Ep #34: Continuing Education and Understanding the Doctor-Patient Relationship with Bill Wathen

Full Episode Transcript

With Your Host

Allison Watts, DDS

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Welcome to *Practicing with the Masters* for dentists with your host, Dr. Allison Watts. Allison believes that there are four pillars for a successful, fulfilling dental practice: clear leadership, sound business principles, well-developed communication skills, and clinical excellence. Allison enjoys helping dentists and teams excel in all of these areas. Each episode she brings you an inspiring conversation with another leading expert. If you desire to learn and grow and in the process take your practice to the next level, then this is the show for you. Now, here's your host, Dr. Allison Watts.

Allison: Welcome to *Practicing with the Masters* podcast. I'm your host, Allison Watts, and I'm dedicated to bringing you masters in the field of dentistry, leadership, and practice management to help you have a more fulfilling and successful practice and life.

Bill does have a long bio here. I couldn't cut anything out of it, Bill. I just couldn't do it.

Bill: That's a little bit embarrassing. I've just been around for a long time, Allison. That's why it looks so long.

Allison: Well I thought everything in here was relevant and important to say so I'll just start out and you can add anything you want to or at the end we can talk about if there's something I'm missing. But I think we've got a little bit of everything in here.

Most of you guys that are on here know Bill I think, but Bill is an associate professor in the Department of General Dentistry at Texas A&M Baylor College of Dentistry in Dallas. He graduated from the University of Kentucky College of Dentistry in 1967 and went to Texas for a general rotating Air Force internship. He began private general practice in Fort Worth in 1970 where he practiced for 35 years.

He served in all offices of the Fort Worth District Dental Society and he was the Texas Dental Association editor from 1975

through 1985. He served as director and vice president of the Northwest Division of the Texas Dental Association and as director of Paid Dental, Inc. He received the President's Award from the Texas Dental Association in 1982, the Texas Dentist of the Year Award from the Texas Section of the Academy of General Dentistry in 1988, and a Distinguished Service Award from the Fort Worth District Dental Society in 1985, followed by election into its Hall of Fame in 1990.

In 1987, he was elected to be editor-in-chief of the American Dental Association. He was soon offered a position of Director of Continuing Education at Baylor College of Dentistry where he created and implemented a comprehensive, patient-centered, hands-on series of clinical courses. He was later named Associate Dean for Continuing Education, Alumni Affairs, and Institutional Development. In preparation for a historic 1996 merger between Baylor College of Dentistry and the Texas A&M University system, he was named Associate Dean for the Center of Professional Development in 1995.

He stepped down from that position in 2000 for a two-year leave. And this is incredible to me, I know you love CE but this is really neat. So he left in 2000 for a two-year leave to develop online CE courses at Dentalxchange in Irvine, California which now are the ADA CE Online. He returned to Baylor in 2002 on a part-time basis to teach the senior dental and dental hygiene clinic where he developed the fourth-year practice management and business courses and write faculty and student calibration and remediation manuals.

Last year, he launched a course titled Dental Crossroads: Secrets of Success in Clinical Practice. The course is about the psychosocial aspects of dental practice that help build powerful doctor-patient relationships. It is planned to be available to all students and alumni in the fall of 2014.

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Dr. Wathen served all positions in both the Dental Continuing Education Association and the American Dental Education Association Section on Continuing Dental Education. He was the ADEA representative to the American Dental Association CERP committee for eight years and has been a strong advocate of distance education as a critical part of lifelong learning for the health professions.

In January of 2006, Bill retired from active private practice but continues his affiliation with Baylor College of Dentistry. He lives in Fort Worth with his wife, Lisa. He has a son in New Jersey and a daughter in Katy, Texas that's a general dentist and he has three grandkids. Bill and his wife are avid walkers, gardeners, art patrons, and readers. So you see? I could not skip any of that. It seems to me like you were way ahead of the curve on this distance learning thing, Bill.

Bill: I guess it turned out that way because when I first went to Baylor, this was in the early 90s, and people hardly knew what the internet was, including me.

Allison: Yeah.

Bill: Fortune sometimes plays good tricks on us. I met a man there by the name of Art Upton who I call him Igor because I met him he was toiling away in the anatomy lab, gross anatomy lab. I kept asking people what they knew about the internet and Art's name kept coming up.

So I went down and introduced myself and asked him what this internet thing was. He sounded like he knew what he was doing. So short version, I ended up hiring him away from the anatomy department and brought him up to be the internet director for the continuing education department.

I'm not sure but I think we launched probably the first web-based continuing education program for CE credit. It was a real fancy thing. For those of you a little bit older with computers, it was a Word Perfect document, just simply a structured abstract of some of the world literature, current world literature in dentistry that I and a number of my—when I was editor of course you know we have a lot of reviewers in different fields.

So I would simply poll everybody every month for the top articles they had read. We did a structured abstract on it and actually printed it as well as put it online. So we've been doing that ever since. This newest course, this Dental Crossroads course you mentioned is going to be a web-based course. This is what I call a poor man's version of a MOOC. Those of you not in education may not be familiar with MOOCs but that's M-O-O-C it stands for massive open online courses.

Places like MIT and Stanford and now hundreds of universities are putting their intellectual property online, open to the public. You can't get credit for it but if you want to take an electrical engineering course from MIT, it's there for you and you can go through the whole course. You can't get credit for it but you can go through the course and learn from it.

So the whole idea goes back to what I was trained in and that is when you know something good about your field it's no good unless you share it. You share it freely and openly. Now I ran CE and we ran it for a profit and I know all about charging for time and I know all about what it takes for people to do meaningful continuing education. It's time away from family. It's time away from practice. So I can't criticize the CE industry because it's led us into wonderful new waters in the years I've been in practice.

