The Importance of the Generalist-Specialist Relationship in the New Economy

by Jay B. Reznick, DMD, MD

Times have changed since I went to dental school. Back then, dental education was about preparing the student to graduate and go out into the world and practice general dentistry. We had exposure to the dental specialties, such as endodontics, orthodontics, periodontics and oral surgery. But our didactic instruction and clinical experience was limited to the very basics and to simple cases that could be done easily by the average general dentist once in practice. For oral surgery, it involved a one-week rotation in the junior and senior years in the school clinic, plus an additional week rotation at a state veterans' facility and a public hospital. The cases the students managed were basically periodontally involved teeth with mostly intact crowns. Anything more complicated, such as surgical extractions, impacted teeth and soft-tissue procedures, other than a simple biopsy, was a case for the oral surgery residents. Dental implants were relatively new on the scene. Dr. Branemark had just introduced the concepts of osseointegration and modern implantology to the world. Not even the residents were doing implants then. Only the faculty was allowed to place implants, and only after completing an official certification course.

Much has changed in dentistry since then. In many of the specialties, new instruments and materials have been developed to help make challenging procedures much easier, safer and more predictable. Most of these were introduced for use by specialists, but over time, many of these new endodontic shaping and filling systems, orthodontic brackets, wires and appliances, surgical instruments and dental implant systems have made their way into general dental offices. Most of these were used in offices of general practitioners whose practices were in more rural and remote areas, as every city, large and small, had more than its share of specialists who were available to treat the more complicated cases and patients. In the 90s and early 2000s, there was no financial pressure for general dentists to perform specialty procedures, since the economy was doing well and everyone was busy doing cosmetic and other lucrative elective cases. Why would anyone want to start doing impacted wisdom teeth, implant surgery, molar root canals, periodontal surgery, orthodontic therapy and similar treatment when those procedures could be difficult and complicated, even in the hands of experienced specialists? Who needed the headaches, especially when one could make more money doing more familiar, less stressful dentistry?

The relationships back then between general practitioners and specialists were very strong. Every GP had two or three colleagues in every specialty to whom they referred their patients for braces, root canals, oral surgery, dental implants and periodontal procedures. Every specialist, in turn, had a list of dozens of “A” and “B” referrals, as well as a hundred or more “C” referrals who kept their schedules busy. Lavish holiday gifts, ski trips and dinners were commonplace for busy specialists to thank the general dentists who kept the patients and cash flowing. About 2007, things started to change and we started hearing about a recession on the horizon, but few of us paid any attention to it. I remember at the 2008 Townie Meeting hearing the first reports of practices slowing down. But for most of us, things were still great. Then, in September 2008, the stock market crashed and Alan Greenspan officially declared the U.S. economy was in a recession. That was when most of us started seeing a change in our practices, no matter where we practiced.

Dental manufacturers saw decreased demand for many of their products and really started promoting more orthodontic, endodontic, periodontic, surgical and dental implant procedures to the general practitioner in an effort to maintain sales. This started a revolution in dentistry, in which many general dentists enrolled in

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continuing education courses in order to increase the scope of their practices. Overall, this was a good thing since this increased access to advanced dental treatment for many patients who were unwilling or unable to travel to see a specialist.

However, in the last year or so, we have seen a major change due to significant economic shifts. Patients are routinely delaying or deferring necessary dental and medical care because of job loss, loss of investments and fear of what might lie ahead. There are very few dental practices that have not been affected by the current economy. Fewer patients are calling for appointments, and even very successful practices are having trouble filling their chairs. With fewer patients coming in for restorative dental procedures, many practices are trying to fill those gaps by keeping procedures in-house that they would have ordinarily referred. Some practices are doing this by hiring recent specialty graduates to work in their offices a couple times per month, and others are simply tackling cases that they previously would not have bothered to do. As a result, referrals to dental specialists have dramatically declined, and many specialty practices are struggling to survive, especially in more urban settings.

For the record, I have no problem with general dentists doing specialty procedures in their practices. In fact, one of the things I have done, and still do in my career, is educate GPs in oral surgery and implantology. What I have become increasingly concerned about is GPs getting in over their heads and getting their patients and themselves into trouble. I get worried when I see threads on Dentsaltown asking very basic questions about how to do a surgical procedure. The bottom line is, as much as we all need to make a living, we are also in a healing profession and always need to do what is best for our patients, even if it is not what is best for our bottom line.

I have been teaching this message for many years in my continuing education courses on Dentsaltown, OnlineOralSurgery and at the Scottsdale Center for Dentistry. If you would like to incorporate oral surgery and implant procedures in your practices, take the time to educate yourself in the proper way to do so. There are plenty of educational opportunities out there. Learn the right way to do surgery, how to avoid complications, how to manage complications and how to recognize the limits of your own comfort zone. Just because you have the time open in your chair does not mean that you should treat every patient. Everything you do in your practice should help to build your practice. Subjecting a patient to undergo a surgical procedure that is difficult, uncomfortable and prolonged will do just the opposite. There are procedures in oral and maxillofacial surgery that I refer to my colleagues because I do not do them often enough to be comfortable doing them. Can I do them? Yes. Can I fit them in my schedule? Yes. But, I elect to do what is best for the patient. I was told in residency that they could teach a monkey to do surgery, but what makes a surgeon is the ability to know when not to operate. We were also taught we should never do a procedure for which we could not anticipate and handle all of the possible complications. This comes from education and experience. If you choose to refer fewer patients to your specialists and treat them in your own practices, please make the investment in yourself to become more proficient at those procedures first. We all know how little specialty training we actually got in dental school and that most of what we see in practice is more complicated than what we did in school.

One of the benefits of continuing education in the dental specialties is the ability to recognize the limits of your training. No matter how many root canal, impaction, grafting and implant procedures you do, there will always be some that are best managed by a specialist who has many more years of training and experience. That is why it is important, even in these changing economic times, to maintain a good relationship with a core of dental specialists to whom you can refer, ask for advice and get help. Most of us understand the pressures GPs are under and are very willing to help out in a sticky situation. However, that willingness might waver if all specialists get from some are your complications. We need you. And, you need us. You do not need to treat every patient by yourself who comes in to your practice, even if times are slow. Learn to recognize which cases are within your comfort zone and which ones are beyond your expertise. Maybe, even take your specialists to lunch and talk to them about what is going on in your practice. We are all in this together and will make it through by working with each other. Try to always follow the principle of “do no harm” and refer your patients where appropriate. Your patients will be happier, and you will sleep better at night.