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THE "HUMMER" OF TREATMENT PLANS
A $50,000 PLAN
EXTRAVAGANCE OR HEALTH CARE REQUIREMENT

What's important in treatment planning—the plan or the treatment? Of course, it's the treatment!

So did an actual planned treatment involving extensive prosthodontic care add up to $50,000? Astonishingly yes! Such a plan was seen and studied, and the plan did not include preprosthetic surgery, preliminary periodontal therapy or implant placement procedures. We're talking a treatment plan for prosthodontic restoration. To be honest, the treatment was planned by an individual with "some" training in prosthodontics, a graduate of Penn's perio/pros program.

The Planners

It's doubtful that there is any single training program that routinely teaches the development of $50,000 treatment plans. We know that that some of the highest level restorative practices are conducted by those who came out of the University of Pennsylvania's perio/pros program, a program that was stopped for some reason. We know too that the products of this program can't be boarded as prosthodontists, even if they so desire; and neither can they seek board status as periodontists. The few graduates of the program are alive and well, but they certainly don't have the muscle to be recognized as a separate specialty.

Does this preclude them or any other dentist from presenting a $50,000 treatment plan? Of course not! Specialty status doesn't create the right to offer a treatment plan or treatment. Any dentist, has every right to create treatment plans, even $50,000 treatment plans. After all, we all had courses in treatment planning didn't we? But should a general dentist without advanced training offer a treatment plan consisting mainly of prosthodontic specialty care? Probably not! A clear definition of what a prosthodontist can do and what a general dentist can't do is never seen. And further the scientific literature has never included statements related to the limits of the general practitioner or graduates of the perio/pros program for that matter. Certification from an advanced education program in prosthodontics does verify the skills and competencies of specialists in prosthodontics, and there is no question that Diplomate status is an added proven proof of the ability to plan and sequence treatment properly. Let's stress that!

The Plan and the Patient

Who would get a $50,000 plan? Could be anybody, but guessing, would it be a truck driver, a farmer, a school teacher, an office worker or a policewoman; or would it be a CEO, a Senator, a TV anchor person, or a high level lobbyist? Do we do what is needed, or is the treatment plan's dollar figure equated to the patient's social status, place of employment, display as an entertainer, size of bank account, or golf club membership?

As a baseline in this decision process, we know we can live fairly healthily without teeth. Board Walk Fries are easily "gummed." At the other extreme, a gnathological reconstruction covers most all teeth, fashions them into a model perfect appearance, and with luck and great amounts of skill forms a functioning occlusion in mandibular and maxillary teeth contacts.

The decisions related to who gets what and why are important decisions, occurring every practice day. Who gets one course of treatment and who gets another is where the experience and skills of advanced training comes in.

In the example $50,000 plan a final treatment procedure was itemized as an "occlusal adjustment" at $1,800. Best training would say that the occlusion and its function should be an integral part of the formed crowns. Best training would say that the occlusal surfaces of the crowns should be planned to function correctly (physiologically). If an occlusal adjustment is necessary (and it most commonly is) there should be an obligation to bring the occlusion into correct function, without extra fee. The opposite, of course, would be to carry out an entire reconstruction with the endpoint being a non-functioning occlusion. Then the $1,800 fee could be eliminated. What a joke! But be assured that in most specialty practices the patient can expect a functioning occlusion in their restorations, with no extra fee to make it so.

Finally, it may make a difference to the patient where the dentist who develops the plan is practicing. The dental school faculty practice, the insurance company office, or the VA hospital each may make treatment choices which are different than those made in a Washington DC, a Newport Beach or midtown Manhattan office. Does the patient understand this and if not, why not? This has to be a consideration.

The Plan and Success

The science of dentistry and its specialty, prosthodontics, really has progressed so far that most all treatments can be done with reasonable expectations of success.

Success in treatment is no longer a gamble, it's there! In addition, successful practitioners carry out only those procedures that can be accomplished successfully. Some practitioners want to be sure the patient sees or hears about their successes with pictures of celebrities on the wall, names of important patients being dropped and seat locations at tennis opens and various pro sport stadiums being obvious, as measures of their expertise. Certainly, nothing should stop any dentist from achieving success, and nothing should stop them from displaying examples of their successes in any way he or she desires.

A scenario of success in dentistry is this: The fee will usually be based on itemized procedures (not time expended for treatment), the location of the office, the office's overhead, the social and life style the provider wishes to achieve and finally, the image the provider wishes to project to the public and to his or her peers. The gauging of success or failure is built in. The provider will do only what is successful and proven, and the patient will hear a history of success based on other patients who have gone through similar treatments with the same provider. The patient then accepts or rejects the proposal and the provider accepts those patients who agree to the fee. This scenario is common. There is probably nothing illegal about it, and if it's understood by all concerned, one could say it's fair, ethical considerations aside.

Following those decisions, as the treatment is started, we really "hope" for success, especially when facing the failures of previous dental treatment. In dentistry we do not see or rely on reports of morbidity and mortality. But as prosthodontists we see failure after failure in treatment and surmise that we can do better. With specialty training, we are assured that we will do better because our experience tells us that what we do is a workable treatment; a treatment based on each restoration we have faith in and the evidence of success in the materials we use. It works! Has success in treatment by prosthodontists compared to treatment by general dentists or perio/pros trained dentists ever been measured? No — but there is a crying need to verify our successes statistically measured against treatments by others in dentistry.

Evidence-Based Treatment A Measure of Success?