However, the internet makes it easy to do free things that people are interested in contributing in. So we've had some real interesting and formative presentations, very much like these you do, Allison. Ours can be a combination. They can be voice over PowerPoint, they can be Skype, they can be video, they can be audio, in person, taped, pre-taped, I mean they take all kinds of forms. But they take a lot of the same structure that your presentations are doing.

I want to tell you, others may not know, but Allison has very graciously offered an intro or a doorway into her programs to the Baylor students. So I'm going to open her presentations up to them too. We've also had Allison, she's done some work for us. One of our presentations is from her. By the way, tit for tat, Allison, we're going to do another one with you here pretty soon.

Allison: Okay.

Bill: But the whole idea is to have web-based courses that are available. Well here, I have to backup, I've got to say this. Lynn Carlisle and Bill Brown have been really powerful motivators behind this because I first met Lynn over this book David Clow wrote. For those of you that don't know, there's a professional writer and consultant in California who's written a book called *A Few Words from the Chair: A Patient Speaks to Dentists*.

His name is David Clow and it's one of the most remarkable books I've read because in a nutshell it just says, "Look, I don't care about the technology so much. I don't care about the fancy equipment. I'm interested in you knowing me, understanding me as the patient, and doing the marvelous things that dentistry can do so that I the patient can achieve my goals and desires."

That spills over into, and that's one of the first courses, one of the first presentations that we do for the students because I

want them to appreciate what it means to sit in the chair. Many of them haven't sat in a chair like people of my generation have. So any of you that don't have that, it's available on Amazon.com. It is a remarkable book. So David was kind enough to do our very first taping of this last year when we had the Baylor version for our senior students.

So we start with David and like I say, I got aware of him through Lynn and Bill, and Bill's blog site is incredible and so is Lynn's. And I thank all of you for being willing to share those because on my list of recommended readings are all the books we've talked about, all the motivational interviewing, and I'll talk about that in just a minute. But all the things, the emotional intelligence books and the… well, the list goes on. I've got about 30 of my favorite books on that and if I put them all on there'd be hundreds of them.

Anyhow, I guess we should get to the point tonight. That's the course and what it's about and how it works. So if it's okay, I'll start on that phase?

Allison: That would be great. Let me ask you a question, where do you have your books listed? Your recommended books?

Bill: It's in a PowerPoint presentation. After we get through with this, I'll be glad to take all suggestions about where we go from here. In a way, I feel like the dog that caught the firetruck. I'm saying, "Oh man, what do I do know?"

Allison: Oh, yeah.

Bill: It's like my friend Dr. [inaudible 00:10:33] used to say, it's like teaching a bear to dance. Once the thing gets you on the dance floor, it's hard to sit down. So anyhow, the idea behind the program was, and this is a story that Mike, I know you talked about, almost everybody in the ISOC study group has got a

similar story. Bob Frazer's got it. Don Deems in Little Rock has got it. Bill Brown certainly has it. I feel like the odd man out in terms of how I was educated at Kentucky but that fits into what I'm getting ready to talk about.

The typical dental school today is what academics call a surgical-based model. It teaches all of our students all the technical information they need to do astounding things. It teaches them the biologic science that underlies those technical things, they call it evidence-based dentistry today. That's simply best practices, or as I call it, stuff that will keep you out of trouble.

What the schools generally miss is the third leg of this dental stool and that is they psychosocial aspect, the interpersonal aspects. This is where Lynn and ISOC and all the people that have written and contributed to most of these programs bring their focus. Dental practice is first and foremost about patients, about people. It serves us well if we understand human behavior, starting with our own and then spreading out to others. The others I'm talking about the team, the family, the community, and most of all, our patients.

How we bring those patients into the practice becomes important, how we speak to them becomes important, and I'm talking about speaking verbally and nonverbally. It's kind of difficult to put all this into a 45-minute discussion because nearly every topic we bring up literally can be a subject for a master's degree. But we'll try to hit the high points and anyone that has questions or comments can interrupt.

Let me tell you what the course—in academics, some of you know, there's always a course description and course objectives. So let me tell you what these are and that will set

the format. Then we can get specifically into how it's made up and how I hope it gets made up in the future.

The course itself, like I said, it's a group discussion kind of opportunity for our seniors. The Alumni Association at Baylor has agreed to—not co-sponsor it necessarily—but we have a website on their page that links to the Dental Crossroads courses presentations. That's going to go to Baylor alums. Then I'm going to do school-wide mailings to all of our students, pre-doc, post-doc, and dental hygiene because I think this kind of material is good for everyone. So that's the plan.

So it's kind of a group discussion web-based series. The purpose of it is to help participants become better at obviously honing technical and biologic skills but the issue is to build patient-oriented dental teams that can help patients become better motivated or more motivated to obtain and maintain their own oral and systemic health.

In order to do that, it's necessary for the team, and I talk specifically about the team, I hope none of you are doctors who think you're the king of the office and you give orders to your team. That's not how teams work. The issue is how do you build powerful office/patient-centered relationships? That's also office team, office patient, and family, and community. It goes beyond just the patients but we're talking specifically now about dental practice.

When you find those kinds of relationships, and Bill Brown has been eloquent in this regard in his blog, *Dental Intelligence*, it develops more slowly because you build these relationships one at a time, but they hold up well. If they're powerful and the patients trust you, I can tell you, and by the way, let me throw in and I always tell the students this. I have never taught anything

out of a textbook. I use textbooks a lot but if I haven't personally experienced it, I'm not going to talk about it.

So what I say is what I practiced from 1970 until actually 2000, well actually I'm still practicing, but as Allison said, I gave up my private practice at the end of '06 I believe it was. So the whole idea is to build these powerful relationships so with this ever-changing external environment that we look at, you know we're looking at mid-level providers, we're looking at governmental influence. We're looking at Obamacare, third party, alternative practice models, DMOs.

