Ep #51: Patient-Centered Practice with Dr. Bill Brown

Full Episode Transcript

With Your Host

Allison Watts, DDS

Practicing with the Masters with 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 Watts: 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.

Dr. Bill Brown has been in private general practice for 45 years. He graduated from the University of Iowa in 1963 and founded Brown Dental Group in Des Moines, Iowa. After a two-year associateship, Brown opened his own practice. He soon realized that he had many hats to wear in which he had no training. Fortunately, association and studying with Dr. Bob Barkley and Dr. Nathan Kohn, Jr. opened new vistas in dental practice that were at the forefront of excellence in dental care and practice.

Holding patients accountable for their oral health was a tremendous change in dental practice. The new technology and scientific information required new systems, including using the normal periodontal tissues as the gold standard for oral health. Dr. Brown developed Dental Metrics to measure patient progress, which set a new standard for oral health.

Previously, patients went to the dentist for "cures" and were objects of treatment. Silver cures, gold cures, porcelain

cures or the ultimate failure of complete dentures. But patients were now responsible for their oral health and dentists had to educate them on the cause and techniques necessary to control their disease. For the first time, dentists enlisted behavioral scientists to assist in modifying patient compliance.

Dr. Brown engaged Dr. Kohn, a clinical psychologist with broad training and experience in the corporate world. Dr. Kohn was also associated with Washington University College of Dentistry, so he had a keen appreciation for the training and expectations of dentists. Dr. Kohn worked with Dr. Brown and his staff for more than two years developing a system of patient management that was unique and highly successful on many levels.

From those experiences Dr. Brown joined Dr. Robert Burns in the development of the Comprehensive Oral Care Model and published their book *An Approach To Comprehensive Care-the Preventive-Periodontal Concept*. This book and other articles published in a variety of dental publications furthered the cause of dental disease control and how it should be applied in practice. Dr. Brown was on the national lecture circuit at the major meetings, and many state and local meetings, study clubs and schools. He also brought his message England.

Outside of dentistry, Dr. Brown and his wife of 53 years initiated the renaissance of the grape and wine industry in Iowa. Started three wineries there, where there are now presently 110 in the state. Since 1994, they have also been involved in ecological restoration of the rarest ecosystem in temperate North America, the Timberhill Oak Savanna. That is very interesting. I wish we could talk about that too, but we're going to talk about dentistry tonight.

Thank you, Bill, for being here. Welcome to everybody.

Bill Brown: Thank you for inviting me. I really appreciate it.

Allison Watts: I really appreciate all of you being here. It really takes something these days to carve out a little bit of time to listen and come and learn. It says a lot about you that you're here listening. So we appreciate you being here. Again, if you have a question, push *2.

I want to start you off Bill by asking you, and you and I have already talked a little bit about this. About why would someone want to practice this way? Why is this type of dentistry, this conversation about comprehensive relationship-based care and even preventive dentistry relative today?

Bill Brown: That's a profound question. Lynn Carlisle and I have talked about this along with some other people who are interested in relationship-based dentistry. It's probably a fairly small percentage of dentists that would really be interested in the commitment to do what we're talking about. Part of the problem is that the value of any achievement is really measured by the magnitude of the effort you put into it. So if you want to achieve something of value, it's going to take an effort.

One of the things I've noticed over the years is that sometimes when dentists get out of dental school it's almost like they feel like they'd like to be semi-retired. That they've already done the hard part. I know that when I got out of dental school, I had like no expectations of what practicing dentistry was going to be like. As I told you, Allison, I ended up at the last minute going with a fellow in south Des Moines in a blue collar neighborhood. He was a wonderful, young dentist who had an outstanding busy practice. We saw patients six days a week. I was scheduled with four

patients an hour. Then we had the aphorism for emergencies were squeeze-ins and there were always a lot of those.

It was after about a year and a half of that, I told my wife that there must be an easier way to make a living if that's was what I was going to do to have to work six days a week the way I was. That's when I started really thinking about what I wanted to do with the rest of my life. At that time, I had a two-year-old and my wife. She was pregnant for our second child. I was going to have to go back to college and basically start over if I wanted to get out of dentistry. That's when I made the decision to build my own office because I thought if I was in my own office that I could be autonomous. That was true but I didn't solve any of my problems.

