Symposium 2002: Dr. John Kois

Diagnostically Driven Interdisciplinary Treatment Planning

Dr. John Kois has not only mastered the clinical art and science of dentistry, he has invested a great deal of time and energy over many years to also master the behavioral/patient management component of dentistry. Being able to deliver technically excellent dental work is admirable, but it does not benefit anybody if patients do not accept the treatment plan. In a manner comparable to a box of Whitman's Sampler, Dr. Kois gave the audience a taste of many components of the topics he teaches, preaches and lives. The audience was treated to a smattering of practical clinical pointers, understanding and working with patient psychology, and general business concepts. The thread running through the entire presentation was how to accurately diagnose, record and manage the various dental risk factors that could ultimately lead to success or failure of a case.

As dentists, we have concerns from an entrepreneurial perspective. We need to have a successful marketing strategy so we can sell the dentistry that we believe is in the patient's interest. If we cannot sell the dentistry, then we lose the opportunity to do what we have spent so much of our lives learning how to do. However, we need to blend in clinical excellence and control our desire for entrepreneurial excellence. We also need to communicate with the patient that we are selling a health care strategy. If a patient has the impression that we are selling them our own entrepreneurial strategy and not a health care strategy, we will not develop trust and they will likely leave our practice.

Rules of the Game:

1. **Patient satisfaction.** We need to exceed patient expectations in order to create a raving fan. This does not just mean delivering magnificent restorations. A patient comes to the office expecting to eventually leave with beautiful teeth. If this is all we provide, technical excellence, we might have a very satisfied patient but not created a raving fan. We need to deliver more than just great dentistry.
2. **Predictable success.** Dentists need to reduce their stress level by generating predictable success. And without predictability, there is no profitability.
3. **Maintain control.** Every job is a self-portrait of the person who was responsible for the job. Autograph your work with excellence. No dentist should have to be the quality control cop for the entire staff. We should not have to directly oversee every job that every employee carries out.
4. **Minimize risk/remake.**
5. **Profitability.** A high-cost Mercedes statistically has a higher profit margin than a more moderate-cost Mercedes. Why is the reverse true in dentistry?A full-mouth reconstruction involving 28 crowns invariably results in a lower profit margin for the dentist than doing 28 single crowns. This makes no sense from a business standpoint. Agreeing to do a big case means the dentist is accepting much more risk. In a business model, greater risk should provide a greater profit margin because a single failure on such an involved case could be financially devastating. We need to start applying basic business concepts to the business of dentistry.

The thought process behind the "rules of the game" is to have the patient walk away with a clear sense that this practice is different. It is not just like any other practice. We are not about a short-term strategy for dental health (although a short-term strategy might be fine and even essential on an interim basis, we cannot make our living or derive emotional satisfaction from it). We must be able to communicate and pass on this understanding to the patient.

When Dr. Kois examines a patient, he divides the exam into four categories and gathers the data in a specific sequence:

1. Periodontal.
2. Biomechanical.
3. Functional.
4. Aesthetics.

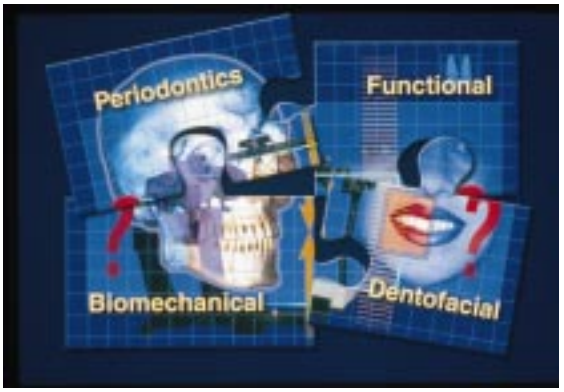

Figure 1

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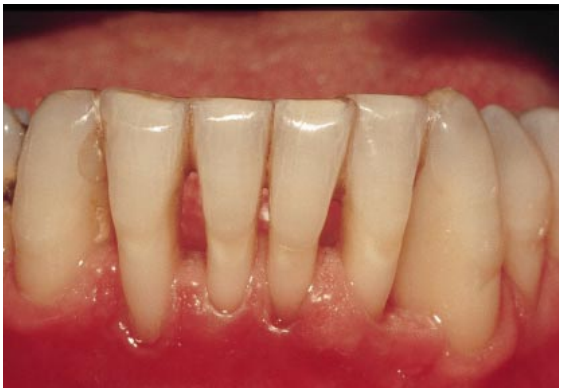

