Looking for an Honest Answer to a Perio Question

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Randy Nolf
Post: 1 of 21
Posted: 11/6/2003
Total Posts: 820

I really don’t intend to stir up emotion with this... but what the heck. I’ve been trying to figure out, for the last 20 years, why so many GPs [general practitioner] won’t refer to a periodontist. It’s a typical day for me to see a patient who self-refers or is a long-time patient in a general office and is referred after changing dentists. These patients are often interested patients who follow through on treatment. I lecture to hygienists occasionally. Invariably, I’ll be asked how they [hygienists] can get the boss to refer the cases that need specialty care. They tell of how the only treatment offered is three-month recalls or possibly scaling... sometimes with local. The hygienists are uncomfortable with the “let’s watch it” approach, but have to defer to the doc. It has become such a prevalent problem and I’m seeing more and more advanced cases. Now, we’re talking extractions, perio heroics and implants. I’m seeing far fewer cases of early-to-moderate perio. If it was only the patients telling me they were never informed of the need for specialty care, I’d write it off as bad communication. With so many hygienists complaining that they are not allowed to suggest a referral; being told “we’ll watch it, put the patient on three-month cleanings,” it just makes me wonder. I have done the self examination to see if it’s my fault. As far as I can tell, it’s not specifically me. If the hygienist suggests a referral, the GP agrees, sends the case and the patient doesn’t follow up... so what? Everybody did their job and the patient chose not to take the advice. What do you think? Please refrain from name calling wherever possible. ■ Randy Nolf, Periodontist

jsfdds
Post: 2 of 21
Posted: 11/6/2003
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I do not see as much perio as the literature leads us to believe exists. I do practice in an affluent area, as many periodontists also do. I have two hygienists who do full-mouth probing and charting once a year on non-perio classified patients. Some localized 5-6mm pockets heal well with localized scaling and root planing. If not, off to the periodontist. Not as many advanced perio cases as I would like either. Many times these patients end up at the oral surgeons (don’t know how they get them) and come out with implants. I gladly restore these cases. ■ John

FrankNelsonDDS
Post: 3 of 21
Posted: 11/6/2003
Total Posts: 6,045

Ah, John. You accidentally hit the nail on the head with your comments. Come visit me for a week in Bullhead City, Arizona; a 50,000 people area on the border of Arizona and Nevada with Nevada gaming across the river in Laughlin, 90 miles SE of Las Vegas. Transient community without much roots (I moved here in 1967 and went from fifth grade through high school and am truly a native). Lots of 24-hour lifestyles, lower socio-economic place, lower education. Average income, moderate-to-low. Moderate-to-low income retirees that are typically WWII vets who enlisted and never went to college. Honestly, if I see a patient older than 30 with only a few 5-6 mm pockets in the posterior, it is noteworthy as a healthy patient. See someone with
nothing more than 3mm? Maybe 15% of my practice. Now, to the thread topic. We have two periodontists in town. Both pretty good, up to date. Both do surgery immediately, use up all the insurance and don’t communicate well with us. I don’t feel that they appreciate the people for who they are. Often, when I send patients to them, the patients are mad at me for doing it! Of course, there are those who appreciate it, but the majority don’t and it makes it easier to give up. Just some thoughts.

I do not refer to periodontists because I have trained myself to perform almost all of the procedures that are routinely done by them. There is no mystery to bone grafting and soft tissue grafting. The bone grafting has become increasingly easier with the advent of Emdogain and resorbable membranes like ATRISORB. Soft tissue grafting is another story requiring significantly more skill. It is a learnable skill. Check out the results that this generalist has achieved with CT [connective tissue] grafts in the case presentation section. If all I did on a day-to-day basis was restorative I would have burned out years ago. As far as the insurance is concerned it should not be an issue. If your dentistry is comprehensive in nature, then the insurance becomes little more than a rebate. If you don’t do the perio and do the restorative, you are guilty of the number-one reason malpractice claims are filed. So, quit letting insurance dictate what you will or won’t do, and do the right thing!

