Hippocrates Revisited

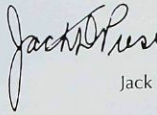
Having been in this profession for over four decades and in prosthodontics for three, I have seen many changes, much progress, and have always felt excitement about the future of our specialty. Technologically, that future is even more exhilarating today. The increasing knowledge of genetics and pathogenesis is bringing new understanding of why oral diseases arise, and how they may be more effectively treated and prevented. Many innovative approaches are evolving and will mandate new attitudes toward diagnosis and treatment planning. I believe that the advent of electronic adjuncts can make patient care more efficient, more effective, and more scientifically sound. To make effective use of them requires us to rethink the entire process of dental care, and to divest ourselves of archaic, rotely learned and applied concepts. The number of benefits that accrue with electronic implementations seem to be limitless. Progress is exciting and makes life challenging and interesting. However, it comes at a price. I read in the numerous journals to which I subscribe that the cost of this technology will be increasingly onerous. It is estimated by some that health care will consume well over 10% of the gross national product by the end of this century.

At the same time that practitioners try to plan for absorbing the costs of technology and improving their practices, there is a more depressing movement toward care that is dictated by cost reduction rather than disease control. In health maintenance organizations the practitioner profits by keeping patients healthy. This is, on the surface, a win-win proposition. How could anyone criticize a program that pays the dental health care practitioner for keeping patients healthy and preventing disease? Such a program uses statistics to assess disease rates within a population and assumes a certain level of disease activity. If a skilled practitioner (or a lucky one) can maintain the population for which responsibility has been assigned at a lower disease activity rate, then the reward is increased. The same amount of money is coming in, and less is expended in therapy. However, when the reverse is true, there is less profit, and something has to give. That "something" may be the quality of patient care. If, for example, incipient periodontal disease is not treated and is allowed to progress, it will be more costly to treat—therefore the practitioner is motivated to provide care that will prevent it from progressing. Such care requires minimal resources and can largely be delegated. However, if moderate to advanced periodontal disease is detected and treated, it will consume a considerable amount of the practitioner's resources (time) and with a little "skillful neglect," that patient can be allowed to progress to tooth loss, which is accomplished with a minimum of resources. It is no longer a win-win situation. The patient is the clear loser.

The advocates of such a care structure emphasize that it will be essential for the practitioner to be able to make more productive use of time, and to delegate and supervise care. In other words, work harder and increase your overhead by increasing your staff. It is of substantial concern to this only-peripherally-involved-practitioner that while the concerned care-giver is working harder trying to provide competent oral health care for the same or less remuneration, there are now additional tiers appearing in the profit structure. Not only are the administrators of the health maintenance organization profiting handsomely, they are even making money for their stockholders. Now, maybe I missed something somewhere, but if the individual who committed a substantial portion of a lifetime to a professional education and continued learning is having to divide the proceeds with a group of people who have no treatment skills, and at the same time is being told what can and cannot be done within the confines of the agreement, then it appears that what we now have is regress—not progress. This is especially true in prosthodontics, where the practitioner has the highest overhead intrinsically and must perform a service that is technically demanding. There is little room for compromise in our specialty.

It appears that our profession is expected to assume additional financial encumbrance to bring to our patient the most modern care with all the advancements science is making available, and to do so with fewer resources and options. Over all this looms the specter of diminishing quality to compensate for increasing quantity. The Hippocratic oath states that "I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone." Are we now to rewrite this to "I will prescribe those therapies that I am allowed to use within my agreement with my HMO and according to the judgment of the chief financial officer of that organization, and I shall hope that the harm that results is not detected by my patient's counsel"?

Such a degradation in the quality of care is not inevitable, but there is a need to be vigilant. If we are to take advantage of technological advancements, we must preserve the matrix in which those applications can be most effective. Prosthodontists probably have more to gain, or more to lose, by the two conflicting scenarios I have constructed. The future belongs to those who assess the options, plan their course, and devote the needed energies to achieve their goals.



Jack D. Preston, DDS
Editor-in-Chief