

## **Be A Plastic Surgeon**

**Dr. Steven L. Rasner, DMD**

In 1980, there were 467,679 physicians in this country with managed care. The average income for a physician was at worst substantial. Today, that picture is a bit different. Almost 87% are under managed care and the average income has dropped to \$187,000, a whopping 25% over recent years.

There are a host of explanations, but the primary reason is that 95% of medical procedures are not elective. The general practitioner still treats that flu that you know you have, coronary bypass is still performed on patients with clogged arteries, and the internist still treats patients exhibiting an array of clear symptoms that even the most stubborn of patients can't deny.

Guess who still thrives? Infertility specialists, dermatologists, and of course, plastic surgeons. What is the common denominator? The infertility specialist is aware that the ability to have a child isn't a matter of life or death, the dermatologist understands that you aren't going to expire from alopecia, and the plastic surgeon is cognizant of the fact that you can still have a full life without rhinoplasty. These are all elective.

Guess what dentistry has in common with our medical friends? With few exceptions, everything we do is elective. We all have seen the multiple oral pathologies from dormant abscesses to crippling occlusions to total edentulous young adults who seem to function rather normally. It is my observation that the apathy toward optimal oral health is peculiar to our chosen profession and it seems to transcend socioeconomic and educational barriers. I cannot be the only practitioner with patients who have no financial limitations, yet they are missing a lower first molar and have no desire for tooth replacement. I cannot be the first clinician to observe early perio and moderate caries on a patient with a PhD who is at most, mildly concerned about his/her oral health.

So what does all this mean? It means that if you care at all about your independence and really want a shot at re-sparking that thrill you once felt when you envisioned your future, it's time to step far beyond your preparations from dental school or a sporadic 1-day course. It's time to become an expert or a specialist, whether you are a general dentist, an oral surgeon, an endodontist, or a periodontist. It's time to become the best at what you are doing. If we recognize that most of our services are elective, it makes infinite sense to train to become exceptionally proficient at multiple areas of our science. This is not just a continuing education pep talk; it is a reality. It is a road to survival. Who do you think is more productive? The general practitioner whose services are circumscribed to basic operative, crown and bridge, and simple extractions? Or the clinician who has trained extensively in occlusion and joint therapy, molar endo, or perio that transcends gingivectomies to include implantology? This position holds true for the specialist as well as the general practitioner. It's no secret that the more productive oral surgeons and periodontists have become leaders in the field of bone regeneration and implantology.

Let it be clear that this posture is not to distance the generalist from the specialist. No matter how much we invest as a generalist, there are clear times when we need to work in harmony by placing our patients' care in the hands of those best trained. Equally, expanding your repertoire

of skill requires a thorough commitment and genuine reflection on your true ability. Taking a 3-day course on a pig's jaw to place implants is hardly a responsible curriculum. Today, abundant venues exist for a total metamorphosis of your clinical skills.

Although I could site creative marketing, five-star service, or a staff that is laser focused and passionate about dentistry, it is a technical commitment to excellence that enables my office to remain, pound for pound, one of the more productive practices in the country.

During my 18 years of practice, education has become a major business. There is only so much money and time we can spend. Whether you are right out of school or have been practicing for 20 years, to maintain independence, you must make this commitment. What areas of study will return the highest dividends? Although your residency will be influenced by your personal interest, this article will outline those areas of study that can universally add significant productivity and spark to any career.

## **Pain Management**

Despite the fact that 80% of my educational investment has been in some phase of restorative dentistry, 50% of my new patient referrals still come from patients who believe we are great at managing fear and pain. Many patients present to our office with complex restorative needs. Their required work is due to a lack of care motivated by fear. You would presume that these patients would seek only a quick resolution for their problems. However, I would suggest that they are the most willing of patients to seek a comprehensive care approach. This is because of the undeniable confidence I exude as the treating clinician to overcome their fear. This isn't something I could fake. It comes with years of training in areas that enable me to truly provide painless dentistry. For example, training in mandibular block techniques. Many of your patients' pain, especially on the mandibular arch is real and not imagined. Twenty two percent of all mandibular blocks are missed. Providing five carpules of local with conventional block isn't always the answer. Training in Gow Gates, Akinosi, or even Stabident, will provide the clinician with profound confidence to numb even the most difficult patient.

