

Curtis Jansen

Dr. Curtis Jansen received his dental degree and a certificate in advanced education in Prosthodontics at the University of Southern California (USC), where he went on to teach in the department of Restorative Dentistry and worked as director of the Implant Dentistry department. He also worked with a dental implant manufacturer in Florida and was extensively involved in the research, design, and development of a number of patented implant restorative components used by major manufacturers today. Dr. Jansen lectures widely and owns a private prosthodontics practice in Monterey, Calif., with an on-site dental laboratory. He spoke with Dr. Bradley Bockhorst, former director of Clinical Technologies at Glidewell Laboratories, Newport Beach, California.

I know you've just spent six hours lecturing at the California Dental Association (CDA) meeting, so I appreciate you coming out here to spend a little time with us. During your presentation at the Academy of Osseointegration (AO) Annual Meeting last March, one of the things you talked about was the "money tooth." Can you expand on that for us?

I'm always trying to think how I can motivate and educate doctors — and there's no better way than with money. So many people are standoffish about the whole concept of intraoral scanning or same-day dentistry. Everybody likes to talk about

anterior teeth and how pretty they are, and how we can achieve esthetic results. But what drives doctors' practices, what pays for their mortgages and their fancy cars, is single-tooth dentistry. And if we break it down even more, when we're talking to those who are doing implants, it's lower mandibular molars. For a lot of the bigger surgeons, it may be as much as 25 percent of the time that they pick up a handpiece or put in an implant that they're replacing mandibular molars. For me, if I break up my practice into single crowns and single implants, it's mandibular and maxillary first molars. I'm either replacing or restoring first molars. It's the "money tooth" — and I love it!

How to cite this section: Jansen C. Interview. Curtis Jansen. Dental Press Implantol. 2013 Jan-Mar;7(1):8-17.

Interview originally published: Jansen CE. Implant Q&A: An interview with Dr. Curtis Jansen. Inclusive Magazine. 2013;4(1):47-52. Available from: <http://www.glidewell.com/downloads/dentist/inclusive/issues/winter2013-v4-1.pdf>.



Do you think part of that is because it's the first tooth to come in, so it's the first tooth to come out?

Right. I think that it's the first tooth that gets the early composite, or the early alloy, and it may just break down. Then one thing leads to another. What's surprising is that 80 percent of dentistry is "re-dentistry." Rarely are we treating a tooth for the first time, and that tooth is the tooth that gets beat up first, gets the endo, so it is the one that comes out first. I think that holds true for a lot of implant restorations and a lot of full-coverage restorations.

At one point you said that 75 percent of the cases you evaluated involved first molars. Is that a true statement?

Yes and no. I found in talking to many surgeons placing implants that about 70 percent of the implants they place are posterior, either single or multiple units. About 45 percent are single posterior implants. When you get down to mandibular first molars, they account for about 25 percent of the posterior implants being placed. I'd be very curious about what you guys do here at Glidewell, and on which restorations you do the most crowns. You've got cases coming in from many different places, but I bet you're keeping pretty good numbers.

After I saw your AO presentation, I came back to the office and looked up Glidewell stats for custom implant abutments: 29 percent of the custom abutments we do are first molars.

So it holds true!

Everybody talks like it's the full-arch cases, but it's those single units that really are the bread and butter.

It is. That's why my perspective is to try to get through to these individuals who are so highbrow, who think, "How could you do that?". If they break it down, they can really see where their business is. Glidewell is extremely good at that. That's how I try to get through to the stubborn ones. I say, give me single posteriors, let us talk about this one area of your practice, and I think you could utilize intraoral scanning. You could do a lot of things to be more productive.

Another thing I'd like to talk to you about is technology. What do you see as being the most significant technologies impacting dentistry right now? Which ones are you incorporating into your practice?

The greatest advancement in dental technology I see out there — and I think it's incredible — is digital, obviously. If we break down digital into digital radiographs and things like that, I think that's it. But for me right now, as a restorative doctor, it has to do with intraoral scanning. I think there's a huge misconception out there and so many doctors are turned off by same-day dentistry. I call it "SDD" and "NDD," next-day dentistry. For me, there is no question about it: The most significant thing that I've incorporated in my practice is not only intraoral scanning, but also lab scanning. Then we get into implants. I like to do a fair number of implants. I like to scan abutments. Glidewell has a very nice abutment. Some of the other manufacturers have nice abutments. I can't tell you how antiquated it is for me to take off a healing abutment, put on an impression coping and make a conventional impression. I've only been doing digital scanning with implant restorations for about six months now, but conventional impressions for implants already seem so last year I just can't believe it!