Whether it's relevant today, I would say I told Allison earlier that I talked to my friend Bob Margeas, who's a dentist in Des Moines that lectures all over the world. We were talking about this very question that Allison and I were discussing about relevance. He sees and talks to dentists all over the world. He told me that he thinks that there are a lot of dentists out there, especially young dentists that have been in practice less than five years, who dream about having an independent private practice that they own and run. Yet because of heavy student debt loads and other considerations, have been turned into worker bees.

My message in part goes to those young men and women out there that would like to fulfill their dream.

Allison Watts: That's awesome. It's true. We have a young girl in our office right now working that's shadowing us. I asked her how she saw herself practicing. She wants to have her own practice. She definitely wants to be in private practice. I don't know if

she's aware of all the changes that are happening right now but I think there are a lot of dentists that are in corporate dentistry that want to do something differently.

I think that definitely some of the things we're going to talk about tonight can be implemented or at least the seeds can be planted for how it could be.

Bill Brown: I agree. Where would you like to have me start?

Allison Watts: You can tell us the short version, but I am curious, I know you spent some time with Bob Barkley. Some of the people on this call have heard that name before and some of the people on this call have spent time with him as well but I think that's kind of a neat story if you want to tell us a little bit about Dr. Barkley and Kohn and what you learned from them and how that affected your practice.

Bill Brown: After I opened my own practice and had a stack of payment book that I had to attach a coupon and a check every month, we had one periodontist in Des Moines at that time. He was strictly a surgical practitioner. I went to his office just to visit him after he'd opened his new office. He got me in his chair and diagnosed me with gingivitis and his treatment plan was to do gingivectomies in all four quadrants in my mouth.

Needless to say, I was somewhat shocked. I was 28 years old. I was a dentist and I used an electric toothbrush. I thought, "What's going on?" He gave me the party line when I asked him what was causing it. He said it was diet and calculus and nutrition and malocclusion and all of these nebulous causes. So I went home—this is before the internet—started trying to learn what the problem was.

It was serendipitous but there was a pediadontist in Des Moines who I knew and referred to. He called me and he

said that he had been to a pediatric dental meeting in Chicago and he heard this dentist from Illinois talk about preventive dentistry. He was also a pilot, both of them were, and they were having some kind of a fly-in in Des Moines. This Dr. Barkley said that if my friend the pediadontist wanted to, he would be happy to talk to a group of dentists. Saturday afternoon, myself and three other dentists were in the reception room of this pediatric practice and we met Bob Barkley.

Bob was a dentist from Macomb, Illinois and one of the dentists in the small audience said, “Where’s Macomb?” He said, “Well, Macomb is the biggest town between Ipava and the Mississippi River.” So we all got off to a pretty good start with Bob Barkley because he had this wonderful folksy way about him. He could take really profound, scientific, and psychosocial concepts and turn them into something really meaningful for a dentist or for any person in a dental office that would be a coworker.

At that time, I had never heard of Bob Barkley. He was just starting to be known on the circuit. He hadn't really published anything. I took it as a seminal moment in my life, that afternoon. I spent like two and a half or three hours with him and afterwards I talked to him. He invited me to come down to Macomb. So in two weeks I went down. I spent three days with him in his office.

He also then told me that he was going to have a conference in Monmouth, Illinois at Monmouth College with a psychologist from Washington University in St. Louis that he’d been working with for I think a year or more, by the name of Dr. Nathan Kohn, Jr. who had studied dentistry and dentists for like 20 years. He was going to do a conference with dentists and their staffs on what they call practice analysis, like a workshop. I took my entire staff and my wife

and we went down. That was the first time I met Dr. Kohn, which was a life-changing experience in and of itself.

Allison Watts: I don't know if you can tell us the light bulb moments with Dr. Barkley and Dr. Kohn. What were your big ahas?

Bill Brown: Well, the first thing with Dr. Barkley when I said to myself, "Toto, I don't think we're in Kansas anymore," was when he explained that there was a completely different change in the relationship with the patient because of preventive dentistry and plaque management because it put the onus for oral health on the patient and not the dentist. That was an aha moment.

The next big aha moment was at this meeting with Dr. Kohn. It was really incredible. He told us about the fact that Dr. Kohn had been hired by the Illinois Academy of Practice Administration, or engaged or commissioned, to find out why more people didn't avail themselves to regular dental care. He did this study—I'll share this quote with you because it's so powerful.