Does evidence-based research guarantee success in total treatment, or does it measure successes of singular episodes in treatment? A practicing prosthodontist may throw away a basket full of individual treatments which were verified to be successful by evidence-based research, but which in the aggregate of treatment, failed. This is not a declaration that evidence-based research is flawed. Rather it causes us to think about the amount of evidence basing required to insure long lasting success in treatment of the entire stomatognathic system. The total function of this system is a very complicated package.

Medical Successes

Deans, government planners and allied scientists want to associate us closely with medicine. [See Letters, page 1.] But if we are allied, how are we allied? Well for sure, we treat the same human patient. But success in medicine becomes a much different set of circumstances than success in treatment in dentistry.

The patient's profile of health, proclivity for infection, immune system responses, age, and physical makeup all have little to do with success in dentistry. Especially they have little to do with success in prosthodontic treatment if the tissue base has been successfully treated and readied for prostheses, no matter what we decide each prosthesis will be.

In medicine, the patient arrives with a disease process or a traumatic injury that needs prompt attention, and all aspects of the medical system are put into play to eliminate the problem. With the possible exception of plastic surgery, there is usually little choice in the regimen of treatment in medicine. Depending on the degree of the problem, the patient may have a choice in treatment facility, but once there, the patient may not have a choice in the treatment their chosen facility carries out. Even up to the point of death, the patient in medicine loses most flexibility in their treatment choices. The medical system will take the patient where it thinks the patient should go, and the cost be damned!

The $50,000 Treatment Plan and the Ethical Dilemma It Causes

Is a $50,000 treatment plan just another everyday "business deal", or does a closer look identify a plan with ethical problems having consequences to both the patient and to the provider?

Every treatment we carry out falls under the umbrella of established ethical guidelines. These guidelines should govern what is "right and good"; right and good for the patient. The patient should hear how diseased tissues will be brought to normal function. The patient should hear how unidentified systemic problems can influence oral tissues, and how these problems will be recognized and eliminated. The patient should hear just how some tissues will be restored and some replaced. They should know that through an informed decision process they will be allowed to make their own choices in treatment; treatment they have chosen because it is a necessity in health care.

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A $50,000 treatment plan especially demands a careful scrutiny for treatments and patient managements which are not ethical. A major ethical consideration will be the elimination of any attitude which lets only the patient worry about the costs!

Thinking About Ethics

The demands on our practices may make us lose sight of what is necessary in a treatment plan and what is superfluous. In the busyness of our days, what is a health care requirement and what is an extravagance might just become vague abstractions.

When considering bioethics it becomes more clear every practice day that improvements in appearance, from esthetic and cosmetic standpoints, enter into most treatment plans. Some patients seek out such "stylizing treatments" only for the stylizing. Some patients learn about them in conjunction with their treatment that will restore lost tissues, and they ask that stylizing treatments be included. And some patients unknowingly have cosmetic procedures included in a broad-based treatment plan, understanding and thinking that the appearance factors are requirements in their need for a return to oral health.

Today's technologies make most things possible in appearance "improvements" (not necessary appearance inclusions to necessary treatment). The costs associated with these technologies are considerable. We ask then, are these improvements through new technologies always necessary in our treatments? And if so, how do we justify them?

We are frequently crossing the line from restorers of lost tissues to improvers of appearance. We go back and forth across the line from being prosthodontists to being cosmetologists. Finding which side of that line to be on becomes the ethical dilemma for both the prosthodontist and the patient, but especially so for the patient. Why?

- There is no formal review process on the plan of treatment, unless there are insurance payment considerations.

- There is no actuarial table to insure that the plan fits a similar course of treatment directed to similar problems.

- And the patient has no informed ethicist who might review an extensive treatment plan for procedures the patient doesn't need or want.

The ethical problem may be solved if the prosthodontist is competent, is honest, respects flow to and from referring dentists, avoids patient exploitation by putting the practice's private gain into a secondary role, maintains patient confidentiality; and most important, insures that the patient can easily identify the health treatment, which has some costs and the "stylization", which will have additional costs.

The Message

The message is: extravagances of treatment are not necessary in prosthodontics!

We put people back together again. We take bad dentistry out and put evidence based treatment in. The results of our carefully planned treatments are proven. Let's not carry our talents too far.

Would the creator of a $50,000 treatment plan submit it without fear to an assessment team of trained prosthodontists; the creator being a general dentist, a perio/pros trained dentist or a even a prosthodontist? Trained prosthodontists, have no fear!

We have every right to practice where we wish and how we wish as long as we stay within the bounds of "good ethics." Because our training, skills, experience and competence is verified by the specialty board process, we have every right to expect a greater return for carrying out procedures that are distinctively different from those of other dentists, including perio/pros trained dentists. Remember:

The specialist in prosthodontics does not do the same treatments that the general dentist does.

For each dollar spent, the patient will receive a uniquely different diagnosis, treatment plan and achievement of outcome. The results will be an unnoticeable, pleasing natural appearance, a function that is totally physiologic, and a measurable diminution of future breakdown, unless caused by disease or gross patient neglect. Specialists in prosthodontics have added these values for every dollar spent.

Additionally, the specialist in prosthodontics will meet the needs of patients with missing tissues that cannot be restored further by surgery with prostheses using techniques and materials not seen in any other branch of dentistry or medicine. No one else is trained or has the skills to do the same treatments, or to achieve equal results.

When the specialist in prosthodontics is not consulted or given the opportunity to meet these special needs, the public at large suffers. ■ NDW