I got a kick out of one of your talks from a couple of years ago when you said, “People, can we make this any more complicated?” And now the question is, “What’s changed?”

What’s changed? It’s scanning! Intraoral scanning abutments. But make no mistake about it, I don’t think it’s necessarily only intraoral scanning. Nor do I think conventional impressions are going away anytime soon. But for me, intraoral scanning and lab scanning are a big deal. Then if you take it even further, what you guys at Glidewell have done beautifully is introduce the one-fee. You talk about mandibular first molars, and that’s what is going to drive their practice. So many doctors are doing single posterior implants. But many restorative dentists have a problem, and they want to make a referral to an oral surgeon or a periodontist. Often this referral makes things harder. The patient can get lost and confused during the referral process. The patient ought to be able to just go up to the front desk and say: “Hey, your doctor just said I should have an implant. I’m ready to go. I want to pay for everything, right here.” But so many times we just screw it all up during the referral process.

The one-fee philosophy, can you talk more about that?

Talking about what’s big for me, practice management-wise — we can talk parts and pieces, intraoral scanning, doing it in the lab, doing it different ways. But from a practice management philosophy, running the practice and seeing the patients who want it white, W-H-I-T-E, and they want it white now, most patients are ready to make decisions fast. We’ve got Netflix, and the 29-minute oil/lube from Pep Boys — all these things influencing patient expectations. Patients want and expect things to happen quickly, and they’re willing to pay for it. And they want one-fee. They don’t want to be overwhelmed with, for example, “Oh, it’s

a graft, and it’s this part, and it’s that part.” They just want to know what it costs, and they’re ready to go. The hysterical thing is — maybe you’ve heard me talk about this — that doctors think they somehow have to justify their fees and have a bunch of appointments. But patients are paying for perceived value; they’re not paying for appointments.

Right. And that leads right into our patients’ perception of the technology that we’re using. There is the clinical utility, but also the practice management aspect of it.

It’s huge. I think doctors miss this aspect, which is a very big component of practice management. Most dentists — and I’m not claiming to be one of them — are getting a lot smarter. But we’re not business people, as you know.

I want to take a step back and discuss some of the details of the technology. You mentioned before that you have multiple intraoral scanners. Which ones do you have, why do you have several and which do you use where?

Well, I’m a restorative guy, and I’m a curious guy. I’ve got to have a little of everything. I’ve got three of the four widely used digital impression systems in my office. I tend to use one more than another — but they’re apples and oranges. I don’t have to explain that to you, but I think we have to explain that to the readers. Two of these systems have an associated mill that allows me to do same-day dentistry. Two are merely impression material substitutes, and I don’t mean to degrade those. But to me, that’s all those really are. I can use those to make impressions and then I can do fancy things with them — I can send the data to you, and I can save twenty bucks or more on my lab bill. With the other ones, I can do Invisalign® cases (Align Technology; San Jose, Calif.).

So does the average restorative doctor need three or four systems in their office? Absolutely not. But they have a big decision to make. They need to decide, for instance, if they merely want to have a substitute for impression materials. If I'm using Cadent iTero™ (Align Technology) or Lava™ Chairside Oral Scanner C.O.S. (3M ESPE; St. Paul, Minn.), they're both very nice systems, but I don't see a model for three to five days. Now, maybe I don't need a model, but I still like my model. I can do a rehab in three to five days. I've got E4D® Dentist (D4D Technologies; Richardson, Texas) in the office, and I've got an attached mill. So I can still do intraoral impressions, I can do lab impressions; but I can also fabricate a restoration on the same day. E4D is probably my favorite from that perspective. But the coolest scanning technology, I think, is Lava C.O.S. It's live, streaming video. The easiest one that I can do all by myself, from a scanning perspective — behind my back, underneath my leg — is Cadent iTero. I can do a pirouette on the tooth with the scanning wand and the data is good. There are a lot of things to consider for restorative doctors, but the biggest decision is whether they are ready to do same-day dentistry in their office, or they want to be able to partner with a lab like you. I would imagine that you're going to start really incentivizing doctors to do some of this stuff.

We receive a huge number of cases using various scanners, and we accept digital scans from all systems that are out there on the market. So have you gone model-less yet?