Dr. Kohn said, "When a patient leaves your office able to explain to his friends his relationship with you and how it benefits him immediately and the years ahead, you've established a relationship with the patient which is the only sound basis for growth of your practice and the development of your profession. Do you enjoy this kind of relationship with your patients? Chances are that your honest answer to the question would be an unqualified yes.

If you were to appraise your practice however, you'd probably find a large number of patients who should be doing a better job of prevention. Some who need improvement in their appearance, comfort, and function, and some who come in for checkups only after repeated follow-ups by your auxiliaries. These are symptoms of

patient's attitudes towards dentists. They indicate that dentists are failing to help people see dental care in terms of good dentist-patient relationship, a cooperative, long-term effort of prevention and correction aimed toward providing the patient with a lifetime of attractive appearance, comfortable chewing, and lower dental repair costs.

Psychologists have discovered as a matter of fact that the inability of individual dentists or the dental profession to establish this relationship with patients is a major contributing factor to the problem of why more people do not avail themselves of adequate dental care. Although it is true that there are people who may reject some part of all dental services, in every practice a substantial majority of people do not have the insight or understanding necessary for them to accept the work that their mouths need.

If the dentist is blind to this lack of understanding, he may fail to approach them in the manner necessary to implement their unconscious wishes. Tragically, he does not only do this but because he feels the patient does not want the work done, he is critical of the patient and not himself. Because of this attitude of the dentist, the patient then fails to have the measure of respect, affection, and attachment for the dentist which he wants and his dental health is not maintained at the degree it should be. This results in the dentist not performing services he desires to perform and the patient not becoming a missionary in a sense of education for dentistry."

When I heard that, that was like what I'd been looking for. It was like the missing link in my dental education. I immediately wanted to start working with Dr. Kohn and I engaged him and he would come to my office, he would stay anywhere from three days to four days in a row in my office. I worked for him for a period of about two and a half

years until he died prematurely at age 52 I think it was of a heart attack. He was lecturing out in Salt Lake City.

What this said to me was that I wasn't really establishing a relationship with my patients and what I found out was that the dental office, because of this new information on preventive dentistry, I needed a whole new set of systems to deal with this because the dental office had transformed itself into a place of education primarily, not as just a place to get your teeth fixed. So that's why in working with Dr. Kohn we came up with this examination procedure, sometimes it would be three appointments, sometimes two, and sometimes one.

I think that that was one of the things that kind of got people misinformed in dentistry. They thought that you had to do a three-part examination to educate patients. It really didn't need to be that way in many instances. But it became an educational experience for both the dentist and the patient. Also, Dr. Kohn helped me with a written philosophy of dental practice which he felt that if it wasn't written that you really wouldn't be able to produce something that was meaningful, that was easily understandable and repeatable by first your coworkers and then your patients. Those were all aha moments or light bulb moments as you say, Allison.

Allison Watts: Before we get into the philosophy conversation, because I do want to do that, I know that's a central piece of your model and I know that made a huge impact on your practice. I know we could go down a total rabbit trail here and I don't know if we want to do that or not, you can tell me. What I was curious about is when you talk about educating your patients, what pops up for me. I have in my mind in our practice we mostly do a three-part exam. Not every single patient gets it, but that's what we strive for and

we definitely see the value of it. I don't always think educating the patients, in those words, is all there is to it.

I think when you're talking about this it has a lot to do with getting the patient involved in the process and having them be interested. Isn't there more to it than telling them? To me, when I think of educating the way we were taught in school is to sit and tell them what's happening with their gums and they have periodontal disease or they have this problem or that problem. To me, I think the word educate could be taken to mean that and I don't think that's what you mean, right?

Bill Brown: No, I don't. I think that the educational component really comes from treating patients as total beings for one thing and not as a root canal or an implant or whatever. I guess my feeling about the educational process, it begins, I think I even sent you a copy of the brochure that we gave new patients, adult patients, we had one for pediatric patients too for the parents or guardians. We started the process by telling them what to expect before I even met them. That was an important thing.

Then the history part, the orientation or interview part, of the examination procedure was really critically important. That's where the relationship was actually established. When we went through the dental history with the patient, you know, after you found out if they had any medical problems, you went into a specific dental history like, "How old were you when you went to the dentist for the first time?" You got lots of information there because they might say, "Well, both of my parents didn't believe in dentistry and the only time you went was when you were bleeding from both ears or had a big swelling or up all night with a toothache." Or you would have somebody say, "They started taking me to the dentistry when I was like a year and a half old and I went to

the same dentist until I graduated from high school." So you get a totally different view of who you're dealing with.

