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SPECIAL ESSAY

Are dentists risking losing their relevance?

Two things occurred in the last few days that helped coalesce for me a gaggle of troubling thoughts I've been contemplating over the past couple of years. The first was a report on network television about a new program at Duke University that has dramatically changed their delivery of primary medical care. The change was stimulated by Duke listening to troubling issues voiced by patients about their care at Duke. The concerns related to both patient access to care and their worries about the quality of that care they received. Prior to the change, Duke physicians provided care in the typical manner. Patients waited to see the doctor. While waiting, someone might take their vital signs, but for the most part they just waited. In addition, patients were given little or no information about how long it might be before the doctor arrived. Once the physician did come, she or he took down the chief complaint and a rushed history of the present problems. They would only ask the key questions needed to make a decision and then order tests. Finally, they'd write prescriptions or make other therapeutic recommendations. The doctor then flew on to the next room. No time was typically spent getting more in-depth information or learning about other, perhaps less acute or severe, aspects of the patient's overall health. Patients and doctors felt hurried, the number of patients the doctor could see was limited, and important features of the patient's overall health often went unaddressed. No one felt satisfied at the end of the day that excellent medical care had been provided.

Duke's answer was to change how care was delivered. Instead of the physician being the only true provider of expert services and the only decision-maker, a team was established to deliver care. The care delivery team was led by the physician and included a physician's-assistant (PA), a clinical pharmacologist (CP), nurses, and a social worker (SW). The PA met with the patient first to gather important information and ask relevant questions; the PA also ordered needed tests. The nurse gathered information including vital signs. The physician took information from other team members and met with the patient to integrate the data and ask any more questions needed to reach a diagnosis and/or treatment plan. The PA, nurse, and CP then carried out the next needed steps, including the CP determining the best pharmaceutical regimen and writing prescriptions. The SW helped to arrange financial assistance, visits to specialists or transportation, or manage psychosocial matters. Why was this approach better? Well, the physicians found they could see more patients and, as importantly, they were able to spend more time with each patient. They used the extra time to learn more about the patient's overall health, including psychological issues. The doctors also felt less rushed and less regimented. Why? Well, it was because the team approach allowed them to use less of their precious time doing routine (and to them less stimulating) aspects of patient interaction that could be done by other members of the team. Instead, they could focus on those aspects of medical care delivery that truly require 4 years of medical school and several years of residency to master.

In the business world, this is known as the division of labor. That is, taking a task and dividing it up into subunits. The subunits are then assigned to different individuals, each of whom bring the skills needed for that particular step in accomplishing the overall task, whether it be building a car or delivering a meal at Burger King. Because an individual focuses on just one aspect of the task, they become very skilled and thereby efficient at that subtask. Some steps in the task may require a much higher degree of expertise than others, such as a physician. By freeing that individual from portions of the overall task that require less expertise, or expertise physicians find challenging to keep current (like clinical pharmacology), the special expert can focus on what they, and only they, can do among the team members. This not only improves the overall productivity of the team, it also gives the special expert

even greater experience and expertise, driving efficiency and quality ever higher.

I do not believe Duke is necessarily the first place to have found the team approach to health care a better strategy; they just happened to get publicized at a time I was grappling for examples to use in my own quest for ideas. More on that later.

The second occurrence in the past week that caught my attention occurred at a meeting of my state's dental society. We were working on a strategic plan for our organization and our facilitator threw a quote up on the screen. I cannot recall whom he attributed it to, so I Googled it and found it was from Jim Collins, the well-known writer of books on good business strategies. The quote, ". . . and for those of you who dislike change, you are going to really hate being irrelevant." is to me one of the best statements for why individuals should always be ready to consider changing how things are done or our beliefs about something. This obviously comes at a time of great stress on the world due to the global economic crisis, with regular calls to make significant changes in how we conduct ourselves as individuals, groups, and nations.

So how do the television story on changes at Duke and the Collins quote come together for me? Well, it relates to an American Dental Association (ADA) task force to which I was appointed last year. This task force was created, I believe, in response to both the growing problem of inadequate access to dental (oral health) care by a sizable percentage of the American population, as well as to recent governmental considerations to allow the creation of new types of dental care providers.

Although there are still some debates about the severity of and reasons for problems in access to good dental care, it seems clear that in many states the citizens and their elected representatives believe there is a serious access problem. This is typically portrayed as primarily a problem in rural parts of the country that have no dentists. Yet there is evidence of concern even in areas that do have dentists. The worry is that access is compromised by the cost of dental care. Also, some patients feel they must wait longer than desired to see dentists. Sure, new dental schools are coming online, and many existing schools are increasing class sizes. But these changes are unlikely to change what I feel is a major root cause of the problem. That is, that the current way most dentists practice is poorly designed to deliver high-quality care to the large numbers of patients who are currently underserved. Every dentist knows there are practice styles that deliver care to sizable numbers of patients. They are usually called "dental mills." These practices commonly (but not always) focus on procedures covered by public assistance programs while ignoring other aspects of a patient's oral health needs. In this way, they commonly see larger volumes of patients, but also are commonly thought to deliver suboptimal care.

In any event, due to the access to dental care problem, several states are now exploring the idea of allowing non-dentists to provide many of the services usually reserved, by license, to dentists. I understand this includes irreversible procedures such as administering local anesthesia, preparing teeth for restorations, placing and sculpting restorative materials, and extractions. Not surprisingly, this fills many dentists with discomfort and even anger. At first blush, it sounds as if legislators want to give privileges to non-dentists to do most of what we dentists provide for patients. However, is that really the case? What aspects of dentistry truly require one to have a college degree and then 4 years of professional school? Put in another way, what dental procedures really require a college degree and dental school? This is a critical question, and the answers may be tough for us to swallow. But if we chew on it awhile maybe the answer might go down more easily.

As an oral-maxillofacial surgeon and an educator, the idea of a non-dentist giving local anesthesia and extracting an erupted tooth seems fraught with danger. I have worked with literally thousands of dental students, and I have seen my share of hematomas, inadvertent facial nerves temporarily paralyzed, and many, many missed blocks. I have also seen teeth broken leaving the roots, extractions taking far longer than necessary, prolonged postoperative bleeding and pain, and occasional infections. Thankfully for the student and the patient, faculty members were there to help remedy the problems. However, it would be wrong to say that the students always needed to rely on us. The truth is that in most cases things went well once the student was taught the mechanics of tooth removal and gave more and more injections. As the students gained more experience with local anesthesia and extractions, they needed us less and less. And, once the faculty signed off on their competence, they graduated and were licensed; they and their patients had no one to rely on in their office other than the dentist we trained. Did they learn how to do local anesthesia and extractions in the classroom? Yes, in part. But, for the most part, they learned how to do these procedures by performing them.

Does this argue that dental school is therefore necessary for one to learn how to give local anesthesia and remove an erupted tooth? Well, to answer that one needs to dissect the care being provided here even further. The actual mechanics of giving an injection and removing an erupted tooth are only one aspect of care in this situation, and I feel are relatively straightforward