

## **A Philosophical Trip Down South**

I was prompted to write this after I read an article indicating the increasing number of U.S. citizens who are crossing the border into Mexico to have dental treatment. Also by questions I am sometimes asked about my take on the relative quality of U.S. dentistry compared with that performed in Mexico.

The reason for this exodus I'm sure is a matter of perceived economics. If I were a retired dentist being asked this question (therefore, my answer not ostensibly self-serving), I would say, "It depends." I'd tell them that here in the U.S. there are definitely some levels, or tiers of dentistry where treatment is performed of similar or less quality than some that I have seen from Mexico, all of which I've observed so far being what I'd consider sub-par. The following will give you my perspective on the status quo of U.S. dentistry in general that might be important to a person who values their dental and overall health, prior to making a trip South.

The first thing I would tell them is that there seems to be three very distinct tiers of dentistry in the U.S. One is that of basically "putting out fires" such as tooth extractions, patchwork fillings, pain elimination procedures, etc. and is heavily driven by dental insurance industry policy.

Another tier is mainly technique-driven, i.e., fillings, crowns, implants, cosmetic porcelain crowns and veneers, partial and full dentures which rehabilitates the results of dental disease or improves a smile. There are various levels of quality within this tier which is substantially influenced by dental insurance policy as well. Most of the procedures leading up to the finished teeth replacement/enhancement fabrications involve a manufacturing process that involves both the dentist and laboratory technician. The result can be of varying qualities, based on the relative quality of each and the nature of their relationship. The best dental lab technician's efforts are only as good as what they receive from the dentist, and correspondingly, if the dentist's efforts are tops and those of the lab are poor, the result will also be poor. As important as it is to have properly designed restorations to repair and replace teeth, even the best of them only address the results, or symptoms of disease, not their cause(s). This is a very important distinction – similar to a physician who provides his patients medications for their high cholesterol and blood pressure, as opposed to one who would counsel them about the influence of their life style choices and holding them accountable for making healthy changes, the comparison of which leads us to a third tier of dentistry.

This third tier of dentistry is quite rare and is relationship and health based, not technique or insurance driven. The dentist is talented, trained and quite capable of providing the finest of the afore mentioned restorative technologies and uses only the services of a top quality laboratory technician. He realizes, however, that these are procedures repairing the ravages of either current or past oral disease and are only part of the oral health equation. Therefore he sees prevention and health development as primary in the bigger picture of his client's oral health future.

The dentist who ascribes to this mode of practice realizes that without the cooperation of his client, healthy changes cannot occur, similar to the above-mentioned physician who would educate his patient and hold him accountable for his share of the health development equation.

His practice purpose is holistic in helping people improve their dental, emotional and overall health, and he knows that he is hand-tied in doing so without first developing a relationship with his client. The term “client,” rather than “patient” is used within this tier, as client denotes a helping relationship, whereas patient denotes passive compliance, which is indigenous within the other two tiers of dental practice, and the norm for the medical practice model. He realizes that true health can neither be purchased by the wealthy nor given to the poor, but results from the integrity of a developed relationship based on trust. This type of dentist first wants to know the attitude and desires of the client regarding their dental health and wants to inspire him towards its improvement through education and defining their respective roles towards that end.

So, the trip down south could unwittingly, be at least on a par with some levels of quality within the first two tiers of dentistry in the U.S., but rarely, if ever I believe with that of Tier 3. Therefore, the items of comparison between dentistry performed in the U.S. and Mexico lie in the word “performed,” which is basically a Tier 1 or 2 term as it has to do with “dental work” that is done to you such as fillings, crowns, implants, etc. rather than a participatory mode seen in Tier 3. Having witnessed lots of the first two tiers of dentistry through the years from both countries, I’d take my chances with a reputable U.S. dentist before I’d go down south, as cheaper isn’t necessarily better.

An example of the tier levels of dentistry practiced outside the U.S. is summed up well in this article snippet from a dental newsletter I subscribe to regarding dentistry done outside the U.S., this one from a dentist who practices in a vacation resort in Portugal: “We have extensive conversations with our potential patients via email and get a good idea of what they need before asking them to come over. As is true in anything, customer service, good communications and high technical standards will set you apart from the competition.”

Yeah, just email me your needs for a diagnosis and who needs to develop a relationship for the “work” anyway?

Unlike a beautiful automobile paint job that radiates its quality, the relative quality of “dental work” cannot be determined readily by a patient, at least immediately, but later on it can become more costly in pain, time and finances when it fails completely. Without a gauge for the patient to determine the relative quality of their “work,” I can see why some people may go out of the U.S. for their treatment. A patient not being aware of the above factors through having been educated regarding them may be one reason that they may think they can get a bargain in Mexico, and I think we all know that some people will do most anything for a bargain.

It is quite ironic (and sad) that some of the finest dentists who graduated from dental school with honors have a difficult time getting enough patients because of a basic introverted personality, while a dentist who was at the bottom of his class and performs substandard care, but with an engaging personality that can put a scared patient at ease, will have a flourishing practice. In other words, quality of “dental work” is not easy to judge by patients. I have more than one patient who had a previous retired dentist for whom they had a high regard, exclaiming that he was a great dentist where dental work was atrocious, with active periodontal disease to boot - a true case of supervised neglect.