The traditional doctor patient fee-for-service relationship, people see it's on the rocks. I argue that it isn't on the rocks for that percent that's usually a small percent is the people who are willing to pursue this behavioral issue and understanding patients and putting patient needs ahead of our own. But once those trusts are established, it's pretty hard to break them.

So I'm thinking that's one really good technique for young dentists to use. They may have to get out of school with their high debt and take some sort of a paying job, that doesn't interfere with that. They can still be human beings and they can be decent and they can learn how to do reflective listening. They can learn some human behavior.

By the way, I'm going to try not to use technical words. Back when I got my degree in clinical psychology, the Abraham Maslow and Carl Rogers, and all that bunch, were all beginning to focus or had focused unlike Freud and Adler and Skinner and a bunch of the people before who dealt with psychiatric and psychological issues, but they were aberrant or abnormal behaviors. So they were looked at as pathology.

When Rogers and Maslow and all this bunch came along, they scratched their head and said, "Well, wait. There's a whole

segment of the population that's not psychotic, that's not delusional, they have behavior patterns too. We probably should know something about quote 'normal' human behavior." So that's were the general field of humanist psychology came from. It is simply a patient-centered approach.

When we talk about reflective listening or empathic listening or motivational interviewing, in a sense, they're all talking about the same thing. It's the doctors and the staff and the team's ability to sit down and basically be quiet and listen to your patients. Not that you can't guide it a little bit but my basic question to everyone when they come in the practice is, "What brought you in today? How can I help you?" Then I actually listen.

I'll go ahead, I hadn't planned to talk about this now but let me tell you, I'm listening for them to say, for any of you that are interested in helping patients assume more responsibility for their own health, I find this works pretty well. I want them to tell me first of all why they're here. What's the primary reason. If it's something that's acute, we're going to deal with it right now and I pretty much stop the interview right there other than to do the systemic review and review of systems. Make sure there's nothing going on systemically.

But the emergency stuff gets taken care of right away. But I want to hear them tell me in their own words where they would like to be. I usually say something like to get them started, I'll say, "If you had a magic wand you could wave over your mouth, what would it look like, your mouth? How would it be in five years? Ten years? Fifty years?" Then I just sit back and listen. They will tell me quite an interesting story and it's going to include six different things.

I'll tell you, the first thing that they want is a team they can trust. That one is hard to drag out of them. So sometimes I've got to say, "Well, if you would wave that magic wand, what would be the characteristics of the people that you have treating you and taking care of your dental needs?" Because essentially I want them to tell me, that yeah, they want to build a trusting relationship with their dental team.

Then in sort of descending order, they're going to tell me one way or another they don't want pain, either incurred by me or incurred by disease or inflected by me. They want to look good. Even dentists as old as I am want to look as good as I can. They certainly want to be comfortable and chew well because we all like to eat. Most people today want to keep their teeth for a lifetime. I'll put this in quotation marks, people want to try to have costs "reasonably contained." Reasonable depends on the patient.

Now those of you that have read history will recognize that as a system—well, I've got to say two more things because I talk about the system. Let me jump to it, to the patient classification system that's important and helpful to you also. There was a doctor named Wilson Southin back in the 50s up in Canada that belonged to The Cox Group which was one of the early consulting groups and dental practice management groups.

I think maybe if I'm not mistaken Bob Frazer talked about this when you interviewed him, Allison, I think. Basically they divide patients into five different levels. The first level is the urgent care patient. That's the emergency, which is pain, trauma, and infection. The second level patient is an episodic kind of patient that comes if a tooth breaks or a filling falls out, but they're not ready to do comprehensive care yet.

The third level patient is ready to at least have a co-diagnosis and we'll talk about that a little bit too. Maybe we can get Bill Brown to jump in here and tell you about co-diagnoses. Most all of us that use this co-diagnosis work are Bob Barkley fans, those of you that are old enough may know that Bob Barkley was a wonderful man who basically was the face of preventive dentistry beginning in the 60s extending until his untimely death in the late 70s.

He was from Macomb, Illinois and a wonderful teacher, a wonderful motivator. Many of us have followed him for a lifetime simply because his materials made so much sense because they helped people become responsible for their own disease.

I'll give you another quick sideline. Barkley has a quote that I've used almost, well, he's got several things that I've used for a lifetime. But those of you that have read his book will recognize this, he says, "Health is a unique commodity. The rich are unable to buy it and the poor cannot have it given to them. It requires others." So it takes at least two people. We don't make people healthy. They make themselves healthy. All we can do is help motivate them to be healthy.

That's where motivational interviewing comes in or reflective listening or whatever because once patients have told me those six things then I can say, "Okay, let me be sure I'm understanding. What I'm hearing you say is that you want…" Then I'll list them. The patients usually say, "Yeah, that's it."

"Did we leave anything out?"

"Nope. That's it."

My very next statement for all these years has been, "The good news is our team can help you achieve your goals." Now, Lynn will recognize that as the beginning step in transferring

responsibility for managing disease from the office to the individuals.

That's the other thing about motivational interviewing, you cannot teach people to control their disease by lecturing and giving them booklets and pamphlets and telling them how bad it is to have plaque on their teeth and bleeding gums and decay and hypertension and obesity and drug abuse and all that stuff. Wagging your finger and lecturing has never worked. It doesn't work with any of us. All we have to do is stop and think how we react if somebody is lecturing to us, maybe very much like I'm doing to you tonight.

But the whole deal is that if we can get people to realize that we're on a track with them and we support them in trying to reach their goals, that becomes terribly important. While this rolls in now, I'm going to skip around here from the course outline itself because I've got to talk to you about sequence in care. That becomes terribly important because we said there are five different classes of patients and I don't think I finished that topic.