That's the tough part. You know, as much as I'd love to go model-less, I'm just not there yet. It's very difficult for me. I like to check my contacts — I like a little clacker! But I'm trying. I've been using a digital scanner since October 2008. I have to say one more thing, for doctors who are making a decision about



going digital: Try to get all the information on all the systems, not just what you hear your buddies talking about. There are so many cult-like things in dentistry. You have these different groups or any one of a number of different organizations pushing a particular system, so be careful. But going model-less, that's a big deal. I think we have to start in the dental schools. What I want to find out is how I can get a printer from you guys because I hate making impressions! But I just can't wait three to five days for a model — it's too long. I like the idea of printing or milling a model in my office the same day.

Heading toward model-less is key for us, too. If you can avoid those steps that are part of conventional impression-taking, not only do you avoid potential errors, but you can obviously move things along more quickly.

With the labor and time and effort that's involved, a majority of doctors don't pour their own impressions.

And the ones I've seen that they have poured make us wish they hadn't!

That's very true. Lee Culp, CDT, chief technology officer of Digital Technologies Inc. (DTI) in Dublin, Calif., has said that 95 percent of doctors do not pour their own impressions. To me, that's a fascinating statistic.



If we can do more intraoral scanning and then go model-less, that's going to be a big deal.

So are you using intraoral scanning for all of your implant cases?

When you look at my conventional dentistry — say I'm doing six restorations in the anterior —, I'll prep and provisionalize conventionally, get the provisionals as nice as I can, make a conventional impression of the patient-approved provisionals and then go into the lab and scan everything: the prep, the model of the provisionals and the opposing dentition. Those are all lab scans. Then I will design and mill the restorations using the provisionals as a guide. But for my implants, it's almost 100 percent intraoral digital scanning. If I can, I'll solely do intraoral scanning with implant restorations. Then design the abutment and restoration. It's just so much easier with implants. I can justify the time and the wait because I'm going to get a model and an abutment several days later. I'm not just waiting for a model. I love this concept of concurrent manufacturing. From the intraoral scan I design the implant abutment; from there I send the information to an abutment manufacturer. They can then mill the abutment and print or mill a model of the abutment and the actual abutment. But I find it difficult to do that with conventional dentistry. I have to wait three to five days just for a model before I can start any lab work. With implants, it makes perfect sense for me.

For those implant cases, do you immediately provisionalize them routinely?

For my implant cases, I think one of the biggest new options out there is the ClearChoice® model (ClearChoice Dental Implant Centers; Greenwood Village, Colo.) with their same-day restoration option. ClearChoice works only with oral surgeons and

prosthodontists, and they advertise big time. ClearChoice has done more for prosthodontists with their advertising than anybody else. But at the same time, I think they're the scariest thing out there, some serious competition. I want to be like ClearChoice — I want to try to take them on. They're doing a really good job, but I think maybe I can do better. But for the concept that they have, this same-day immediate tooth, my office is too small. I built the wrong office. I'll do some same-day dentistry that's just conventional dentistry. But many times I'll be doing immediate non-occlusal loading, or I'll do an All-on-4™ (Nobel Biocare; Yorba Linda, Calif.) case on implants. I don't think there's anything bigger in my practice to make patients happier than allowing them to get rid of their beat-up, useless mandibular or maxillary dentition, put in four to five implants and give them fixed teeth the same day. Loading the implants the same day, that's big. It will be interesting to see how Glidewell addresses this because a lot of doctors don't know how to do this type of dentistry. Glidewell is good at educating doctors on products, and there is great opportunity to do the

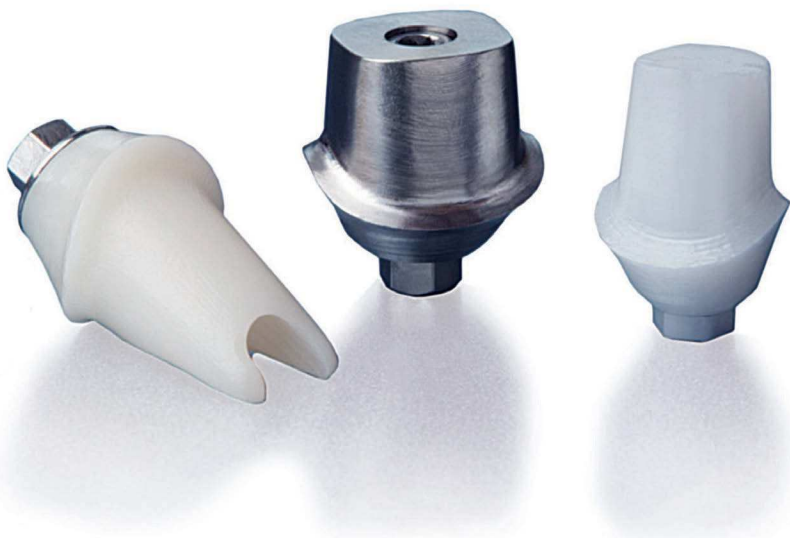
same with procedures. I just think we need so much help from the laboratory for these immediate-load implants. I can do it. But the average guys out there, they can put in the implants and get it close, but they don't know how to connect a fixed restoration. They don't know how to convert that denture to a fixed restoration. That's going to be the difficult thing. But I think there's a big business model there.