"Have you ever had a bad experience in a dental office?" That's like opening Pandora's Box. I mean, some of the stories that I heard over the years, both good and bad. Some of them where the dentist was the role model for the person for the rest of their life, they loved their dentist, they loved the dental office. Then there were the other end of the spectrum, where the dentist had alcohol on his breath and spots on his glasses and blood on his white smock.

So you get a frame of reference with the patient, a common reference point. Then you can finally come to the point where you can say, "How do you feel about losing your teeth" after you've gone through all of these other questions. The patient might say, "That's not something I'd ever want to do. I would like to keep my teeth for a lifetime."

Then you can say to the patient, "We have two main goals in our practice. Number one, that you never lose your natural teeth. Number two, that you can ultimately lower the incidence of dental repair. Do those sound like goals that you could agree with?" If they can't agree with you on those basic goals, you might be wise to take care of whatever their emergency is and then help them find a dentist who can agree with their philosophy of dentistry.

I thought back many times before I actually was doing these kinds of interviews with my patients of how I would have a patient that I had been seeing for two or three years and I found out that they didn't really agree with what I believed in as a dentist. I could have found that out at my first contact with them. So that was an important thing.

The next thing was that we would do these co-discovery as I think Bob Fraser has called it, Bob Barkley called it a co-

diagnosis, what it really entailed was a guided tour of the patient's mouth. We either used a hand mirror for the patient to hold as we went through and I responded to a checklist that my dental assistant would read off to me. Then we would go through and show the patients both normal and abnormal things in their mouths. We had to be careful because it could be psychologically deprecating but when you were finished with that, that was basically the consultation was done. The patients were ready to accept whatever treatment you were going to offer them.

What we usually did was start out with the interruption of the disease process, which was our plaque control, our preventive program. Then we would make the unmanageable areas manageable. Then we could proceed if it needed to have the expensive extensive, we could do that on their terms as far as time was concerned. It wasn't like we were going to give them the gold cure or the porcelain cure or whatever. Does that help, Allison?

Allison Watts: Yes, I think that was what I was looking for exactly. I knew there was a process that you were speaking to when you talked about educating them. Once you said "educational process" I thought, oh yeah, that's what I'm looking for. I think that was very helpful. We have a hand raised. I'm going to unmute Dr. Carlisle.

Lynn Carlisle: I have two questions for you. You talked about this co-diagnosis process. How much did Nate Kohn help Bob develop these specific questions that you just asked now? Did Nate suggest them or did Bob come up with them after he worked with Nate?

Bill Brown: I can't give you a complete answer on that. I worked, as I told you, I worked with Bob first. Soon after that I started working with Nate. It was my impression that Nate really

helped Bob develop this whole educational process. Nate's background really was in educational psychology. He was a clinical psychologist but his first PhD or whatever it was, was in educational psychology. So he was really an educator. That's what he was wonderful at. That's what he helped me with was to try to draw things that I wanted and I believed in out of me. He didn't really tell me to do this or that. He would suggest it or make me come up with the—like with my idea. So to answer your question specifically, I never heard Bob Barkley say, "Nate specifically told me to ask these questions or to do this procedure." So did I answer your question, Lynn?

Lynn Carlisle: Yeah. My second question is I often thought of this over the years and particularly now with all that's going on in dentistry and our society, what do you think would have happened with dentistry particularly preventive dentistry and relationship-based dentistry if Bob Barkley and Nate Kohn had lived into their 70s, which is close to the age you and I and Bill Wathen are now. What do you think would have happened if they'd…?

Bill Brown: The first thing that I think of is what Nate Kohn did—this happened right before he died—he wrote a letter to all the deans of every dental school in the United States with a proposal of how he thought dental education should change. In this proposal, he said that every incoming dental student should have a personality profile. He didn't call it a test, he called a profile because he said you can't flunk a profile.

He said that then have brief sessions with a skilled counselor or behaviorist to find out some of the blind spots, prejudices, biases, strengths, and weaknesses in your personality so you have a better understanding of yourself so that you can understand as the foundation for

understanding others. He then thought that there should be like almost, I think the way he referred to it was like a vestibule training, that before the students actually went into classes they should have some kind of a discussion about what the life of a dental student is, what you should expect, and what you might not expect.