For 15 years, I managed the majority of our phobic patients with good local anesthetic and old-fashioned tender loving care. And it simply was not enough. It is clear to me now that some patients genuinely require oral or intravenous sedation. Treating a patient for two hours on a single crown prep because you stop every other minute for the patient to compose himself is not a service to the patient or healthy for you. I used to feel like a hero following such as case. Today, I believe it was a poor decision. A vital part of your curriculum must include a thorough review of at least oral sedation. When can we safely use Valium and triazolam as preoperative sedatives? If we employ the use of opiates, what effect will the concomitant use of barbiturates, benzodiazepines, or even antihistamines have on our patients? Pharmacodynamics will require a serious and continual commitment.

## **Occlusion**

Simply put, it is the starting point of all our restoration procedures. It is often the common denominator of our failed restorative and the fulcrum for a successful and enduring treatment plan. A thorough commitment to the study of occlusion will include an understanding of muscles of mastication, the temporomandibular joint, and their interrelationship. Of all the areas to

master, occlusion will be loaded with the most polarity and controversy. Whose philosophy do you embrace? I would implore you to stuffy more than one point of view. Names Dawson, Lee, or Panky are hallmarks in this area of study. If you have any question about specific courses to the areas of study recommended, you may call my office. Whatever camp you follow, two clear benefits will emerge from your study of occlusion. It will open up the size of your treatment plans by changing your examination and treatment planning approach. (You will start to feel uncomfortable sandwiching a single crown into a mal-occluded dentition.) And it will save you money in the long run. So many of us repair chipped porcelain, restore recurrent decay under crowns, or just redo failed cases due to a lack of understanding of the envelope of function. Whatever you study, you can be certain that occlusion will pay high dividends toward achieving the independence still maintained by the plastic surgeons.

### **Restorative Materials**

It has been said that a little education can be more dangerous than none at all. That is because if you haven't been out there for a while, and some persuasive clinician tells you a certain material is the future of restorative, you can get yourself in a heap of trouble. For example, although resin-bonded bridges have a place in our armamentarium, they were not as much of a solution to tooth replacement as many of us first thought. Do you think just replacing the amalgam with white material should be our level of master? Different stomatognathic systems warrant different materials. Do you use Empress, Spinell, or Procera? What MPs of strength do each of these materials have? How does sheer, tensile, or compressive strength factor in? Your study needs to include places and persons who are not in bed with any one company. This is not an indictment of any of the fine restorative companies marketing their materials. It is simply responsible that we understand there is no one material that serves all dentitions. (It is not sacrilege to employ gold as one of your restorative solutions.)

### **Treatment Planning**

The last areas that is basic to your productivity and your excellence is comprehensive treatment planning. Far and away, this is an area where we need more than one point of view. Frank Spear takes a facially generated treatment approach. Peter Dawson's approach would perhaps initiate a plan with function and harmony of the joints and muscles. It would be common for Dawson to start with the lower anterior teeth in this treatment plan. Whomever you chose as your mentor, you need to acquire a systematic approach to examining your patients. Not only will your treatment plans be solid and responsible, but your patients will perceive your organization with confidence. Confidence leads to trust and trust leads to case acceptance.

### **How to Get It Done**

Sit down twice yearly, once in August and once in November. At this time, you will select your fall and spring curriculum with a key staff member. I suggest you take at least one 3-day course per quarter. Make sure the staff member arranges your schedule ahead of time and makes a deposit on the course you select. Set up your residency 2 years at a time. It won't be unusual for you to take a series of courses with the clinicians or institutions you select. If you don't arrange your courses in a formal meeting as discussed, I assure it won't get done. Don't base

your selection on location or convenience. If you do, there will always be a reason not to attend the course. I know all of this can be somewhat overwhelming. Serious training demands an investment of time and money. We haven't even touched on training for staff, which is another article entirely. Some of you may be wondering whether this is all worth it. Managed care or management service organizations are not going away. They will devour those of you without commitment or direction – just ask the physicians.

Are you really comfortable selling out or allowing someone else to dictate your future, or is that simply an easier solution for now? This article suggests alternatives. If you understand that most of what we provide is elective, then it is essential that you broaden your elective skill and become masterful at each of them. Dedicate yourself to the time and money necessary to make yourself a specialist. At the very least, you'll become a masterful clinician. You will more likely rediscover a profession filled with excitement and challenges that will re-spark your joy of dentistry and enable you to achieve enduring independence. Just ask a plastic surgeon.