That's exactly one of the projects we're really working on. You're going to see that package in the near future. To go back and clarify something for our audience, ClearChoice is a group of practices with offices around the country, and they primarily do All-on-4. They market to their local communities, and they're really drawing in a lot of patients who had given up on going to the dentist. At one point, I heard a statistic that about 60 percent of patients who go to ClearChoice haven't been to a dentist in more than 10 years. So, their marketing efforts are reaching people. When ClearChoice first comes into a market, dentists are often concerned. But, in actuality, it has really helped educate a lot of people on procedures like All-on-4. What they ultimately find is that the whole market is more educated about implants. So we end up getting more business because of it.

Right. I think it's a good thing.

What's your opinion on putting the abutment in one time, as soon as possible, and then leaving it there?

That's the beauty of what I was doing initially. After confirming that the implant could be loaded, I'd really



take my time with the zirconia abutment. Or I'd use a titanium abutment, but I'd really take my time with it and get it perfect, with margins below the tissue, etc. Then I'd impress it or scan it and put it in the patient's mouth. And people would ask me how I could determine margin placement at the time of surgery. I can do that because I'm working with good surgeons. If a surgeon takes out a tooth and takes a whole buccal cortex out with it, they're going to warn me not to do that one. But 9 times out of 10, the tooth is taken out very atraumatically, the implant is placed, and we know we're not going to have a lot of recession. In those cases — especially with thin biotypes, or highly scalloped tissue — I think it really pays to take as much time as we can to decrease the number of what we call "switches," when the abutment or the impression coping comes on and off the implant. So, if I can leave that abutment on, fantastic. But that's where this whole concept of what I call forecasting comes in. If I could then scan that and come back in 12 weeks, people ask, "How do you get your margins?" Well, I've scanned it outside the mouth. Then I can scan inside the mouth. There are enough data points to where I can merge the two data sets. It's very exciting. If we can, we want to limit the number of switches and transfers because every time we raise a flap, every time we take an abutment off, it sets up a series of consequences, and we lose hard and soft tissue.

You will be presenting on risk management. Can you tell us a little bit about what you're doing along those lines, and what recommendations or suggestions you have for clinicians out there?

Right, this is a great course. It's something that I've done probably the last six or so years with The Dentists Insurance Company (TDIC), which is one of the bigger insurance companies here in California. They use actual

malpractice cases as examples in the seminars. I don't know if you've ever sat through one of those courses, but you get a 5 percent reduction on your premium if you do. That's one reason why the people are there, but these seminars are also very helpful. An attorney and a restorative dentist present four to five different patient situations and review various learning points. We're going to draw more than 1,000 people over the next three days. One of the common themes is recordkeeping. Doctors keep miserable records, and at times they pay for it because they can't defend themselves. We have so many responsibilities as clinicians, and at times we may get sloppy with recordkeeping. What I would recommend for doctors is consent forms, which is kind of a given. You can go to www.thedentists.com and get consent forms. But for some of these cases, it's bigger than just a consent form. You need certain things in your treatment notes. If a patient has some type of potential problem and you're worried about, say, a root canal, you've got consent to cover that — but many times it helps to also write in the chart that you spoke to the patient about RBAs (risks, benefits and alternatives) to proposed treatment. The other thing that's very interesting when we talk about implants and these big-ticket items is that you've got these piranhas, these ambulance-chasing attorneys out there. I only work with what I call the "good guys" — only the attorneys who defend. But as far as risk management, I don't think doctors can protect themselves enough from both patients and employees. You can never be Teflon. But you need to look at these consent forms. You need to look at treatment plans. You need to cover yourself the best that you can. I cannot tell you how much help there is with a company like TDIC. It's important to discuss informed refusal on these All-on-4 cases — you're talking about a whole different type of treatment. A lot of people know what informed consent is, but not informed refusal. When you tell Mrs. Stieglewitz that you're going to take out all of her teeth, you're going to give her some implants and

everything is going to be peaches, if it's not all peaches, you've altered a significant portion of her life — it's like taking away an arm or a leg. It's more than just a single-tooth implant. I don't think a lot of doctors get that. When you're talking in that realm, and when you're talking about that kind of money, then you've got some attorneys who are pretty interested in that. And Mrs. Stieglewitz has more of a case to make than that she just didn't get her single tooth. She doesn't have any teeth!

