me floating around Dentaltown.

Allison: Okay. Do you have anything to say in closing? I thought we could open it up and see if anybody has any questions or comments.

Michael: No, this is new and different for me, spending a full hour on the phone without seeing or without being able to use my hands to speak. This was fun. I had a great time. I'd love to hear some questions.

Allison: Interesting for you, you're a facilitator so it's got be kind of interesting. I know most of the people who do more facilitating say it's a little strange not to have the interaction. I've got the line open. Does anybody have any questions or comments for Mike?

Michael: Might have put them all to sleep.

Allison: No you didn't.

Dave: Good to listen to you, Mike.

Michael: I miss you, Dave. I miss everybody out in Washington. Jeanine and I hope to see you next year in Boston. I'm hopefully placed to get my mastership.

Dave: Cool.

Michael: Yeah, I'm very excited about that.

Dave: That's great.

Allison: Thanks for being on, Dave.

Michael: Thanks, Dave.

Dave: It was a pleasure.

Ep #36: Communication, Occlusion and Your Patient with Dr. Michael Melkers

M. Martin: Hey, thanks Michael. It's Michael Martin from Seattle.

Michael: Hey, Mike. How's it going?

M. Martin: I'm doing well. I just tuned in like five minutes ago because we had to eat dinner but I'm excited to hear what you said.

Michael: I look forward to seeing you next time. I was just at Inspired Facilitation with Joan and ran into Sherry there. We were reminiscing about Leadership and Legacy.

M. Martin: Yeah, I saw some of the pictures on Facebook. It was awesome.

Michael: Well, there's always pictures on Facebook.

Allison: You weren't there at Inspired Facilitation this year, huh? Me neither.

Michael: It was a neat experience. I'd never been to Annapolis before and it was just gorgeous.

Allison: Yeah, it looked gorgeous in the pictures. Is it pretty quaint?

Michael: It was. It was all cobblestone streets and little local eateries. We stayed in an old historic inn and that's where the program was. It was Denny Byrne's group and as you know, just sharing with others. It was a wonderful couple days of facilitation and learning and sharing.

Allison: We sure appreciate you being on here tonight. I'm sorry about my little bit of jetlag but you did beautiful. It was fun to hear really what you're teaching. I wish there was a way to communicate. It's a little better from my standpoint. I was just thinking I bet your course is amazing. I'm actually really interested in trying to come see you and learn from you more.

Michael: It would be lovely to meet and I'd love to just sit down and share and learn. It would be a good time. And I love this experience,

although like I said, it's a little strange being on the phone pacing around my office but once we got rolling, I thought it was great.

Allison: Yeah, thank you very much and thank you everybody for taking time out of your busy schedule to be here. We'll see you next time.

Michael: All right.

Allison: Have a great month and take care. Thanks.

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