Tier 1 and 2 are the only real US to Mexico comparatives then, as they primarily address repair and maybe cosmetic “dental work.” Therefore, in evaluating these tiers, we must take a look at the dentist and the dental laboratory.

There are a many factors having to do with the relative quality of the dental work, or final “end product” that goes into the mouth which is based on interplay between the dentist and laboratory technician. The laboratory works in partnership with the dentist and is subject to his instructions that are placed on a prescription. The ultimate quality of the finished restorative product reflects the coaction between the dentist and laboratory, driven basically by the talent, care and integrity of the dentist. The level of quality of the dentist will usually match that of the laboratory, which can span a very wide latitude. The following is a potential scenario of the process of fabricating teeth restorations from dentist to lab, back to dentist and then to the patient’s mouth:

- The dentist takes an impression (replica of teeth, or teeth prepared for crowns from which the restorations are made), and sees a defect in it. He is running behind schedule, has another patient waiting and has a decision to make: does he re-appoint the patient for another attempt to get a flawless impression or send it to the lab as is? The answer to this question is based on the integrity, talent and training of the dentist as he assesses the situation. Another appointment is more time/money out of his pocket, as well as another impression that may cost from \$30 - \$100.
- In a Tier 1 or 2 insurance-driven practice, allotted fees for a procedure are the same across the board, irrespective of the difficulty of the teeth, mouth, health or disposition of the patient. Most dental restorations I see daily are mediocre, and any top dentist and laboratory will agree. I don’t say anything about these of a new patient if they are not causing them any harm, but I will accolade the work I see that is above par or exceptional. Until the mediocre one causes a problem, most always the patient doesn’t know the difference. .
- Other than staff, the highest overhead factor for a general dentist is the laboratory bill. As previously indicated, there are vast differences in the quality of dental laboratories, here in the U.S. as well as those in Mexico, and even cheaper, in China. Laboratory fees can range from 3 times plus or minus “the norm.” Dental laboratory revenues are also based on time, which can inspire quantity over quality depending on the philosophy and integrity of the laboratory owner. As mentioned earlier, the result of even the best dental lab technician’s efforts are only as good as the relative quality of each of them. The truth is that water seems to seek its own level in this area. A poor dentist will select cheap labs, and an excellent dentist will only seek the finest quality dental laboratory, as they would want to dignify their efforts with the very best.

Note: If that impression with its imperfection(s) gets to the lab and used to fabricate the restoration, its defects are magnified from one step to another through the many steps taken along the manufacturing process. If the dentist knew of the imperfection, but whose ethics level was such that he would give it a pass even though he observed the flaw, or is running behind in his appointment schedule, the next step falls on the laboratory. If the truth be told, many laboratories are placed on the spot when they see the imperfection(s), and when/if they call the dentist, they will most often be told “Do the best you can with it.” If the dentist is a good account and pays his bills on time, the integrity of the lab is tested by the reality of economics.

Then it is placed in the mouth, and most of the time the patient isn't aware of the deficiency, but it will definitely manifest in time. Most dentistry performed today is replacing failed dentistry. Most dentistry I see today is sub par.

Any highly talented dentist will tell you that even with many years of experience and the many improvements in technology and anesthesia, many treatment procedures are quite difficult and demanding of the dentist as well as the person being treated. The spatial tolerances for proper teeth preparations and flawless impressions are less than that of a heart or brain surgeon, and performed in a wet, dark oral environment on a sometimes moving target to boot. If the person is a client with a good relationship with the dentist, they will have been coached and prepared for its difficulty, and the relationship can sustain it as impressions may need to be retaken, etc. In an insurance-driven practice where time is a constraint and relationships are not built, there is more opportunity for errors as there is a temptation to rush procedures and accept impressions with flaws, as well as a more fearful patient that does not have a relationship with the dentist that would balk at extended treatment time and attendant discomfort. They also may be in a clinic with a different dentist each time, and all these factors contribute to the promotion of the mediocre dental work that is commonly seen.

The finest of dentistry is performed by a dentist with high ethical standards with a caring philosophy that drives his talent, training and experience towards excellence, not only in his dental treatment, but the relationships between he and his clients that allows it to occur. The preventive learning experiences and treatment processes are performed within an atmosphere of trust. The client's oral health improves through caring coaching followed with the highest possible quality of restorative technology.

A Tier 3 dentist knows that most patients may have been conditioned by earlier experiences that may stand in the way of the potential his dentistry could now offer him. Realizing this, he will provide the atmosphere, dedicated team and sufficient time to allow for relationship building to occur and earlier experiences to be assuaged. The developed trust will open the ears of his client to the wonders it offers for his life quality and longevity. He recognizes that where excellence is concerned, quality is the constant and time, the variable.

His laboratory has a similar viewpoint, in that they hire the most talented personnel, use the finest in materials and equipment and are proud of their products which are heavily acknowledged by the dentist.

