We’re dentists. We went to dental school. We were told that we would become “physicians of the oral cavity,” and then we spent four years learning to become tooth and gum doctors. We graduated and unlike our friends in medical school, who were appropriately prepared and trained for their internships and residencies, we found that we were less than well prepared to become private practitioners. Many of us quickly joined the ranks of those private practitioners working, in our own offices within our own four walls. The two surface restoration that we struggled to complete in a full afternoon clinic session in dental school three months ago was now to be completed in a half hour time slot in our private office. Our knowledge of business principles and staff management was limited. Knowing we were young and inexperienced, we looked for help. We looked to join dental societies and participate in dental study clubs, only to find that most dental study clubs were disbanded. The dentist across the street was seen as competition as we checked the increased size of his yellow page ad with every new edition. Unlike the physicians in our town, we had no real need or built-in opportunity to communicate with each other on a regular basis. There was no hospital staff room in which to see each other and say “good morning.” There was just good old fashioned competition. Competition increased with the introduction of ethical advertising. A new term, busy-ness, was coined by the American Dental Association.

This lack of communication didn’t seem to get better with time. In fact, in the mid 80s, with dental malpractice at an all time high, it was obvious that many of the dental malpractice suits were a result of either verbal or nonverbal communication to the patient from a dentist about the previous dentistry completed by that guy across the street. You know, the one with the big yellow page ad, which was now in three colors.

Many general dentists attended continuing education classes to become more qualified in some familiar field of dentistry. Some concentrated their studies on restorative dentistry, others on periodontics or prosthetics. Some studied orthodontics and then became competitive with their local orthodontists. General practitioners learning orthodontics utilized functional appliances and became critical of those local “real” orthodontists who often proposed the use of bicuspid extractions. Others became proficient in endodontics. Some studied in a field then unknown to us in dental school: Cosmetic Dentistry. Others questioned if that terminology meant that those who were not advertising as Cosmetic Dentists were therefore Un-cosmetic Dentists. There were several reasons the general dentist wanted to be more proficient in the specialties of dentistry, and one of them certainly was economic. Why send all that potential revenue to the specialist? More training meant more therapy stayed within our four walls—less need to refer patients. With that decreased referral pattern, there was a decreased need to communicate with others, consequently less sharing of patient care responsibility.

Some of us put the emphasis of our post graduate training on the treatment of temporomandibular joint dysfunction and chronic pain. We took a course that excited us, which led to another . . . and then another. This field was significantly different from any of the other fields of dental specialty. Concepts that were required were not building on those which we were taught in dental school. They were new concepts. Many of the concepts were indeed in conflict with the ingrained principles that were handed down from generation to generation. Re-examination of these concepts became necessary, especially since these very concepts that may have been incorrect were leading to less than adequate treatment for many of our patients. The concept of infringing on freeway space, of any joint posture other than centric relation, of creating anything other than a centric splint for patient care, among many others, needed to be reevaluated.

The oversimplified notion that less than ideal occlusal schemes with nociceptive premature contacts led to hyperactive muscle and headaches was the precursor to a greater understanding of the role of mandibular posture to cervical structure and the pathophysiology of chronic pain. Diagnostic and therapeutic improvements
for internal derangements, as well as myofacial pain dysfunction, continued to widen the scope of the types of disorders we as dentists could help to treat. We no longer sat in lectures teaching preparations required for anterior veneers, but instead on the use of glucosamine and chondroitin supplementation for our patients with degenerative joint disease. The study of the microbiology of periodontal disease was replaced with learning the pathophysiology of ligament insertion injuries and the referred pain pattern of stylo-mandibular insertion tendinitis. Acute periapical pain was replaced with the complex role of the sympathetic system in chronic pain patterns. Patients and their physicians began to appreciate the expanded role of dentistry for these patients with what was called TMD syndrome.

