"Raising Specialty Issues Not Seen Elsewhere"

The Newsletter for Specialists in Prosthodontics

Institute of Medicine Future of Dental Education Report

Happy summer everybody! I've had a great response to the first issue of the ProsStars Newsletter. I am not doing it for the response, but I was very happy to receive all of your telephone calls and letters. It's especially gratifying to me to stay in close contact with you all!!

I'm sure some of you are wondering why someone would go to all of the work to write a letter to his friends? After all, don't we have television, telephone communication, E-mail, and faxes? Well, my upbringing and life style dictate what I do, and I know a letter has advantages for content, but probably not for speed.

The Wall Street Journal has been my daily newspaper for some ten years. I also follow national events from a perspective seen in the Washington Post, and I thoroughly go through the New York Times each Sunday. In the late 70's and early 80's, while living in Hawaii, I read the Sunday Los Angeles Times. Then also during most of my adult life, I was away from my parents who lived in Wyoming. I always wrote a weekly letter to them—my way of catching them up on our family's activities. I well remember that for a period of 30 months when we lived on Okinawa I spoke with my parents only once—and that was via a short-wave radio hookup that allowed only a one-way conversation. During the last two years I was at sea (on the Enterprise), I sent frequent tapes (reel-to-reel) to my mother and father. As a matter of fact, they retained them and I have them all. [The events of the 60's—Vietnam where we were, riots, the Martin Luther King and Bobby Kennedy assassinations, Lyndon Johnson's visit to the ship, and the Enterprise's disaster-at-sea are all held on those tapes.] I wrote almost daily letters home to California, even though it usually took two weeks to get a letter off of the ship and across the Pacific. Of course there was no way to make a telephone call routinely from the ship.

Therefore, I read and I write as I must, and hence my desire to communicate with you in writing—slow writing. Based on that premise I'm sure some of you are surprised that I don't print this whole thing out in script and ride a horse down to the post office to attempt getting it on the Pony Express. I might just try that!

Statistics—

I mailed the first ProsStars Newsletter to 71 addressees. Ten of those reside in foreign countries (one in Panama, three in the Republic of China/Taiwan, two in Korea, one in Canada, two in France, and one in Israel).

Management Prescriptions—

When I taught at the School of Dentistry, Georgetown University, the Associate Dean for Clinical Affairs was Dr. Carl M. Caplan (some of you remember him). Carl had an interesting background in that he was a pharmacist who later went to dental school and then went on to get an MBA degree. Since the closure of Georgetown's dental school, he has been in his own business management consultant firm that focuses on dental practices. He lives in Baltimore, Maryland. He recently made some excellent recommendations directed toward gaining financial control in practice (article in the January Today's FDA—Florida Dental Association). He recommends:

1. Purchase a computer that will provide a means of financial entry and other safeguards not possible with a manual system.
2. Separate the patient treatment record and the financial record.
3. Make sure all charges can only be entered "irreversibly" into a patient's account. Once entries are made they cannot be changed without using a security code that only the dentist/practice owner will have.
4. Make certain all patients ask for a receipt for proof of payment and number all receipts.
5. Ensure that all deposits are made at the end of each business day.

The management world today is rife with fads such as reengineering. Generally our dental practices are small in numbers of personnel and if we are involved in hospital or academic systems, the organizations are still relatively small compared to corporations. Still, we should be ever aware of new management adaptations. As practice management fads come and go in the literature and at continuing education events, practices, departments and schools should recognize and hold on to their core values.

A core value is something that does not arise from a competitive advantage.

> Example: The patient is held above all as the primary recipient of every action in the treatment system.

A core value is something that is held even if it becomes a competitive disadvantage.

> Example: If regulatory demands place burdens that unnecessarily stretch the personnel in the organization beyond their capacities, the emphasis should not be to the regulation (i.e., "paperwork," labels, management of materials, reports, etc.)—the emphasis should be directed to the core value (i.e., the care of the patient).

How do test a core value? If the world changed such that you were penalized for this tenant, would you continue to hold it? If yes, then it is probably part of your core ideology. Recognize it, write down, direct most energies and assets toward it, and change what you must, but don't discard or diminish the core value(s) of the practice.

[Adapted from James Collins--Built to Last, Successful Habits of Visionary Companies]

Reflections from the Academy of Prosthodontics Annual Meeting—
[Tucson AZ, May 19–24, 1995]

1. The two "Es"—Efficacy and effectiveness of oral implants

   The clinician spoke of the rationale for the use of oral implants and alluded to research that will help develop guidelines for their utilization. My comments—If any implants are elective procedures then the decisions to do them most certainly are ethical decisions. Another "E" for sure. How do we make and how are we trained to make these ethical decisions?

2. Another clinician spoke about the effect of cigarette smoking on bone quality and implant success. He suggested that based on his results (smoking negatively affects bone and bone healing) we might not accept some patients for treatment with implants due their smoking history. My comments:—A medical/ethical decision? YES, but the words were never mentioned. Can we "not select" patients for treatment based on their habits? Is this ethical? How do recognize these decisions for what they are? Are we trained to do so? What are actions and choices in such matters and how do we relate them to the patient—ethically?

The Future of Dental Education—

Fortunately or unfortunately the Institute of Medicine (IOM) recently released this report.

The problems as they saw them:

- Six dental schools have closed and others are vulnerable.
- Dental school enrollments have been cut back from the highs of the 70s and 80s.
- There may be too many dentists in practice and in training.
- Dental education represents high cost to students and universities.

An 18-member panel met from February 1993 to May 1994. It was made up of individuals from within and out of the profession. It visited eleven dental schools and contacted all parts of the education process in each school. Half of their funding came from the private sector and half from government sources.

Broadly they found:

- Dentists will use more medical knowledge in the future. They will need to work more closely with other health professionals.
- The student will need to be taught "desirable models" of clinical practice in dental school.
- Dental schools will have to prove their value to their parent universities and communities. They cannot be independent of or isolated from the missions and problems of their parent institutions.
- There is a need for reform in accreditation and licensing.

- There will be renewed focus on team and multidisciplinary health care and practice beyond the office setting.
- They could find no valid indicator of the correct balance between dental school enrollment, supply of dentists, and demand for dental services.
- They see "tensions" between the academic communities and the professional in practice.
- They see organized dentistry trying to stay away from "health care reform" in order to insulate the profession from demands for change and accountability.

My comments—

Don't get too excited about this. It will cause discussion among the Deans; it will do very little to directly change a university's policy toward its dental school/college; there will be no revolution in the way dentistry is practiced for years to come. The study is physician directed and carries the practice philosophy of the physician. If we are to take that as a basic premise—then know that medicine is in a continual search for self always falling further and further behind financially and in the ability to solve the basic problem they have. [Examples of health care reform failure: the Hilary Clinton health panel; the Congressional studies of US health care; the cyclic attempts of the US Navy Medical Department to reorganize and reconfigure q. four years in order to solve their problems.] As I see it, very simplistically the basic problem of dentistry is to prevent and treat dental disease. I think you do a phenomenal job of it. In addition we prosthodontists are called upon to enhance appearance and improve function. Again we do wonderfully well. Medical problems are the same except that they get into life threatening diseases and injuries. I think they do a very poor job of treating the commonplace and I think they do a great job of treating the extreme. I can say from experience that it will do dentistry no good to place itself within medicine—for planning, education, finance, facilities, organization or any other way. They can't solve their own problems and dentistry doesn't need to be shown that they can't solve ours either.

My very best and until next time—

Sincerely,

Noel Wilkie