It should be done in conjunction with the faculty and that the faculty then could maybe get an—and I thought back at the time of how, and you and I have talked about this, Lynn, about I much I hated dental school. I mean, I don't know how I ever made it through. Part of it was because I had no relationship with any of the professors, maybe one or two peripherally, but there was no real relationship. What Nate was talking about was actually having relationships with your mentors. Here you were the empty vessel and trying to learn from these professors.

Then he felt that that should be an ongoing thing that you should keep up. That maybe they could even have graduate students that were working on masters or PhD dissertations or thesis that they could deal with two or three students and actually act as counselors with them and help them develop as professional people. He wanted to even go on with that after graduation and then re-interview them in three years and then six years and so on and so forth.

I always felt, and of course, it was met with a groundswell of apathy. I don't think he even heard back from any of the deans in the dental schools. I'm sure they thought it was too radical and far out. But I've often thought if that had been implemented in even one school, it could have profoundly changed dentistry and the way the dental profession has moved forward.

With Bob Barkley, the problem that Bob had, and a lot of people don't realize this, his whole message was he was trying to promote a disease control program. What happened is it turned into a flossing and brushing technique. That's what the dentists took home. They went home to a drill, fill, and bill practice and tried to tack on a five-day plaque control program. It wasn't a disease-control program, it was, again, a technique of flossing and brushing instead of trying to teach and educate a patient about interrupting a disease process and of having a reference point of what was healthy and what was unhealthy in their mouths.

Bob actually was really bothered by what was happening around the country because there were all these failures of dentists trying to implement what he was saying. He turned to academia, he went to the University of Iowa, he went to UFC, I can't remember where else he went, but he turned to academia and he was trying to change things when he unfortunately died in that plane crash.

Lynn Carlisle: But yeah, I've often wondered that because as you know Bob was extremely charismatic, almost in a negative way because his charisma, like you were talking about the plaque disease control program, the dentists reacted to his charisma and didn't really hear his message. You and I and Bill Wathen and Bob Fraser and Mike Schuster and a lot of other people have spent our dental lives trying to promote what Bob talked about but none of us have the charisma that Bob did.

Bill Brown: Oh absolutely. Yeah, I remember the specific incidence that I told Barkley about. It really upset him. I had a patient, she was a grade school teacher, a really nice gal. She came in and we took her through our plaque control program, which we called it our disease prevention program. She loved it,

just thought it was wonderful. She ran into a guy that she'd actually gone to high school with who was a dentist, a young dentist in Des Moines. They went to the same church. She told him, she said, "I've learned how to take care of my mouth and I just think it's wonderful." This dentist looked at her and he said, "Are you nuts? We learned how to brush our teeth in fourth grade. What a rip off." I told Barkley that story and he just groaned.

Lynn Carlisle: I know, I know. Well thanks, Bill, you answered my questions.

Bill Brown: Good. You're welcome.

Allison Watts: We have another one, Bill Wathen.

Bill Wathen: Just a real quick comment about Bill's comments about the educational process. It is educational process. The whole thing starts with the dentist and all of us that have talked about knowing yourself. Knowing yourself is a whole lot more complicated than most people realize. It's sort of a lifelong study.

The second point, welded to the dialogue with patients is that I think it's important for anybody listening to understand you can't use Bill Brown's words. You can't use Lynn Carlisle's words. You can't use Bob Barkley's words. You can't use Bill Wathen's words. It has to come from your own insides, from your own understandings, and your own value system. That doesn't mean that you can't repeat some of the words but it has to be internalized as the psychologists would call it. Once that happens, the whole trick in my experience has been to help patients get where they want to be.

So we used to call it reflective listening—Lynn, you know this. I think all of you know that Lynn wrote a tremendous

book on motivational interviewing. We used to call it reflective listening back in the days when I was doing clinical psychology but the issue is paying attention to what patients want out of the dental experience and giving them time to voice the things that we know they want. Then help them as Bill Brown just said, helping them get where they want to be on their timeline within financial ranges that they can use.

Once that happens, it's just simply a lifelong dialogue to help patients move toward wellness and that's the beauty of today's world where we've got more and more information about the oral systemic connections because inflammation tends to be at the bottom of a whole lot of diseases. Didn't mean to jabber so long, but, Bill, it's good to hear you again on the interview and, Lynn, I'll talk to you later.

