Guest Editorial

A Referral-Based Periodontal Practice – Yesterday, Today, and Tomorrow

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Like it or not, if you are a periodontist, you depend on general dentists, first, to identify patients with periodontal needs, and second, to refer them at an appropriate time in their disease process. Over the years, the American Academy of Periodontology has attempted to facilitate this process through the creation of *Parameters of Care*,[1] *Guidelines for Periodontal Therapy*,[2] the Periodontal Screening & Recording (PSR) program, and educational programs such as the Professional Partnership Program. Despite these efforts, the referral process has remained problematic for both new and established practitioners.

This month's *Journal of Periodontology* contains an article by Cobb et al.[3] evaluating the difference in referral patterns in 1980 versus 2000 (pages 1470 to 1474). Those 2 years happen to coincide with my (MKM) first full year in practice and the year my aspiring partner (ETS) entered practice. One of the most important issues for the periodontist establishing a practice, that of being referred periodontal patients at the appropriate time in their disease process, remains a problem today as it was 20 years ago. The dynamics behind the referral process, however, have changed dramatically over the past 2 decades, causing the problem of obtaining appropriate and timely referrals to become even more challenging – especially for the periodontist building a practice. The experiences of my partner in obtaining referrals at the appropriate time in the disease process have differed considerably from my own experience 20 years ago, yet our goals remain the same – providing successful periodontal treatment outcomes. If we are to continue to meet these goals, and if our specialty is to remain the premier caregiver for the diagnosis and treatment of periodontal diseases and replacement of lost dentition, we must face and successfully overcome many new challenges.

The Cobb et al. article evaluates the differences in referral patterns in 1980 and 2000 in three different periodontal offices. The authors found that patients referred in 2000 were older than those referred in 1980, exhibited a greater number of missing teeth, had more severe disease, had less incidence of cigarette smoking, and required extraction of more teeth. Based on the advances in knowledge and technology over the past 20 years, one would expect our current referrals to reflect the opposite trend – referrals would be younger with less advanced disease. We doubt, however, that these results come as a surprise to any practicing periodontist. The data provided in this study should not be confused with epidemiologic information pertaining to disease prevalence, severity, and tooth loss. Instead, this information should inspire today's periodontist to analyze the current trends in patient profiles and use this information to plan for the future. Cobb et al.'s paper points out that epidemiologic studies have indicated that prevalence rates are not reflective of the periodontal care that is delivered. In other words, the majority of existing disease is left untreated. Reasons for undertreatment include the patient's lack of accessibility to care and poor economic status, managed care, patient anxiety and/or fear, patient non-acceptance of referral and/or treatment recommendations, and ultimately, the control of the primary caregiver in initiating the referral for treatment. Access to care and the socioeconomic structure of our culture are issues that must be addressed to assure that those most in need of our treatment and education receive it. Our practice would support the notion that managed care has not had a strong influence on referral patterns in our geographical area. The most significant roadblocks preventing appropriate treatment seem to be the patient's anxiety, fear, lack of education, and lack of acceptance of being referred, as well as the fact that the initiation of the referral is ultimately in the hands of the primary caregiver. If the referral is made, the question becomes whether it is a quality referral, or a referral made because of an acute problem that cannot be solved by the referring doctor. Often in the latter cases, the patients are in pain and are not well prepared for the diagnosis and treatment plan we develop for them, and do not receive the treatment they need. A quality referral solves many of the anxiety and fear issues. The patient has been educated on the benefits of advanced periodontal care, and is more likely to expect that the experience will be a positive one.

When I was building my practice in 1980, several factors influenced the way general dentists referred

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patients to a periodontist. A basic tenet of the day was that "good" dentists referred patients to a periodontist, or at least never admitted otherwise in public. Morally and professionally, it was the right thing to do. Today, it is not uncommon for some general dentists to proclaim that they alone can identify and treat all their patients' periodontal needs. Since 1980, practice management seminars have been encouraging general practitioners to partake in soft tissue management protocols, and non-surgical treatment is looked upon as a much more important income center in the business model of today's general practice than it was 20 years ago. Many of today's graduating dental students are burdened by significant student loans and may delay their referrals to maintain their revenue stream with soft tissue management programs. Increased knowledge pertaining to host modulation and chemotherapeutics is intriguing, but that knowledge needs to be utilized by those trained with proper outcome assessment abilities. Many of today's referring doctors can be strongly influenced to delay their referrals and maintain their revenue stream with soft tissue management programs that have not created strict guidelines for outcome assessment and have not delivered definitive periodontal therapy.