The third class was the ones that are ready for a comprehensive exam but for usually economic reasons, they're unable to do everything right now. That brings up a terribly important point. That is that everything we diagnose and treatment plan on patients has got to be on their timeline. The sequencing of care that we teach at Baylor and that I always practiced was deal with systemic and acute issues right now, as fast as you can get the patient in the office. Or if they're already in the office, drop your format and go ahead and take care of the pain or the fracture right now.

The second step always has got to be control disease. You have to control the contributing factors to disharmonies in the

oral cavity and systemic disharmonies to the extent possible. Now I bring Bob Barkley up again. I've used this story with nearly everybody. At some point early in the interview, after I've got those six things, I will ask patients, I say, “Let me ask you just a silly question, if you come up to your house this afternoon and smoke and fire were coming out of the roof, who would you think to call first? The carpenters to fix the damage or the fire department to stop the fire?”

Well of course, eventually and usually right away they say, “Oh well, I guess I would call the fire department.” That gives me a chance to be very simple and direct. I say, “You know, when a dentist or dental hygienist looks in your mouth and sees plaque on teeth, active decay, bleeding gums, that’s the smoke and fire. So the fire department has to come. By the way, guess who the fire department is going to have to be in this case?”

Most people get it right away. “Well, I guess that would be me.” I like to wisecrack with patients. I like to keep smiling and keep them smiling. So at that point, I will say, “Now, we do have this special home care program if you would be interested. I’ll be glad to come to your home and clean plaque off your teeth each day. It’s a $500 house call and I expect a nice meal and a good bottle of wine. Would you like to sign up for that program?”

Of course, then they do just what Allison did, they laugh and say, “I don’t like you that much, doc.” The point is, again, I’m smiling and they get the idea. Everybody understands the fire story. So I don’t have to go into aerobic and anaerobic bacteria. I don’t have go into the Krebs cycle. I don’t have to go into cytokines, the C-reactive proteins.

I don’t ever go into that because when I first started, and I think Bill Brown did the same thing, we’d sit patients down and start

telling them about the Krebs cycle and where lactic acid came from and what kind of bacteria were doing it. I can't believe anybody ever stayed with us, Bill, but they did and we finally learned not go into such detail. Anyhow, once we get to that point and that way I never have to fuss at patients if they come back and they're not real compliant, because all I've got to say is, “Looks like the fire department was asleep at night. What’s going on here?”

This is another sidebar comment but I found this to be extremely powerful all my practice years. Every patient that comes in our office for a visit, whoever touches that patient is going to give me a bleeding index and a plaque index because if you don’t monitor disease status consistently over time, you can't follow whether they're getting better, worse, or staying the same.

So everybody, even my office manager, whoever seats the patient, is going to look in their mouth and do a plaque and bleeding index. When my assistant walks in, she’s going to do a plaque index and a bleeding index. When I walk in, the patient’s probably going to tell me what they're indexes are. What’s happened over time since we do that every time, it got to where I'd be sitting in my chair working on a patient and I'd hear some rustling at the door and somebody would shout out, “I’m up 1+ today, Dr. Wathen.” Because they knew our system. They knew what we were going to look for and they paid attention. The patients as a group stayed remarkably compliant. So I would suggest that.

I also will suggest quickly, everybody has to use different words. We can't mimic anyone until the words belong to us. So it has to go through our own filters, our own distillation process. Once we’ve done that, then some of these little lighthearted

things become very powerful statements to people. I know Bill Brown does this. I'm sure you did too, Lynn.

There's a phrase in psychology called overhear psychology. When we're doing these joint, the name is co-diagnosis because the patient is involved too, but we're talking to our assistants. They're writing down or entering into the computer what we're finding when we do our health history, our intake, and all that sort of thing. I'll usually tell the patient, "Don't pay attention to us, we're going to talk some technical stuff here. I'll be back with you in a minute."

But you can bet as soon as I say that, all ears are focused on what Jill and I are saying and doing. Because that way we can say, "Well, there's a cavity in that tooth and it's not real big but it may cause a problem, so put that down as something that we need to consider. This next one is really big. That needs pretty quick attention" because I've already talked to patients and we'll list everything there and list them in their order of importance for their ability to cause trouble.

So that pretty much is it in a nutshell. I mean, without getting into the details. We just do standard intake interviews and try to record as much information as we can so we're familiar with the patient. That's kind of how that goes. In order for all of that to happen though, the first thing that needs to happen at all practices is to create that relationship between doctors and patients.

I never did finish the course description that we use because at some point in there, one of the comments in the description says that hopefully for our students we hope to give them a taste for a lifelong learning path. I know some of you are in academics or have been in academics and if you remember the academic path, you start as a novice learner. When you can

barely spell the name of the subject. That's totally teacher control.

Then the next step is the beginning learner, where you start to frame your own questions. That's the 200 level courses. Then you go through the 200, 300, the 400 level courses. Then you come to a point of graduation which we call competency, reaching competency. In dental school and hygiene school, that's saying that, okay, you get this degree, we think you're competent to practice basic dentistry or dental hygiene unsupervised for the dentist and some supervision for they hygienist but they should know what they're doing at that point too.

Then you pretty much lose teacher control and it falls over on the shoulders of the student, the learner. This course actually is the Baylor student's first taste of what professional learning is about because my mantra to them is, "I'll have a big obligation to you. I accept no obligation for you. So I'm going to point you to rich resources. The use you make of them will be determined by your own career path and where you want to go."