Stepping out of the box and learning to understand the role of occlusion and mandibular posture on the myofacial system was exciting. We all hit the books and relearned the anatomy that we memorized for our dental school anatomy exams. But now there was purpose. We moved our attention to sympathetically maintained pain. We studied the critical trigeminal nerve. The temporomandibular joint anatomy was physically and mentally re-dissected. Clearly if we were going to treat this joint, we needed to understand it as well as the orthopedic physicians understood the knee.

We learned quickly that mandibular repositioning affected cervical lordosis and head posture as well as joint function. That structural alteration led to muscular changes throughout the upper quarter and beyond. Observations of many symptomatic changes led to further study, taking the dentist further and further out of the box. These observations included the fact that repositioning could decrease headache intensity and frequency. We noted that parafunctional control could actually decrease migraine symptoms, and that referred otalgia and cervicalgia could also be relieved with our therapy.

This was an exciting time for dentistry. Unfortunately, our dental model has at times prevented cranio-mandibular therapy from teaching its true potential. We were the same ones who learned all phases of dentistry and were trained to, as much as possible, take sole responsibility for our patients' dental health. Treatment decisions were our own. We didn't need to communicate them with anyone. Our records were our own. As long as we could read them, they were satisfactory.

It shouldn't be surprising, then, that the most successful dentists in the treatment of cranio-mandibular disorders are those who have learned to abandon this dental practice model of relative isolationism. The successful practices are those that have accepted the notion of convergence pain. They understand that while their treatment may in fact reduce the intensity and frequency of their patients' headaches, it is essential that their patients' physicians diagnose and rule out any systemic factor as a contributing source of their symptoms. They know that having some basic knowledge in fields that seem to be foreign to their basic practice and dental license is essential, not so that they necessarily have to be the ones to treat their patients, but so that they have enough information to make intelligent referrals. A successful practice is one in which intelligent diagnostic decision making begins with the first step of deciding whether or not the dentist should be the primary caretaker in the patient's treatment, or should he make a referral to a more appropriate primary caretaker and possibly then take a supportive role in his patient's care. All too often the most influential factor determining patient treatment is the first office they contact for their care, as opposed to what is their malady and whose treatment would be most effective in its resolve.

The new model calls for a change. We must properly diagnose. We must continue to learn and become more proficient at treating that which we should, and more knowledgeable to refer that which we should not. The new model calls for diagnostically driven therapy with the patient as part of the decision making process and the treatment team. It calls for active and effective communication between the dentist and other dentists and physicians, chiropractors, physical therapists, nutritionists, psychologists, acupuncturists, and massage therapists. It calls for real multidisciplinary therapy as
opposed to the lip service the concept often receives. Multidisciplinary therapy doesn’t mean that one discipline treats until the maximum benefit is derived, and then a referral is made to another discipline. It doesn’t mean that if our profession alone can’t be totally effective in the therapy of the patient, then we have failed. It means multidisciplined diagnosis and triage and simultaneous therapy when indicated.

Our present health care delivery system makes this model a challenge. Our history as dentists with a different model further complicates the challenge. I suggest we need to meet the challenge. Our patients and our profession will benefit greatly.

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"Tres Dias Con Rocky"
An Invitation to Spend Three days with
Professor Mariano Rocabado, D.P.T.
in Nashville, Tennessee at
Belmont University

May 21, 2004 Friday
TMJ-Basic Craniomandibular/ Craniocervical
Facial Assymetry

May 22, 2004 Saturday
Intermediate Tx and Dx; TMJ Pain Map:
Synovial Classification for TX Approach

May 23, 2004 Sunday
Advanced TMJ/Cervical Spine
(attendees may elect to attend one, two or all three days)

Professor Mariano Rocabado, D.P.T., is the world-renowned physical therapist from Santiago, Chile, who teaches TMJ and craniocervical biomechanics and dysfunction. His courses are invaluable to the practicing physical therapists, dentists, or physicians who are seriously interested in relieving the head and neck pain of their patients. His techniques are legendary. Plan to attend while openings are still available.

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