Even before that legal aspect is managing patient expectations, which I'm sure is a huge part of this topic. Can you expand on that?

Again, it's the informed refusal, informed expectations. You have to compare all the available treatment options. If you immediately load some implants and give the patient a fixed restoration on the same day, that's great if it works. But if it doesn't, you have now taken the patient's teeth out and they have nothing but a floating plastic replica of teeth. Oh yeah, and they don't get the fixed one for at least 12 weeks. Well, some patients are not going to be too happy with you, so the topic of patient expectations is huge. You need to tell them what's going to happen if it doesn't work. So, you hit the nail on the head. Patient expectations are a big part of it. And so many doctors are so eager and so enthusiastic to get into the treatment that they forget about that part, if it fails or they can't go fixed the same day. If they don't cover that with their patients, it could be a big problem. Suddenly your records are subpoenaed, and you're asked to give a deposition.

Regarding major catastrophes during implant placement, like injuring a nerve, from your work with the insurance cases, what are the usual things people are getting in trouble over?

The biggest thing is simple informed consent. Like politics, it's not necessarily the damage of the incident; it's how it's handled. And a lot of doctors don't handle it well. And what happens is a second party gets involved, and that's when it gets ugly. Dentists, they just can't help themselves. They can do a simple occlusal alloy, and the guy across the street will find some fault with it. So, it's not necessarily that you see an injured nerve or an implant that fails. Most of the lawsuits I see start from a critical second opinion. The amazing thing, in my experience, has been that somehow juries can always ferret out the truth. I've worked with a lot of attorneys and they have the utmost confidence in juries figuring out the truth. And a lot of times, doctors are less than truthful. What we do is very difficult, and sometimes we just have to ante up and tell the patient that it doesn't always turn out right. It's not going to work right all the time. I think juries understand that. Patients should understand that, too. So I don't think it's necessarily the act itself, it's how these doctors are responding to it. Or, unfortunately, not responding to it, and leaving the patient to their own means. And that's when the patient goes out, finds somebody else and all heck breaks loose. It's really unfortunate. You get paid the big bucks so you need to pick up the phone and deal with the problem. You can't just hope that it goes away, or assign a staff member to deal with it.

We've talked about a lot here. What are some of the things on the horizon that are affecting the future of dentistry?

I just went on a tour of your facility, and the things I saw are fascinating. Talking with Dave Casper [Vice President of Sales & Business Development], some of the things that you're doing are absolutely amazing. Some of the biggest things on the horizon are what you're doing here at Glidewell with intraoral scanning. But more than that, it's patient management — and you guys figuring out that it's about one-fee. Patients look at everything, as with anything. If they're going to buy a couch, they're doing it online. And they don't want to have to chase answers. They want to know what the cost is going to be. So, in terms of patient convenience, what we're doing for patients is the same-day stuff. It's about managing one-fee. It's going to be the coming together of not only parts and pieces, but like we talked about — it's patient management. And you're going to need to help the doctors with that. You've already helped tremendously with your one-fee approach to getting a tooth. They're not just getting an implant. It's not the implant, it's not the prep; it's the restoration they're walking out with. That's what you guys want to do, and that's what patients want. So I think it's a coming together of these technologies: old traditional ways are going to meet hi-tech. Because, at the end of the day, it's about keeping our patients happy. How do we keep them happy? They want technology, and they don't want things to take too long. What an exciting time to be involved in dentistry!



INTERVIEWER

Bradley C. Bockhorst, DMD

» After receiving his dental degree from Washington University School of Dental Medicine, Dr. Bradley Bockhorst served as a Navy Dental Officer. Dr. Bockhorst is Director of Marketing, Restorative/Zfx for Zimmer Dental. He also maintains a private practice in Oceanside, Calif. A member of the CDA, ADA, AO, ICOI and the AAID, Dr. Bockhorst lectures internationally on an array of dental implant topics.