So as they move from graduation, they become proficient at some point. Proficiency loosely can be defined as that point after graduate school or after reaching fellowship or mastership in the Academy of General Dentistry or just after practice experience and going to CE courses, totally self-administered. Then for that handful of people that wish to go further, there's the mastery level. These are the boarded people. In dentistry, it's the American Board of General Dentistry and the specialists, it's their particular boards. So that's kind of the lifelong learning track.

Sorry to bore you with details about education but I think it's important for people to know where they are on the scale. What

we're doing is introducing them to the self-directed learning technique that will determine what they do the rest of their life. It's like that old joke that we use, "Some people have been in practice ten years doing the same things they learned in dental school. Others have been in practice ten years doing something different every year because they found a better way." So there are two different ways to look at years of experience in practice.

So the whole point of this thing in order to achieve this result that we're looking to do is to stress the behavioral science skills necessary to run the office people-wise. And also built into that is a CEO module because our students generally don't get too much in the way of business. I basically help put together with the help of some of other faculty about five years ago a new business course that looked at an MBA and deconstructed it and built it back again with a focus on issues of dentistry and business finance and that sort of thing.

Those courses are going to be made available through the Crossroads program also because we hand recruited all the people that are teaching that course and they're all nerds, they're like some of the rest of us that love what they do and they're perfectly happy to give us their content free of charge. Our reciprocal agreement is that we'll never charge for any of the contents and materials we put out there on the Dental Crossroads strictly to help people learn.

So that's what we're hoping to do is to help people build up behavioral skills so that they can build what I'm calling a patient-centered preventatively-oriented sequential comprehensive dental practice that is prevention-oriented so that there's constant monitoring of disease levels, as I just talked about.

There's a whole list of course objectives but I can kind of say it in a nutshell and it was the philosophy at the University of Kentucky. Sorry to keep bringing Kentucky up but you know, I'm like everybody else, I know what I was taught better than anything else. The good thing about Kentucky was that we had all three of those stool legs. So my objective here is to help our students become more technically capable, biologically-oriented, and socially sensitive practitioners in the oral health sciences. So that's the premise of the course.

Let's see, I guess the next thing I could talk about would be expectations for the students. The workshop, it's a selective course at Baylor. Selective courses mean that they can sign up for it but they don't have to, it's not mandated. We have a class of 106, we've got 27 that are taking the course this semester or this academic year. They're all seniors.

But I've got a number of them that wanted to—and another one just came out today that wants to monitor the course. Which is fine, it's a MOOC, it's wide open for us. The ones taking the course get an hour of credit but in that course, I'm going to ask them to write a philosophy of practice document. What will your practice be like? I want you to write your personal and your professional philosophy of life and practice.

I think that will be interesting. I think that will turn out some very interesting kinds of things because in spite of publicity to the contrary, I'm pretty impressed with today's students. I'm not impressed with some of their study habits but when I get them in conversations, I find out that they're smarter than I thought they were.

So Bill and Lynn, I think at least this generation has learned how to say it all in 160 characters. I mean, if I ask them a question, they'll put out their iPhone and have an answer here

in just a minute. So it's quite different from the way we learned but I've come to appreciate it because these kids are serious and they can have a wonderful discussion about the nuances of a case. Now there's some things that they won't know simply because they've not had exposure to more complex cases.

I should digress too and tell all of you at Baylor we have basically a vertical curriculum where the first two years are basic science and the second two are clinical sciences. The senior year at Baylor is set on a general practice model. The class is divided up into six groups, each one has a group leader which sort of serves like a residency director would. They'll have 15 to 18 students in each group. They're assigned an initial block of somewhere between 25 and 30 students and their requirement for the year is to diagnose treatment plan and complete treatment on that group of patients.

We work hard to get the patients mixed so that they have what educators call the essentially experiences built in there. Most of the students will finish that and take more. So most of them end up with a book of somewhere between 50 and 60 patients. So the senior year belongs to the Department of General Dentistry where my academic appointment is. We try to run the clinic and everything they do as near to a private practice model as we can.

That being said, those of you who are dentists will understand, they still have to sit in the chair out in a big clinic. They don't have their supplies right there by them. They've got to go to the dispensing window to get them. They don't have a dental assistant. It's pretty barbaric conditions for those of us that couldn't find our socks if we didn't have our office team. But nonetheless the students by and large have impressed me.

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I never thought I would get into dental teaching and then when I did, I didn't know what I would find. But I have been pleased with the quality of young people we're having. That doesn't mean we don't have a bell curve distribution. I think Mike knows that at LSU just like any school, they do their best to take a wide distribution of people and they end up with a bell curve distribution of competency and drive and motivation and ethics and everything else.

Allison: Can I ask you a question? I'm sorry for interrupting.

Bill: Yeah.

Allison: I was thinking back to dental school when you were talking about the technical and the biological and the psychosocial or the social sensitivity. I don't remember getting much of the psychosocial. It seems to me and I don't know what the people on the call were hoping to get but I thought this was an important point after our last phone call also.

I got straight out of school and I felt like I needed to go take more courses. I think a lot of dentists get out and we focus, at least I can speak for myself and a lot of my colleagues that kind of went down a similar path that I did, is that I don't know enough about how to keep myself out of trouble with these cases. So I started going to a lot of CE. I think I kind of forgot along the way a little bit about, I mean the biological, you kind of learn it and then you think, okay, I got that, I can check it off the list. I think it's really easy to forget that that's important.

We tend to become fixers. The patients come in and they tell us their problem and even if we're doing what we think is a good interview, at least for me, I think even with my Pankey training and some of the blessings I've had of getting to know you guys along the way, we kind of get in that fix-it mode. Then things

fail. Or maybe the patient doesn't take as much responsibility for things as we hoped they would.