Another factor mentioned briefly above, is the path the dentist has taken in his training. Some dentists are "education junkies," in that they continually take post graduate courses. This is a good thing, as it shows that the dentist is interested in improving his knowledge and skill beyond the minimum number of courses required by state law. Here again, it depends on the basic motivation of the dentist. The preponderance of courses out there have to do with the latest materials and techniques used in restoring teeth, and how to apply them in practice. Again, this is good, but very few dentists are attracted to courses that involve an understanding of how a healthy mouth appears and functions, mostly because there aren't many given. In fact, there is only one organization that really owns and understands the true model of dental health –

Orognathic Bioesthetics International. You may be wondering why this is, and the best answer I can give you would be summed up in the following quotes:

“Truth only reveals itself when one gives up all preconceived ideas.” ~Shosek

“In order to recognize truth, you must be true enough to yourself to see it when it appears.”

~*Robert P. McBride*

In other words, I believe that this is a life question, not a dental one, in that it has to do with the innate passion within the person that is the dentist which drives the curiosity behind his search for truth. The research behind Bioesthetics defines how a healthy mouth appears and functions, as it is based on the study of 10 – 14% of the population that is naturally blessed with common, healthy attributes that have been quantified. It is a study of the truth of Mother Nature’s success!

Numerous dentists have been introduced to Bioesthetic introductory courses, but some do not continue further onto the other learning levels. I believe this is so because of the following reasons:

- The learning process is lengthy, arduous and costly, but well worth it if you are motivated per the above.
- Bioesthetic dentistry has a large client-learning component, and most dentists are doers, not teachers, being selected for dental school not on their teaching ability or interpersonal skills, but on their manual dexterity and problem solving ability.
- Most dentists are contracted with dental insurance companies that view patients essentially as “units of work” in a “factory,” to be handled cost effectively as they move along through various dental treatments. They base their benefits mostly on basic repairs and procedures restoring the results of dental disease, not listening and learning experiences that involve prevention and the promotion of health, such as the principles of Bioesthetics and the oral systemic connection.

This insurance mentality emphasis on repair rather than a learning process only helps to support the public’s already low value of taking the time to learn and diagnose by offering “fix it” benefits only. The whole language of dental insurance companies presents a view of dental health not so much as a service, but as “units of things being sold,” such as fillings, crowns, partials, dentures, and cleanings. Their benefit schedules list one fee for each procedure, with no flexibility for the differing needs of each mouth, tooth or patient. This is supported by their language, such as “usual and customary” benefits, and their denying of these individual differences coerces the dentist into not taking the time for interaction. I find that this way of thinking has permeated most of dentistry as well as the expectation of many dental patients. The insurance industry influences dentistry in much the same way that it has the medical profession with denial of benefits, limitations on treatment, and fee schedules that allow little time for the all-important feature of interaction. It has been estimated that the average physician sees his patient 17.4 minutes per year.

This having been said, a dentist so entrenched in this manner of practice and going through the Bioesthetic learning process would experience a major paradigm shift, and if he were unable to transform himself into an effective teacher while going through it, he could suffer frustration and a huge loss of revenue.

What a dentist must do if he really wants to assist a patient in becoming a client, is to set the stage for it to occur by establishing a written health-centered, relationship-based philosophy, and developing a team around him with similar values that are defined within it. They all realize that the success of their client, the team and that of the practice lies in their creating and sustaining an environment conducive to the cultivation of healthy relationships. Ones that permit the process of developing oral health and appearance that reflects the dentist's innate passion in delivering the highest level of care possible.

The truth is that if two people were tracked through their lifetimes, one having seen a Tier 1 or 2 dentist and the other being in a Tier 3 practice, the latter would have healthier periodontal and systemic health and understand why, fewer dental restorations and a more attractive smile with no tooth wear or bite-related head and neck pain.

I think that before anyone takes a trip to the dentist in any area in or out of the U.S., they might want to travel through this information first so that they can make an educated choice.

Another item for consideration - Mexico carries one of the highest seroprevalence rates of Hepatitis, not to mention other communicable diseases. There is a reason we require what we do here in the U.S.A. for sterilization, cross contamination, and general health codes. It's for OUR protection as well as our clients. When these patients come back to the U.S.A. with no knowledge of what they may have contracted across our borders, they then blindly share their infectious processes with the rest of us!

This started out with a seemingly simple question about a trip to Mexico which is more complex under its surface than it might sound. Hopefully, this information can assist a person who may be contemplating a trip to the dentist anywhere, including south of the border.

A Tier 3 dentist:

- Is passionate about his beliefs
- Is self-confident
- Is interested in health, therefore has training well beyond the norm
- Has a well defined written philosophy
- Selects team members who ascribe to the philosophy and are themselves passionate about providing their clients something of rare value.
- Sees as primary the development of a relationship with his client
- Is not dictated by insurance company time and quality constraints
- Uses the highest quality of laboratories
- Has knowledge of how a healthy mouth appears and functions – uses the “The Bioesthetic Model” in diagnosis, prevention and treatment.
- Offers individualized periodontal health programs that not only develop optimum periodontal health, but quantifiably improve systemic health, such as decreased blood glucose and CRP.
- Realizes that the health of the relationship is more important than the health of the client