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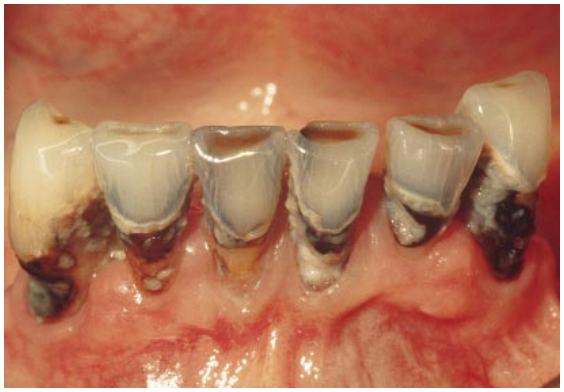

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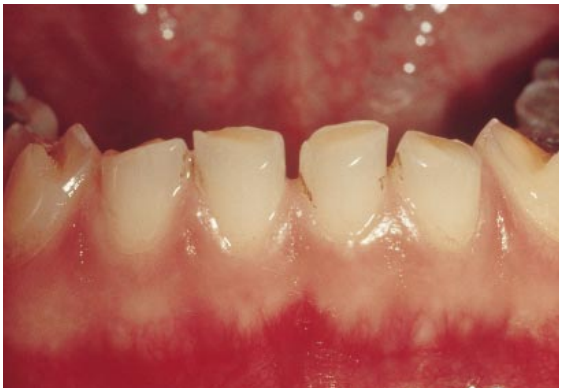

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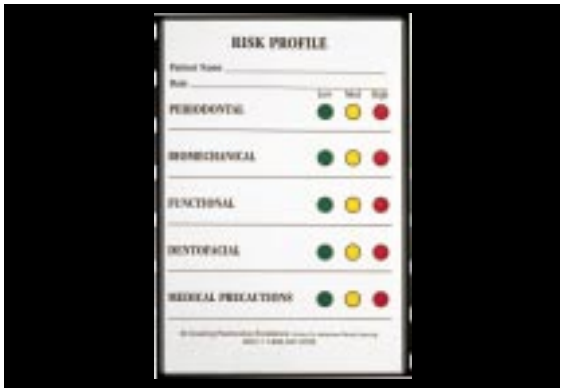
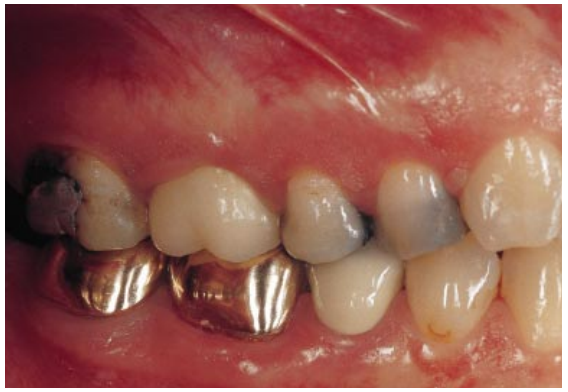


Figure 6

The transfer of science into practice remains a challenge because we practitioners often face individual patient needs and demands that are not reflected in the required rigors of randomized, controlled clinical trials. Nevertheless, decisions need to be made by the public and health care providers everyday.

The "father" of evidence-based medicine (EBM), Dr. David Sackett, has defined this approach to medicine as the integration of individual clinical expertise with the best available external clinical evidence from systematic research. Sackett also emphasizes that patient choices must be incorporated into the provision of care.