Somewhere along the way we find ourselves feeling like, "Oh my gosh, I shouldn't have done that crown." I think what you're saying, I don't want us to miss—because when you and I had our preparation call for this, you didn't say it in a way that made it feel like a blow to my gut but if felt like, oh my gosh, this is important. This is something that I think a lot of dentists today have forgotten how important it is to have those conversations with patients.

You know, we learn the bleeding index stuff but I guess I was kind of hoping you could say a little bit more about that. I don't want to lose that in this conversation about the disease risk monitoring and helping people own their problems because I think every dentists on this call that is practicing or has practiced, we don't like seeing our stuff fail. It's terrible.

Then whose responsibility really was that to help make sure that it didn't fail, you know? I just wanted to see if you could circle back around a little bit and just—do you have something that can kind of bring that home or really hit home with that a little bit harder?

Bill: Yeah, let's circle back around. Thank you for bringing that up because this whole picture is so complex and all of these topics are interwoven so deeply. Your story, Allison, is similar to the vast majority of people graduating from today's dental schools because the socially sensitive part, I mean, we had four years, it was in what we called the Department of Community Dentistry. We had the first community dentists I think of any dental school back in the 60s.

The whole idea was about human behavior and understanding human behavior so that you could help patients gain the

motivation to be as well as they could be. Then when I talk about being well, we're talking about obviously periodontal disease and caries, plaque control.

Let's go back to behavior. In order to really practice that effectively and efficiently, the dentist should have been through a program like that. All of the staff should have been through a program like that. Because if we're not doing this for ourselves, what is it they say? If we talk the talk and don't walk the walk, people get that pretty quickly and ignore us. If you're going to be a credible, dependable source of information, you've got to practice what you're preaching.

So for well-being, and all of us know this now. Let me back up. It wasn't called this at the time, but at Kentucky when I went through, we had a medical model. We had no idea what a C-reactive protein was, they hadn't been found yet. We didn't understand cytokines and we didn't fully understand interleukins. We knew that inflammation was destructive and that's what caused periodontal disease.

What I'm striving at is the issue of mental well-being, physical well-being, nutritional well-being, emotional well-being, and oral well-being, all of these things are in the patient's best interest but the information is all out there. We say to ourselves, "Well, people know that. How come they're not doing it?" That's what this whole issue of empathetic listening and I call it being a cheerleader for the patient. That's why I don't ever get fussy with people. I just say, "Well it looks like the fires kicked up again" because that one analogy does a lot at helping you get where the patient is.

Maybe this will help frame it for you. I do this in my classes. I'll walk in fairly early in the course and we don't have blackboards anymore, we have whiteboards. I'll draw a big circle up there

and just fill it full of gibberish. Dots and circles and squares and figures until it's almost full. I say, "Okay, that's your patient that's coming in today and all of those marks represent something going on in that person's life."

Then I take a red felt tip and put a little red dot somewhere in all of that mess. I say, "There is your dental appointment. So remember, you're dealing with somebody that's focused on the dental appointment but all this other stuff is going on in the background and you need to be aware of that to some degree and understand that the patient may not be making exactly the decisions you think they should be making today because of these other things."

I find that to be a fairly effective teaching model. It's also effective because when you talk about having a trained staff, I mean this is the whole second part of this series where doing this to obtain, train, maintain, and retain a philosophical congruent office team. Because if your office team is not on the same page you are, it doesn't work very well. You have disharmony and a lack of congruence all across and patients sense that.

That's why I bring up this topic, the business topic, of dentists learning how to work like a CEO. You've got to be a personnel manager. You've got to be a human relations manager. You've got be the financial officer. You've got to know all of these things on the side so that you can have an effective, functional, philosophically congruent team. So that's the people business too.

Back to bringing this thing full circle. Part of the thing that we use with people, and you brought this up. If we do definitive care, and in fact, let me back up all together. Excuse me,

everybody, because I didn't finish the sequence of care that we teach at Baylor now.

The sequence of care is to deal with systemic and acute issues, disease control, and after disease control, we will do then interim treatment plan. Interim treatment plan means we're going to get disease under control. That includes malocclusion, hyperocclusion, the idea being that we've got to have a stable occlusion and healthy periodontal. So we want to get the caries under control. We want to get occlusal issues under control and we want to get all of the plaque control issues under control the best we can.

That in a sense determines what we're going to suggest next because a definitive treatment plan, and all of you that have been in practice for any length of time and for those of you that haven't been in practice a long time, let me assure you. The last thing you want is seven years after you put in $15,000 worth of bridge work is to have the patient come back in and there's recurrent caries and one of the abutments is loose and the patient didn't know it or didn't report it. Underneath it you find what's left of the tooth is a nice brownish, orange-ish piece of leather that's [inaudible 00:43:51] and all of a sudden you're out there alone.

As Allison said, what do you do? Who's responsible for that? Well it's easy to say well the patient didn't brush very well but do we have a responsibility having put that bridge in because we were in a hurry to make $15,000 and we put it into a diseased mouth? Or maybe it built it back to an abnormal occlusion so know we've compounded a malocclusion by putting $15,000 worth of bridge of work in a malocclusion because we didn't get the bite adjusted and didn't get the articulator set correctly.

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So the whole business of being patient-centered puts us in the hot spot because there are many times we've got to do things that we really would not like to do because there's a pressure to perform. That's why sometimes I think there are many good options for students today if they don't want to go directly into practice.

I got to make a quick comment because I've been talking to some people. There's an economic model out there that basically argues that new graduates can't afford not to buy an existing practice. This as so many ifs in I'm almost hesitant to even mention it but it's something that all of you can think about. This is coming from a contact of mine that's in the business of marketing at AFTCO, the ADA sponsored practice transition group.

