How I Built a Successful Dental Practice and also Served Special Care Patients

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Cosmetic, Implant & Family Dentistry

I opened my solo fee for service practice, 27 years ago in an upscale community where 200 other dentists also made their living. The question was, how to set myself apart as a G.P. What could make me stand out?

I went the usual route of introducing myself to specialists in town. Then I went to the Medical Doctors in the area. I gave them a presentation to enlightened them: that a dental education included heavy pharmacology, medical and psychological disorders, aging and various disabilities, transplants dialysis, biopsies, and head and neck knowledge. Dentistry is a subdivision of medicine and plays an important role in maintaining a patient's overall wellbeing and confidence. I explained that we are all partners in the care of patients. I needed to know I could refer patients to them and that they were aware that I would be available for their referrals if they felt a patient required a consult.

That step led me to receive medically compromised and physically compromised patients from various specialists in the private sector who either were not comfortable treating those “complex people”, or did not want to allocate extra time, as would be required, in their practice. Since my practice was still small and growing, time was available. Seeing a patient who needed 15 or 30 minutes of extra time meant I was expanding my patient load and getting paid, rather than staring at the walls worrying about meeting overhead expenses. This led me to try to see local homebound patients, whom I learned to schedule during my downtime. Word got out in the community, and suddenly a homebound medical doctor and a visiting nurse service began referring occasional patient. While all of this was beginning to grow nicely, so was my Cosmetic, Implant, and Family office practice. Instead of seeing 15 to 25 patients per day, 5 days per week, I chose to slow my pace, breathe a little, and see 6 to 12 patients some days and 1 or 2 house calls on other days, working 5 or 6 days per week.

I discovered that although I never joined Medicare or Medicaid, HMO's or DMO's, Special Needs patients and/or their families who needed my services were quite willing to pay out of pocket for high quality work. I performed exams, cleanings, simple composites, denture adjustments, repair and relines, and simple extractions at the bedside. Traveling X-ray vans took my x-rays. I did not always need my dental assistant (but since she was salaried it was no big deal if I did.) Patients were willing to pay for the house call and the treatments. If a case was too involved the medical doctor and I developed a plan to ambulate the patient to my office, and an Anesthesiologist was scheduled for the case, if necessary. It also did not hurt that I had O.R. privileges at a university hospital (where I taught Special Care Dentistry to GPR I’s) to accommodate more serious cases.

While it was fun placing implants and doing full mouth cosmetic cases in my office for routine patients, it was also rewarding and satisfying to know I had helped people who could not get the care they needed or desired from other doctors in the community.
You do not need the latest and most expensive equipment (often to be replaced every 3 to 5 years). You do not need high overhead (it always behooves us to control overhead while maintaining or enhancing quality.) What is important is patients feeling comfortable to contact you at any time, to trust you and truly appreciate you. Seeing throngs of patients each day is exhausting and can leave you feeling unfulfilled and with little free time to enjoy family and personal life in general. You need to examine your fee schedule to maintain a desired lifestyle, while being cognizant that you are not causing undue stress for your patients. You need to keep a happy staff. They have a stake in your success.

I have had a very comfortable lifestyle. I traveled to interesting and beautiful destinations, dined at some of the best establishments, enjoyed great shows and art museums, watched the whales up close and had the thrill of viewing the Aurora Borealis in Northernmost Canada. I was able to put my children through college and grad. school. I was able to be there for them when they needed help and support or even just the latest new cell phone or the hottest concert. I have seen them each achieve success in their chosen fields. I have retired to a beautiful home in a great area of Florida, and I maintain a vacation home in a wonderful hamlet in Atlantic Canada. I took 100 credits per year and achieved my mastership in AGD, a fellowship in geriatrics, and a diplomate in special care dentistry. I remain a member of AGD and SCDA.

I was always a sole practitioner and owned the building where my practice was located. I did all this as a General Dentist! I have much empathy for the less fortunate, and I made it work for me. If we all could take the time to go on a house call (or perhaps 2) or be willing each month to take a little extra time to see patients who have issues, many patients would be living better lives, and they would have you to thank! It does not require a special degree. It does not require loads of heavy equipment or a huge van. It does require your knowledge, your compassion, and just a little extra time and perhaps a good old-fashioned house call bag too!

Do you have WISDOM you would like to share with colleagues?
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Ignorance Is Bliss
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We’ve all heard this statement, but, unfortunately, it’s especially true when related to nursing home patients. It’s understandable when nursing home staff and/or family members don’t grasp the importance of appropriate oral healthcare for their loved ones in nursing homes. They are fairly overwhelmed with the whole end-of-life scenario, medical decision-making, etc. However, it is another issue entirely when our dental colleagues do not understand. Let me explain.

A common response, when I ask the nursing home staff about their idea of proper dental care, is, “we only refer patients when they have oral/dental pain.” Similarly, family members may say, “why would we do treatment, when they aren’t in pain?” When this occurs, I share the following points of reference to overcoming this ignorance:

- Medical literature advises that patients with cognitive issues cannot tell you if, nor where, they hurt. So, if you are waiting for the patient to tell you, you are waiting on the wrong person.
- In dentistry, like medicine, pain is not going to be an issue until the pathology is quite advanced; whether it be decay/cavity or periodontal problems. So, as you might guess, the earlier you catch the problem, the better as regards dental stability, comfort/discomfort, and finances.

I think the real issue is that the nursing facility staff concentrates on the most pressing, painful issue and so, the “ignorance is bliss” quote becomes key. And, while that’s understandable, it’s certainly not in the best interest of the patient since dental care is rather easily accomplished in the earliest stages of dental issues. So, bottom line, it’s up to us, the dental health professional, to keep advocating and educating so we can “stamp out ignorance”.
The problem comes in when dental health professionals don’t understand the numerous issues I’ve discussed above. I’ve certainly had numerous dentists over the years, that were responsible parties, advise me, when I called with a treatment plan from the exam they requested I do, that they just wanted their loved ones teeth cleaned, “since they weren’t complaining of pain”.

How does that make sense coming from the mouth of a dental colleague? Academically, it doesn’t make sense, but, realistically, I’ve found that the average dentist is not well-schooled in treating elderly patients (who are medically complicated), especially nursing home patients, who also exhibit cognitive- based cooperation issues. So, we need to “get the word out” about what’s “appropriate dental care” for the elderly and nursing home population. In this case, knowledge is bliss.

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