In 1980, the specialty of periodontology and treatment of periodontal diseases were clearly understood by the profession. Dental education emphasized the importance of periodontal health as related to proper patient care. Dentists knew what periodontists did, and dental students had significant interaction with periodontists while in dental school. Today, many periodontal courses in dental schools are taught by hygienists. Because of the general practice model used in some dental schools, there is far less opportunity for contact between dental students and periodontists. In this model, a general dentist leads a group of students through multidisciplinary treatment without the guidance of specialists. The average dental school curriculum, which in the year 2001/02 contained 4,888 total clock hours, devoted only 295 clock hours to periodontics.[4] The student is exposed to fewer hours in periodontics, while the scope of periodontal practice has broadened. Many of today's young dentists do not understand what periodontists do and what value they bring to patient care. Most of Dr. Scheyer's referrals do not come from young dentists who would be considered his peers. Instead, they come from established practitioners who have mature practices and possibly a more periodontally aware philosophy. It is our opinion that the reason for this is not so much the difference in financial security between the young and established practitioner, but the fact that the established practitioner has the periodontal education experience and understands that they need to maintain optimal periodontal health in their long-term patient population. Again, it is up to us as periodontists to educate the general practitioner on how we can make their practice stronger and better equipped to manage patients.

Another reason the new periodontist was able to build a stable referral base with more appropriate periodontal referrals 20 years ago was that there was little confusion regarding when advanced treatment was indicated. At that time, the "5 mm standard" was a fairly common guideline in periodontal treatment.[5,6] Mild to moderate periodontal cases were often referred to our office. If the periodontal pocket could be reduced to less than 5 mm through scaling and root planing (and periodontal offices did most of the scaling and root planing at that time), then surgery was not indicated. If the probing depth remained greater than 5 mm after scaling and root planing, then surgery was necessary, and was almost always performed by a periodontist. There were clear guidelines for reevaluation and definite endpoints of treatment – pocket elimination. And, there was no doubt what surgical intervention achieved.[7] Today's treatment of periodontal diseases employs different endpoints that may be more subjective and difficult to interpret. Therapy is focused on disease management, and even the best informed general dentist may have difficulty evaluating the effectiveness of periodontal treatment performed in his or her office. This may be why most of today's periodontal referrals have severe disease and teeth with questionable prognoses. Unless researchers and industry provide us with better ways to monitor disease progression, as well as treatment outcome, this trend might continue.

Disease prevalence and severity have not increased dramatically within our population, but instead, periodontal referrals today consist of patients with more severe disease and a greater need for dental extractions than patients referred 20 years ago. This demographic change is likely due to two factors: 1) the success of periodontal therapy delivered in the general practice is not appropriately reassessed, and 2) dental implants have greatly increased in popularity. Literature support for dental implants has had an influence on which teeth will be treated and maintained via periodontal therapy or extracted and replaced with an implant-supported prosthesis.[8] All of this builds a strong case for making sure that our specialty remains a leader in implant dentistry and that we are

involved in relationships with general dentists who want to successfully treat periodontal diseases.

Disease etiology and classification were fairly simple in 1980. Disease was plaque based, and it was believed that the host played very little role unless, of course, the treatment was unsuccessful and then the patient was thought to be refractory. Patients either had gingivitis, which would progress to periodontitis if not treated, periodontosis, or insufficient attached gingiva. Etiology and classification are much more complex today, providing the periodontist with better knowledge to diagnose, establish accurate prognoses, and successfully treat periodontal diseases. Unfortunately, that knowledge has not translated well to general practitioners and hygienists. Because there is much more confusion now than ever regarding the etiology, diagnosis, and treatment of the complex periodontal patient, it is incumbent on each one of us to continue to educate our communities.

Increased public awareness of the periodontal-systemic link has at least provided the initial caregiver (general dentist) the ability to improve patient acceptance to manage their periodontal diseases. The periodontal-systemic link is the only wild card on the horizon that could possibly reverse the trends discussed here. If the links between periodontal diseases and systemic health or disease are undeniably and directly verified, then the entire referral landscape could change. It is likely that many more patients would be appropriately referred, and it is equally likely that our profession would face new challenges, such as physicians beginning to treat periodontal diseases, or even more competition between the periodontist and the oral surgeon as to who will be the source for dental knowledge in the medical world. We must work tirelessly to educate dentists and the general public and continue to assume leadership in periodontal and oral medicine developments.

The American Academy of Periodontology's 2020 Vision recognizes the changes in the referral of periodontal patients and acknowledges that in the future, most treatment for slight to moderate periodontal diseases will be rendered by general dentists and auxiliaries. It is essential, therefore, that our specialty continue to educate general dentists and hygienists to ensure that the periodontal population is well treated. Periodontists will surely continue to treat severe periodontal diseases and disease in systemically compromised patients, but the question remains whether this model will produce enough referrals to sustain a vibrant practice. The environmental scan performed during the Vision process suggests that the answer is probably "no." If this is correct, the importance of educating dentists and dental students on the value of collaborating with periodontists becomes paramount. Periodontists must continue to have an influence in American Dental Association guideline development as well as an influence in education in academic institutions. We must work diligently to educate general practitioners and auxiliaries through all avenues possible. Today's successful referral-based practice depends on the strength of outreach programs to the general practitioner, not only for education pertaining to diagnosis, prognosis, and treatment of periodontal diseases, but also for information about periodontists' abilities to expand treatment opportunities involving oral plastic surgery, regeneration, oral medicine, implants, and other advanced therapies and technologies. As periodontists, we do not want to abandon our heritage, but we cannot depend on referrals for periodontitis to be the foundation for our practices in the future. We must embrace the 2020 Vision and, even more importantly, begin taking the steps today to make this vision a reality for our own practices.

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