Bad Fruit From an Ill Wind

It is said that it is an ill wind that blows no one some good. There is certainly such a wind blowing in the dental community now. It appears from my conversations with prosthodontists internationally that we share the rigors of a struggling economy, with diminished capital to support the more demanding health needs of the worlds' population. In the private practice of dentistry, when there are diminished resources, those practitioners reliant upon the free-market economy feel the impact directly. Patients postpone optional and needed treatment. They may make shorter-term treatment decisions feeling that they can reevaluate their needs in future, more prosperous times. Dentists whose income relies primarily on third-party reimbursement, whether insurance based or government sponsored, find that approvals for procedures are more parsimonious and patients' choices for therapy are more restricted.

When the volume or quality of treatment rendered is thus compromised, the consequence is manifest in the monthly balance sheet. Much has been written about the "busyness problem" and some of the purported solutions border on the unethical or, at least, on the ill advised. Dentists are encouraged to suggest various therapies or regimens to patients, intercepting problems of dubious consequence. In general, such attempts to increase busyness use methods and procedures that are not in the best interest of the patient or the profession. Most ethical dentists recognize such procedures as being outside their sphere of interest and their patients' well-being.

To meet their economic obligations some dentists may begin providing therapy that they previously referred to those properly trained to render such care. As a result, practitioners who lack the necessary skill or training begin assuming the burden of care for patients whose needs are beyond their ability to treat. Often they cannot continue to provide an acceptable level of care. Thus, practitioners who could comfortably place a good crown or onlay may find themselves addressing complex complete-mouth restorations often further complicated by advanced periodontal destruction. Others may begin placing and/or restoring dental implants with little, if any, understanding of the essential biologic concepts or technical comprehension. They recognize too late that the needed therapy is beyond their abilities, if they recognize the problem at all. The expansion of one's scope of care without first acquiring an adequate basis can only lead to failure, patient dissatisfaction, and the eventual demand for compensation or litigation. The end result is worse than the initial condition, for both the patient and the dentist.

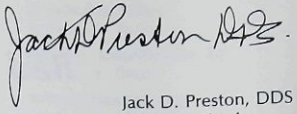
I have heard murmurs of anticipation rising from the prosthodontic community contemplating the windfall that would come to the prosthodontist and other specialists from whom patients will be forced to seek remedial care following these therapeutic mis-adventures. In all likelihood, there will eventually be such an increase in the number of patients requiring corrective therapy. This would appear to be the logical consequence of the economically motivated overextension of treatment beyond abilities, even when such acts are well intentioned.

Another radical problem will become evident. The proliferation of third-party health care providers has caused many patients to base their acceptance of treatment recommendations on what their provider will underwrite, rather than assuming primary, personal responsibility. When patients abrogate their obligation and allow an uninvolved party to limit treatment decisions, they sacrifice autonomy and accountability. No one buys automobiles or clothing or even plans vacations expecting someone else to assume the primary obligation. Such decisions are not based on an insurance-policy limit or governmental largess. Patients must assign higher priority to preventive and quality dental care. This is especially true in prosthodontics. Until the profession of dentistry is able to educate the public about the proper motivation for quality dental therapy we shall only attack the apparent problem, not its roots. Dental schools must increase their efforts to teach communication skills and produce students that are committed to providing patients with good information as well as good dentistry.

There is no doubt that health care, including dental health care, will continue to be strongly influenced by third-party support, but the profession must mount a coordinated effort not only to provide optimum care, but also to teach the general public, those who benefit most, that the use of discretionary income for health care is not a frivolous expenditure. Many patients understand that such a commitment is a basic investment in personal well-being and appearance. Yet when the availability of discretionary income declines, priorities may be reassigned and care may be postponed.

Until both sides of this two-tailed enigma are resolved the problem will continue. Dentists must adhere to the established guidelines for optimum care without extending into areas of therapy best referred to more qualified individuals. The public must be educated and encouraged to seek and underwrite such care, even when the expense must be borne personally.

There will undoubtedly be some monetary fruit falling from trees blown by the winds of economic constraint. But that fruit is bitter, and the initial thrill of finding it will be replaced by the later realization that the source is misrepresented and the benefits are limited. It is an ill wind, because regardless of the illusion, no one really profits. The economy merely highlights the real problem and, as usual, it is the patient that ultimately pays the greater price—both biologically and economically.



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