AN ETHICIAL, BUT NOT EASY, PATH

INTERVIEWING DR. REBECCA GRIFFITHS

HOW LONG HAVE YOU BEEN IN PRACTICE, WHAT DO YOU PRACTICE, AND WHERE?

I had $250,000 debt for dental school and four years of accompanying living expenses when I graduated from Temple University as a dentist in 1982. My best options for employment were the military, which I was strongly considering, or working in a group-owned welfare clinic in downtown Philadelphia for a gross salary of $100 per day. I chose the welfare clinic, which was set up administratively like the dental school, and it became essentially my unofficial residency in endodontics.

About nine months later, I entered into a group partnership situation with my ex-husband, who was also a dentist and in the same boat financially. Together we purchased a well-established large practice, the building in which it was housed, and a home shortly after. Within two years of graduating, we had $1.25 million of debt. After seven years of extremely frugal living, driving old cars, not taking vacations except for driving to campsites for rare weekends, and working the practice twelve hours per day and six days every week, the debt was gone.

While practicing in Pennsylvania, we developed and produced a comprehensive, thorough, and efficient staff video training program called *The Video Dental Assisting School*®, which is copyrighted in the Library of Congress. The timeless and pertinent information it contains is still used today by trade schools, community colleges, and dentists who use it as their curriculum for their own staff training schools. It is also used by many individual dentists who desire cross-trained staff quickly or by those who want to hire the personality to fit in with their team and the candidate doesn't have any dental training. This training program was conceived to satisfy our own needs to limit the potentially serious effects of staff turnover, medical leaves, personal days, and vacation absences. We saw the need in the profession for a program like this, and it worked so well for us that we made it available to all through its website, www.dentalvideo.com.

We sold the practice in Pennsylvania and moved to Arizona for the weather in 1999. The marriage and practice partnership failed, and I went out on my own into solo practice in 2002, taking less than 30 patients with me. After over ten years of being debt-free, I was now in debt again from building out my office in Phoenix and having few patients from whom to derive income. My mentors were extremely important to me during that time, encouraging me and convincing me that I would succeed on my own, while others predicted that I would fail. My professional ethics never faltered; they got stronger. I continued to practice the same way I had my entire career, spending time with patients, treating them with respect, and providing excellent care. My passion for 27 years, since 1985, is treating TMJ/head pain patients successfully and non-invasively, having been one myself, and I continued down this path whole-heartedly. This type of practice requires seeing few patients each day and challenges regularly your knowledge of anatomy, neurology, and physiology when presented with each individual patient's symptoms. It is very unlike routine dentistry and not many of us practice this way.

In my solo practice, I could no longer participate with insurance or accept their fee assignments because of the associated need to produce in volume. The overhead expenses for time and materials were too high to accept insurance assignments. My oldest patients of record, and those I attracted since, understand this concept and remain in my care. Many think insurance plan participation represents "free" marketing, but it exacts its cost in reduced procedural income, reduced

doctor/patient interaction, can produce compromised professional ethics, and can produce increased professional burnout from the volume it requires to be successful with it. I have witnessed all of these side effects in my previous practice experiences.

Instead, I have developed a referral base of other healthcare practitioners who understand my TMJ treatment protocols and are impressed by the results we accomplish for our mutual patients. Other dentists may send me their TMJ patients and they know I will return those patients to them for their general dental needs. My website was one of the first TMJ sites on the Internet in the 1990s, and although the format looks antiquated, it still provides me with patients. The path I have taken for the last ten years has not always been easy, but it has been fulfilling for my soul. My passion has grown for the way that I practice dentistry and for the rehabilitation of the patients I am called to serve.

DO YOU HAVE ANY HOBBIES THAT YOU'D LIKE TO SHARE WITH YOUR COLLEAGUES?

My main hobbies are spending time with my daughters, cooking ethnic foods, scuba diving, and skiing. This next one may be considered nerdy, but I also enjoy communicating with patients via the internet. I try to help them understand and validate their symptoms from a functional standpoint and try to give them hope when others tell them, "It's all in your head." I have been contacted by patients from Thailand, England, South America, Ireland, and elsewhere. Although I know I probably will never see them as patients, I try to find them competent practitioners in their home area or at least in their country or state through my memberships in the American Academy of Craniofacial Pain and other international organizations.

HOW DO YOU SEE THE FUTURE OF DENTISTRY?

I see too many caring, young professionals matriculating with large amounts of debt and less than adequate understanding of functional dental anatomy and dental occlusion. The interest in dentistry as a career waned in the 1990s and as the applicant pool reduced, many dental schools closed their doors. Renewed interest in the profession, which I believe was spurred on by demands for cosmetic dentistry, implants, and the financial rewards they supplied, mushroomed the applicant pools for dental schools. Instead of keeping the bar raised with regards to admission requirements, more dental schools opened, and the previous average requirements for admission were lowered in many. Unfortunately, this has produced too many dentists with too little prerequisite knowledge.

WHAT WOULD YOU CHANGE ABOUT CURRENT DENTAL EDUCATION?

When I was a freshman dental student, way back in 1978, dental anatomy and dental occlusion were separate courses, as they should be. Now it appears that

the concepts of anatomy and occlusion have been integrated into courses for the other disciplines of dentistry. I have not been impressed with the results of this integration. Many practicing dentists do not understand, nor can discern, a restoration that will function well as opposed to one that will not. Patients can tell from their symptoms that something isn't right, but they are dismissed summarily as expecting too much, or they are sent for endodontics. The endodontists I have worked with have told me that they often perform adequate occlusal adjustments and send the happy patients on their way.

One of the more disturbing observations I have made in the last 10-15 years is that dental laboratories are producing restorations with far less than ideal interproximal contacts, facial/lingual contours, and in hypo-occlusion. The laboratories brag about their "5-15 minute delivery times" because no adjustment is necessary. This is a pet peeve of mine. Key supporting stops are being omitted and most often, if there is any occlusal contact at all, it is on the inclined planes of cusps or the wrong cusps. Occlusal tables are too narrow compared to the natural tooth it is replacing and inclined planes are too steep or too flat for the opposing and adjacent teeth. Lateral, medial, and interproximal food traps abound in our patients' mouths, along with thermal sensitivity from improper occlusal contacts. TMD, bruxism, gingival recession, wear facets and cracks on the teeth appear as results of iatrogenic malocclusion. Restorations are seated permanently at the try-in visit, so patients don't discover that it isn't right until they try to function with it and symptoms appear. Dentists are not receiving the proper training necessary to enable them to evaluate restorations adequately and to refuse to place those that do not meet the requirements of a good, functional restoration.

The advents of the sectional impression (triple tray), quadrant dentistry, one visit full mouth reconstruction, and the increased emphasis on the business profitability side of dentistry seem to have produced many TMJ/dental rehabilitation patients for those of us that still practice the "old school" type of dentistry. Something is terribly wrong here, and patients are suffering because of it. Let us not forget that most patients appreciate excellent work and trust us to produce it for them. Profitability will happen when patients recommend you to their families and friends, and your practice grows because of it. Priceless!