Bill Brown: Okay. You know, in fact, to kind of hitchhike on Bill Wathen's comments, and you mentioned this earlier, Allison, one of the things that Nate Kohn emphasized to me and I'm sure he must have to Bob Barkley, Lynn Carlisle, is what he felt that this process in the co-diagnosis examination, it was involving the patient in their health story. I thought that was a wonderful way to think of it in terms of. Sometimes it was the first time they had ever been able to verbalize how they felt about like if they'd had a bad experience or a good experience in a dental office or what they felt about their teeth or the prospect of having to have procedures done in their mouths. So they were involved in their own personal health story. I think that's a really important component.

Allison Watts: Yeah, I love that. I'm just going to point this out, this maybe the stater of the obvious, but I'm noticing that almost every time you talk about this you talk about how the patient feels about things, how they think about it. It's not necessarily an

intellectual conversation. We've talked about knowing yourself and the bottom line is, who is this person? You want them to know who they are. Is that what you're saying, you want them to know who they are in the context of their dental health and their health story?

Bill Brown: Something as basic as having them understand for instance that bleeding of the gums is not normal. When I was in dental school, we had a perio department in name only. Until I really went back to school with Dr. Bob Burns who was a periodontist, he won the Orban Prize, I mean, the guy was tremendous. He made me realize that what the real gold standard was was 32 virgin teeth in perfect occlusion with no bleeding of the gums and the anatomy the way it was supposed to be. But what most people think is normal is actually what's average, which is disease. So that's one of the things that we wanted to try to do is to give them that perspective with their health story in the examination procedure. Does that make sense?

Allison Watts: Yeah, I like that. So you're relating where they are to where they could be. You're helping them see where they could be and helping them move toward that.

Bill Brown: Right, and it was a realizable goal.

Allison Watts: Right. We've got another question. I'll come back to mine, okay?

Ryan: This is Ryan.

Allison Watts: Hey, Ryan.

Ryan: How are you?

Allison Watts: Good.

Ryan: I was just listening to you say that just now about bringing the patient to the awareness that they need something

different or they can have something different. I would like to hear what Dr. Brown has to say about why that's important to the patient. Then what's possible is great, but why does that even matter to them? I feel like that's an important piece for patients to really want to actually move forward and do something about it. You know, why it matters to them.

Bill Brown: I always felt that this comprehensive oral examination that I did on every new, adult patient in addition to involving them in their health story, I realized that it was what was best for them was finding out what all the conditions were in their mouth, both normal and abnormal.

The examination procedure itself was a powerful, nonverbal communication tool that I was going to be thorough with them. It also helped me break their so-called preoccupation barrier. When somebody is thinking about the teenage son that just got a speeding ticket or the fight that they had with their spouse at breakfast that morning, how do you get through those everyday things that people have to deal with? That's one of the ways that it was. Then we used the checklist. In fact, it was interesting, one of my good friends had a fixed-base airport. I asked him why pilots use checklists. He said, "We don't want to land with the wheels up."

Again, it was non-verbal communication and I've read that most people don't retain 20 percent of what they hear. So I wanted to try to have this common reference point with them so that they would understand what was going on in their mouth and what it could be. In other words, if they wanted to. It's like what Bill Wathen said earlier, they have to decide what they want. I can't decide that for them. But they have to be educated enough so that they know what is

a possibility. I don't know, Ryan, I don't know if I even answered your question.

Ryan: Yeah, I think that definitely hit all around it. For me, I think for us to ever be able to truly help people treat conditions and help them get to that place, we have to treat the relationship first. In doing so, I think we can get to the bottom of what they want and why. Then what we find and what's possible actually matters because we connected to something. But yeah, you answered my question.

Bill Brown: I also told Allison earlier when we were talking about this podcast, I said I've often thought if you want to get an annual physical and you went in through your physician and he didn't check your heart or lungs or your blood pressure or weigh you or measure you in any way, I mean you'd probably say, "What is this?" You'd get up and probably find another doctor.

Let's say that he did all that stuff but never wrote it down and had no way of keeping track of it and you came back a year later and he says, "What was your cholesterol level? What was your blood pressure?" It sounds preposterous but I know that it's changed a lot with the new software where the hygienist can put the information metrics in to see if patients are getting better or worse.

The most important thing that I think we as professionals can offer our patients is diagnosis. I mean that's really the reason for our professional education is diagnosis. It's all based on a comprehensive examination. When you first see a patient, this is my own prejudice, but when you first see an adult patient, the dentist should be the one that's doing the examination. It shouldn't be a hygienist or a dental assistant. I think that that's a critical fallacy in a lot of

practices. I don't know if I'll get any response from that or not but that's my own personal belief.