Honestly, here is not where you find the answer to a question like this because those who run in this realm are striving for answers and excellence. Always learning and striving to do better. The type of docs you speak of probably don’t even know what Dentaltown is. Those docs and hygienists who are the burned out, don’t care anymore, uninformed, “I-just-want-to-make-a-paycheck” sort... who care about the money, but don’t care about the patient sorts. They are the types of peers who are out of touch with current trends for perio management. I know that I have updated two docs myself. Me, a nothing peon about things like Arestin or meds with perio management. I carry around my course information from my CEs [continuing education] with Bhaskar and Connie Drisko. I show them the information and poof, they start doing some things that they weren’t before. I have enlightened-to-date, in my travels as a temp, more than 20+ offices about what Dentaltown is and why they should use it. Why should I have to do that? They should want to learn and stay up to date. It only makes sense that the cases that periodontists are seeing are more advanced these days because of the increase in the variety of technology... and the effectiveness of technology with non-surgical periodontal therapy. There are many offices with skilled docs and staff who have developed amazing in-house perio programs that can be successful in managing perio in the 5-7mm range.

I practice in rural Idaho and see all types of perio. I try to refer the more advanced cases to periodontists, but the ones that I have referred have just refused to go. They don’t like surgery, they don’t like the cost and they don’t like having to travel 30 minutes to Utah to a great periodontist. Honestly, it is beyond me! We talk about pockets, periodontal disease, losing teeth, replacing them with more expensive things, etc. and many just refuse to do it. I can’t say that this phenomenon is strictly limited to the lower socio-economic stratus of our area because this same attitude is demon-
Their priorities are not where you would like them to be. It is not wrong, it just is the way it is. Your job as a health care professional is to educate your community and make keeping their teeth a priority. A certain amount of fear must be imparted. If keeping their teeth is not important to them, perhaps living longer is. Talk about the increased prevalence of stroke, diabetes, etc. Talk about living six years longer. You can appeal to their fear of infection or perhaps influence the town leaders by appealing to their desire to be superior in some way. The way could be by keeping their teeth!

In my early dental life, I was heavily influenced by Harold Eissman, a periodontist-prosthodontist in Reno, Nevada. There was never any doubt that periodontics is the very core and foundation of all dental treatment, and without excellent periodontal health, there is no excellent restorative care. The reverse is also true. When I’m “in there,” I like to be in control. The captain of the ship. The only time that I’ve worked regularly with a gum gardener was when he was in my office. Then, I could coordinate preps, temps, occlusion, gingival contours, implant placement, etc. I think the problem with perio is that those who don’t care about it don’t refer, and those that do care about it find that soft tissue management is so critical to their patient outcomes that they (by necessity) get good at it. Most of the general practitioners I know of fall squarely into one of these two categories. Technology and educational opportunities are moving general practices into many areas formerly reserved for specialists. That trend will likely accelerate over time and not reverse itself. Endo, surgery, implants and orthodontics are all becoming mainstream technologies. So, I’m not being flip when I say, if you want to be partners, why not be partners? A group practice (even with multiple facilities) could be owned by and directed by a periodontist, and then you diagnose and refer the patient to the restorative dentists as you see fit. Or better yet, just close your office and work with the guys you like in their places. Sure makes treatment planning a snap when you are right there to do things together!

[Apollonia wrote: “A group practice (even with multiple facilities) could be owned by and directed by a periodontist…”]

Hi Neil, I love that idea. I’ve thought about it for years. I was a pretty good restorative dentist in my day and I still do the occasional bridge, crown and implant restoration to keep current. I know I could provide restorative care, as well as 90% of the work I see. Ten percent of the dentists have made good use of their experience and have perfected their craft. It’s the difference between having 10 years of experience or having one year’s experience 10 times. What’s stopping me? I know the model to deliver perio and implant care, but I’m 20

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years out of touch with the GP model. Also, amalgams and tooth-colored restorations are a barrier, I haven’t cut an operative prep since 1981. I still like the idea. I believe a practice centered on risk assessed, targeted treatment and disease management, using the PreViser risk calculators would be a significant practice distinction and marketing advantage. If advertised, it would attract a patient population that does not want to continue in a repair model of care, continuing the cycle of breakdown and restoration (I believe this will be the next revolution in dentistry). Health preserved is superior to health restored; all treatment should be done to eliminate the need for future treatment. I’m about to open a new office in a larger urban market. It will come with all the same frustrations I have now, but I was hoping to find more “partner” dentists within the larger community. Possibly this is my opportunity to re-invent my business model. Thanks Neil.