They tell me that their statistics indicate that the average first year net income for a dentist that buys an existing practice nationwide is about $165,000, net. So they come out with a $300,000 loan and they're going to need to borrow some money to buy the practice and they're going to net $165,000 or so. Most bankers will look at that and say, "Hmm. That's pretty good cash flow. I believe we could make that loan."

So just a business thing on the side, there are many ways that students can handle the business part. That's not what this call is about but our business course gives students a timeline to follow. It starts with the students and the first thing they have to do is get their own credit scores. It's private business so they don't announce their credit scores unless they want to but the deal is they need to know what that means.

The first thing they have to do is they get spending under control and learn how to get right side up with their credit card debt because as all of you know that have been in business,

that affects the FICO score and if the FICO score is below 700, you probably aren't going to get a loan. If you're maxed out on your credit cards, I guarantee you your below 700.

So anyway, I don't mean to digress to business but all that fits in because the mindset of the dentist, the pressure is on the attending dentist. The pressure is on the new owner, the new graduate. Those are horrendous pressures and I don't even have to wonder if they gnash their teeth when they go to sleep because they do. They're worried because they've got all these bills that are due and they only had three patients today. What am I going to do?

So the issue is to plan carefully and break into dentistry in a way that's predictably successful. That's part of what we talked about in the second semester of this course. In order to do all that, communication skills, psychosocial skills, become terribly critically important. And Allison, you're right, you weren't trained that way. Baylor is strictly a surgical model. Even though in our papers we say that we're a comprehensive care, we're patient-centered and prevention-oriented, we aren't. Because nobody takes responsibility for it. The problem is none of the faculty were trained that way.

It's pretty hard to ask a faculty to do something they weren't trained to do because one they don't know how and they don't want to admit it. Sometimes when you look in the faculty's mouths, you can see that they're not practicing what they should be preaching. Most of them are in pretty good shape, but some aren't. So the whole idea is in terms of turning the curriculum around at a given school, how do you begin to do that and how do you get the faculty oriented?

Well that's also where motivational interviewing comes in because I've got a group of 15 people now to talking among

themselves trying to come up with ideas about how we can improve the student experience because at the end of each year as you recall, Allison, we have the students write their dream. The question is, if you could change one thing about your dental experience, what would it be? Then we tabulate all that stuff and we go to work to make it happen.

So we're in the middle of changing the curriculum now and we'll see how that goes. It may do me in but I'm going to plug away at it. The whole idea of all this is for the office team, the whole staff, to write their own personal philosophies to match that dental practice philosophy so that everyone is on the same page. The only way that can happen is if the dentist sits down, takes the time to put everybody through what Harold O. did originally and that's let plaque grow on their teeth until they get gingivitis so they see how fast it can happen.

Then they start cleaning and flossing correctly and they see how fast the sulcular epithelium reepithelializes and that's the end of that lesson. You don't have to repeat that lesson because people have experienced it themselves. It's internalized now to use a psychological term. When it's internalized, it's coming from themselves. They're not repeating something they read in a book.

So that whole business of positive reinforcement of optimal health becomes important. It's also important to at least broach the subject of their physical health and their diabetes. All these things have to be controlled. I think, and this is just a supposition, and probably has no place in this particular presentation but I'm going to do it anyway. I think the dentist of tomorrow is going to have to be some derivation of a model that's been around for a while and that's an oral physician.

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Nobody that reads much anymore I think can argue that there's not a link between oral disease and systemic disease. It's not a causative link. Oral disease doesn't cause systemic disease. But anything that triggers the immune response, the inflammatory cascade, anything that triggers that adds to systemic issues. So that's a comorbidity or a cofactor, the state of the mouth.

Another thing that helps—I'm firing stuff out of the far reaches of my mind. I'll get everybody to try this on for size. Sometime when you're bored and don't have anything better to do, sit down and calculate how many square millimeters of sulcular epithelium there is in a mouth with 28 teeth and 4 millimeter pockets. Then assume that there's bleeding from each pocket and tell me how large that ulcer is, that is what an ulcer is.

I can hear the phones, computers coming out now trying to figure this out. Let me tell you, it's going to be about the size of an adult palm of your hand. Somewhere between one and a half and two centimeters if it's 28 teeth and 4 millimeters pockets. That's a decubitus ulcer that would have you in the hospital if it was on your back. So that's an open gateway for infection.

I don't talk to patients about the kinds of infections or the contents of the inflammatory cascade. I simply tell them, "You know, there are two kinds of germs in plaque. One kind makes acid with sugar and starch and eats a hole in your tooth. The other kind produces chemicals that eats a hole in the gum.

The tooth with a hole in it is going to hurt. The gum with a hole in it is going to let germs in the bloodstream. They call that bacteremia, that's the fancy word. Most people call it blood poisoning. It can be fatal. And that's as complex as it has to be for patients. You know, no skin on your gums? Constant

infection. You lose teeth. Bone goes away. It exacerbates other areas of your body.

I think you leave it up to patients because you say, “You know, you want to be healthy because.” I’ll get into them too and ask them if they’ll give me a ten-year, and a twenty-year, and a fifty-year outlook about what they want their life to be like because we talk to them sometimes about behavioral issues and functional issues as they get older.

Well, diabetes is a big thing. We’ve got a lot of people in Texas that are losing toes and feet just because they won't control their diabetes. That’s an interesting conversation because then you do the same kind of motivational interviewing you do there as you do with addictive behavior and plaque control and everything else. It’s the same business. I don’t try to get into it deeply with patients, I’m not a want-to-be doctor. But I’m a want-to-be supporter and cheerleader for patients achieving the best health they can. So that’s the other part of the human behavior part.

It all has to do with how effective we are at helping patients get motivated to do what’s in their best interest already. It’s a realization that we cannot talk them into doing it. It has to come from within. That’s why we try to have them articulate in their own words where they want to go and our message is always the same, “We want to help you get there. The fact that the fire is still going in your mouth is impeding our progress.”