Allison Watts: You know, Bill, I've heard that comment that diagnosis is the most important thing that we give our patients. What I loved was the other day when we were talking you said, "If you go to the doctor and they misdiagnosis you, everything else from there is like…" That made total sense to me. Even though I've heard that before that diagnosis is the most important thing, I think on some level I got it, but when you said that, I thought, wow, that's so true. If something gets misdiagnosed or doesn't get diagnosed…

Bill Brown: The other thing is then—this I'll direct to Ryan—you as the dentist are what the patient experiences. How the patient sees you is how the patient sees dentistry. So you have to ask yourself the question, how does the patient see the dentist? How do you as the dentist want the patient to see dentistry? You have to consider how the initial contact between you and your staff and the patient influences the role the patient assigns to you. Also, to the patient's view of oral health.

I said to Allison the other day, if the new patient goes in and basically the dental hygienist does the examination and the diagnosis and then the dentist happens to come by for a drive-by exam to see if there are any holes or spaces to fill, that shows the patient that you as the dentist are assigning your role as a professional to someone else. I don't know if I'll get an agreement or disagreement on that, but that's again my own personal opinion.

Allison Watts: Hallelujah. Amen. Ryan, do you have any more questions or can I mute you?

Ryan: No, mute me.

Allison Watts: Okay, I'm going to mute you.

Bill Brown: I was just going to put one little old thing in here. We had a mantra for our new patients. I would say to a patient, "What dental care have you had in the last five years?" Many times they'd say, "Oh my god, doctor, you're going just take me out and whip me because I haven't been to the dentist." We had a mantra. It was we had unconditional amnesty for dentist evaders. When you'd say that a patient, try it the next time somebody tells you that they're really guilty about not having been to the dentist. Try that. "We have unconditional amnesty for dentist evaders." See how it lets them off the hook and how much they appreciate it.

Allison Watts: That's nice. Yeah, so speaking of that, that's what I'd like to touch on because I can't believe it but we're getting close to the end of time. Can you finish us by talking a little bit about your model and specifically maybe a little bit about the philosophy and how it's the center of the model? Could you just share the model with us? The importance of the model or how you use it?

Bill Brown: I'll give you the CliffsNotes version of that. What happened was working with Bob Barkley and working with Nate Kohn and Bob Burns, I realized that I had to develop whole new systems. This transformation took place over a period of probably two and a half or three years. It wasn't like some overnight thing. What I came up with was these five pillars of the practice. The first one was dealing with patients as total beings, the humanistic. That dentistry is primarily about people and not teeth. That goes for your coworkers as well. I mean, how important is that?

That was the first element, component of comprehensive oral health care. The next one was the biologic considerations. That's what I was talking about like being

able to really understand the biology of health and disease and the anatomy and what's normal and what's abnormal. Being able to translate that in ways that patients could really understand it and so that your coworkers could understand it.

Then the third element was the diagnostic. That was the most important thing that we could offer our patients and that was completely based on a comprehensive examination.

The fourth part was the therapeutic which is where most of dentistry takes place but we were able to let patients off the hook if they didn't want to for whatever reason, whether it was financial, emotional, or whatever. If they didn't want to do the extensive expensive treatment, that was their decision. What we did insist on is that they had healthy mouths and unmanageable areas made manageable.

Then the glue that held the whole thing together was the philosophy. It was the written philosophy. Allison and I talked about that. I have a whole thing on how I put this thing together. I had a patient who was a PhD educator and he helped me with it. We called it "Extensions for Change." How we did this with the examination and so on and how we implemented it in our practice. So that is how comprehensive oral healthcare came about. If there are any comments on it, I'd be happy to listen.

Allison Watts: I can open the lines up because you did great. All right, let me open up the lines and then everybody can say hello and goodnight and ask questions if you guys want to. Let me open everything. Okay, there. So you guys are unmuted.

Caller: Great, Bill. You did a great job.

Bill Brown: Well, thank you.

Allison Watts: Anybody have any questions, comments?

Allen: I just want to say thank you and good night. Nice meeting both you and I hope it will happen again and again.

Allison Watts: Thanks, Allen. Great to have you here.

Bill Brown: Fun to be with you all.

Caller: Thank you so much. I thoroughly enjoyed listening and have a good night, folks.

Allison Watts: You too. Thanks.

Caller: Thanks.

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