[Posted: 11/9/2003]

What I’m having trouble with is the blatant non-referral or uninformed patient who really would follow through on care. When the hygienists are complaining that they are stopped from suggesting specialty care as an option to instead “watch it” with three-month recalls, it’s different than what you’re suggesting. I’m really not about making this thread a whine session for ineffective perio disease management. As I was pondering the subject from my limited vantage point I thought I’d ask the Townies for comment. I still don’t understand it. I will say this, I have several very good referring practices with very different models of care. One is an office that never met an insurance program it didn’t sign on to. Overwhelmed with patients, doesn’t have time to deal with perio and has a “my-way-or-the-highway” attitude. Great referrer. Another referring doc worked as a hygienist in several perio practices before dental school. Probably the most knowledgeable of all the GPs in the area on perio and best trained to do the majority of the perio in that practice. She does not mess around until it’s a difficult case before referring. She told me recently she sends the cases because she knows the outcomes are better when we treat as a team. Another office is a low-volume comprehensive office that does very well-planned treatment. They treat perio, but take the time to fully inform and refer cases when they feel it’s beyond their scope. I’ll say this and then leave this topic alone: I believe the mechanics of perio treatment (especially non-surgical) are no mystery. The difference is in the assessment of the outcomes. ■ Randy Nolf, Periodontist

Corey Young
Post: 17 of 21
Posted: 11/9/2003
Total Posts: 2,559

Randy, very thoughtful posts. I think you might really be able to make a difference. Just some more thoughts: I really see this as a lack of communication issue (or even bad communication) on the macro scale. As a general practitioner, I’ve heard the equivalent of “I know Jim Bob down the street had some of that gum surgery and he lost his teeth anyway,” or, “My sister went to Dr. Ripeveryoneoff and he made her come back four times just for a cleaning,” more times than I can count. I’m sure you have also. The difference to me is, with you, they either take it or leave it. Not really much for you to do if they don’t except treatment. For a GP it may mean losing an otherwise good patient (and all the other treatment you can do on them) because you’re pressing too hard. Is this good that decisions regarding treatment might come down to this? Absolutely not. You gave three examples of dentists that don’t fall into the trap in your mind (even bad communication) on the macro scale. As a general practitioner, I’ve heard the equivalent of “I know Jim Bob down the street had some of that gum surgery and he lost his teeth anyway,” or, “My sister went to Dr. Ripeveryoneoff and he made her come back four times just for a cleaning,” more times than I can count. I’m sure you have also. The difference to me is, with you, they either take it or leave it. Not really much for you to do if they don’t except treatment. For a GP it may mean losing an otherwise good patient (and all the other treatment you can do on them) because you’re pressing too hard. Is this good that decisions regarding treatment might come down to this? Absolutely not. You gave three examples of dentists that don’t fall into the trap in your mind and I can see why. The first person runs a high-volume practice. If a patient leaves because he or she doesn’t want to do perio treatment, the dentist probably has three more patients waiting to replace that person. Thus, they can afford a “my-way-or-the-highway-approach.” The second person has
an extensive perio background and is probably superior in selling perio because of this. The third person runs, what I like to call, a “Cadillac practice” and somebody who won’t accept perio treatment probably doesn’t belong in this practice in the first place. Unfortunately, a lot of practices don’t fit into any of these groups and tend to be more of a low-to-medium volume with medium fees and a Chevy-to-Pontiac product (not that this is good either, but that’s another discussion). To this group, every patient is precious (especially in this economy), they tend to have to work with insurance benefits, and don’t have an abundance of patients really interested in comprehensive care. There within lies the problem, IMHO [in my honest/humble opinion]. What are the solutions? Besides, as Howard Farran says, picking a market segmentation and sticking to it, is a major educational (read: marketing) campaign to have the patients already knowledgeable (read: pre-sold) on the importance of perio before they even hit the door. If we accomplish this, everything else will take care of itself. Maybe I’m in left field on this, wouldn’t be the first time.