It’s a gentle approach but it’s a consistent, constant approach. That’s why you monitor it every time they come. So that’s pretty much the top of the pile. We could go into way more detail in another venue but that’s it for tonight I think.

Allison: Lynn has his hand up but I also want to say that you know when you're linking that back to their whole health and

everything you can also relate—to me, it just popped in my head, we're really talking about patient-centered care and we're talking about the bacteria not only getting in the bloodstream but getting in the gums and the teeth.

It all links back also to what they said in the beginning that they wanted. Just kind of what you were saying. If they want no pain then this is a way for them to get that. If they want to look good, this is a way for them to get that. If they want to be comfortable, if they want to keep their teeth, if they want their costs reasonably contained. All of the things that you said come back to this very thing. So anyway, I think I'm starting to get this.

Bill: That's the whole pitch for preventative dentistry. That was Barkley's whole pitch and that movement died when he died in that silly plane crash. There are people like me and Brown and Carlisle and others that have continued to practice it but what was a really popular way of practicing has kind of diminished because you have to keep adding fresh talent to the pool and help others stay convinced that that's the ideal way to practice. So yeah, it's all about disease control, whether it's fix the hole or systemic.

Allison: Okay. I'm starting to catch on now, Bill. This is good. I'm going to unmute you, Lynn. So you're unmuted.

Lynn: Thank you. Bill, while you were talking I was wondering how long have you been at Baylor?

Bill: I first worked at Baylor pretty soon after I left the ADA as editor, I was back in practice with my partners as their associate. The dean asked me what I thought of continuing education. I laughed and said he should be ashamed to call it education because it was a pleasant episodic social event but it didn't lead to behavior change. So he said, "Well, how would you fix it?" I said, "Well, I would make the courses more like a graduate

program where people actually do things and they practice on it until they can do it and then they go home and practice on their patients."

Then he said, "Do you think you could do that?" I said, "Well of course I could do it." Then he said, "Well, I'm glad to hear that because my CE director is retiring and I would for you to come to Baylor and do that." So that's how I got there in 1991 to revamp the CE program. So I've been there off and on well since '91.

Lynn: So it's almost 25 years. Is that fair?

Bill: Yeah.

Lynn: I'm counting on my fingers. How would you compare the students of today and the dental school's openness to patient-centered approaches versus say 5, 10, 15, 20 years ago? Do you see a shift or a change now versus a while back?

Bill: It sounds like you're trying to break my heart, Lynn. I think you know the answer. I don't see any difference.

Lynn: The reason I ask that, I would have agreed with you maybe even a year ago but I'm starting to sense that there's a shift of people. Specifically, we had a conversation not long ago and particularly with this Crossroads course, of just to have this Crossroad course in a dental school I think is cause for hope. Mike Robichaux has a similar program through the Harold Wirth Foundation at LSU. But just the fact that you're doing this, to me, is cause for hope about this. Because like five years ago, would you have been able to have this course in your dental school?

Bill: No, because five years ago I wasn't smart enough to go outside the curriculum—I have proposed this course several times to

the curriculum committee and their answer is, “Well, we’ve never done it that way.”

Lynn: Yeah, yeah.

Bill: So that’s why I went to selective because that way I can do what I want to and students take it if they want to.

Lynn: Didn’t you tell me that you feel like, you said, if I’m right, when you did this survey of the students, the senior students, if there’s one thing you’d change about your experience. Didn’t you say that this year’s seniors wanted to have earlier contact on the clinic floor, in their freshman, sophomore year? And they wanted to have more courses like your Crossroad course? Or did I make that up?

Bill: That’s correct. No, you didn’t make it up. I've actually got the written reports. I've got the actual comments the students made and that’s exactly what they said. They want earlier clinical experience and they want more understanding of human behavior.

Lynn: Yeah.

Bill: So that helps.

Lynn: So is that different?

Bill: That’s different but I don’t know if it’s the sun coming up or just that last flash of light before the sun sets. I can't be sure.

Allison: It’s the sun coming up.

Lynn: Yeah, I really think like Bill Brown and Mike Robichaux. We’ve kind of bemoaned, we’ve been tilling this soil for a long time and there hasn’t been much rain. It seems like things are starting to happen. So I’ll really be interested to see, like with my book *Motivational interviewing in Dentistry*. I think that will

give us a pretty good read on the interest in the bigger world of dentistry out of the 10,000 or fewer dentists that practice that way.

Bill: I was going to jump in a minute ago and if Mike hasn't gotten off and ask him how he feels about things down at LSU. Because he's in a situation there that can introduce this kind of thing too. I think maybe at one point you and he and Brown and I ought to get together and we're going to write another book. We're going to call it *Swimming Upstream*. It can be this long story.

Allison: Mike raised his hand but I had already unmuted you, Mike, as soon as he said that. So your mike is open.

Mike: Well, you know, it just tickles my heart to listen to this whole conversation because like Lynn and everybody on, Bill, and everybody on this call, many of us have been living this out of frustration and not being able to connect at a deep level to share the story that was just told to us for an hour. Because until they're ready to hear, there will be no listening. So I really appreciated the call.

In November, I was invited to give the keynote speech. We're having a F. Harold Wirth pin ceremony where the dental students, the hygienists, and the lab people created their own oath. They pledge out loud and then we pin them with the Harold Wirth pin. It's a pretty emotional time.

So I'm not losing hope. There are people out there that want to hear this message. I think if we just keep screaming, somebody will hear. For every dentist we help, think of how many people we help, how many patients we help. So I was just glad to be a part of this phone call. Thank you all.

Allison: Thank you, Mike.

Bill: Thanks, Mike.

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Mike: Thank you, Allison.

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