I think you need to talk to the hygienists. I have never felt that I cannot refer to a periodontist. If that is the appropriate treatment, then that is what needs to be done. And, if the hygienists cannot stand up to their doctor, then they are not good hygienists.

Twenty years ago, I started referring my perio patients to a local periodontist who had just moved to town. My main incentive was that I was tired of doing perio surgery and having patients complain of the postoperative discomfort. So, I decided to let him hurt my patients and not me. He could also be responsible for the failures that were inevitable. Over the years, I have gotten very outdone by my periodontist. I would send him patients, and I would never see them on a recall basis, even years after surgery. When my office kept complaining to his office, I would get a note that the patient desired to have all of their cleanings done at his office. That really made me feel unappreciated. I also discovered that the periodontist did things that I had not told him to do. I would send a patient for a perio problem in a certain area, and he would end up doing something else. If

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he had consulted me on this, I would not have minded, but he didn’t. He took it upon himself to pull some teeth on a patient that I sent him for a perio consult, and I ended up losing that patient. Recently, I had a patient who had the root part of an implant placed years ago, but never had the top part or a crown placed. I sent him to the periodontist to see if he could get a part for the top part of the implant. He did this and the patient came back for a cleaning last week. He wanted to get a crown before the end of the year, but I was booked up the whole month of December. So my secretary told him on a Monday that we would call him in the next few days and get him in. When we called on Tuesday, a day later, he told my secretary that he called the periodontist who agreed to place a crown on his implant. I later confirmed what my secretary said in a conversation with the patient. To say the least, this infuriated me! He sure won’t get any type of referrals from me again, and he probably wondered earlier this year why I purchased a PerioLase to treat my patients with. So, my experience has not been so good.

I am going to give you my take on why GPs do refer and don’t refer to periodontists. My position on dentistry as a periodontist is that in order to do great perio, I need great restorative. I need great cores, great provisional and obviously great margins. Those who know me know I don’t care about perio. I care only about perio-restorative. No restorative commitment, no perio. I am not interested in eliminating pockets if...
there is crappy dentistry on top of them. I am the ultimate team player because without the restorative dentist, I am nothing. My referrals know that when they refer me a patient I am going to do my darnedest to get the patient to do a total comprehensive program. NO restorative, NO perio. They also know that when I do surgery it is with their needs in mind. No black triangles, tissue ideal for impressions, easily prepped margins and a slam-dunk crown at the time of cementation. They know they will get plenty of connective tissue and full papillas for proper contoured crowns. I have spent my whole dental career learning about restorative so that my surgeries are geared towards benefiting my referrals. No shortcuts! Now, take the restorative dentist that doesn’t want to do cores or provisional and wants his periodontist to do surgery. The case comes back crap and he blames the periodontist. Slowly he starts to eliminate the referral, but in the end his work is average, if not lower. BW [biological width] invasion doesn’t disappear; we just get used to apologizing for red, bleeding tissue. Next comes technology, i.e., lasers and all-new technology without anyone teaching the biologic principles behind them. In fact, in California, laser companies were actually advertising how to eliminate the periodontist by getting a laser. The laser is great, but it does not replace a biologic understanding of the periodontium. Once again, use the laser wrong and you will be apologizing for red bleeding tissue! The great restorative dentist still wants the great periodontist as a team player and visa versa. I won’t even touch on implants, which seem to have replaced the periodontist. Keeping natural teeth is no longer in fashion and if periodontists are simply doing implants, then why would the restorative need the periodontist more than the oral surgeon, or take a course on implants. Done for now, but it is all about the team approach and working together!