Under the current understanding of EBM, the individuality of patients tends to be devalued; the focus of clinical practice is subtly shifted from the care of individuals toward the care of populations and the complex nature of sound clinical judgment is not fully appreciated.



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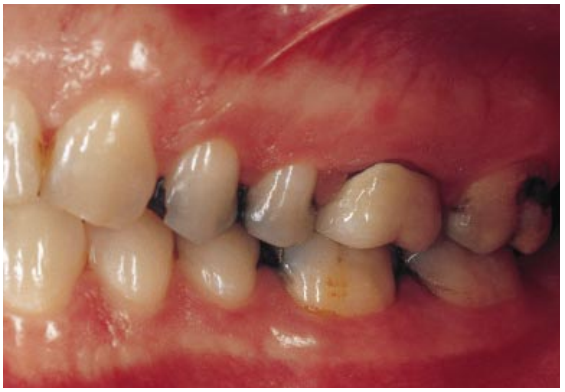

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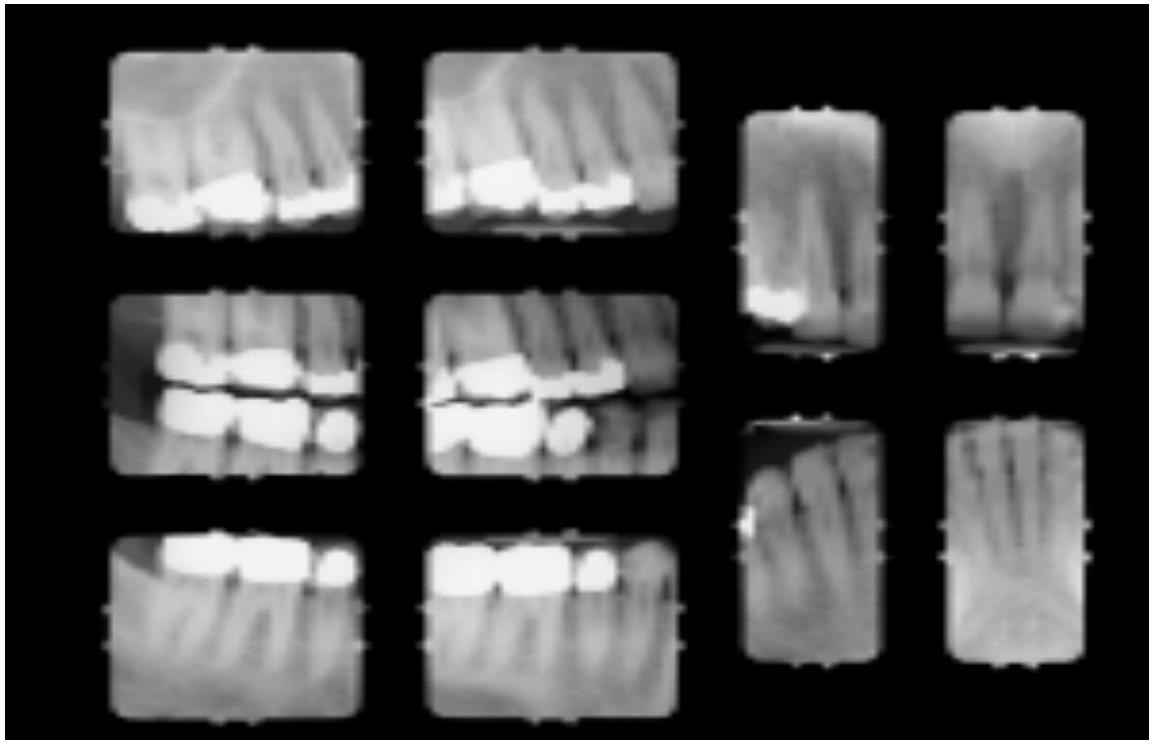


Figure 11

Treatment Options

1. Selling commodities.
2. Longevity?
3. Increase risk/stress.
4. Decrease profitability.
5. Decrease passion/happiness.

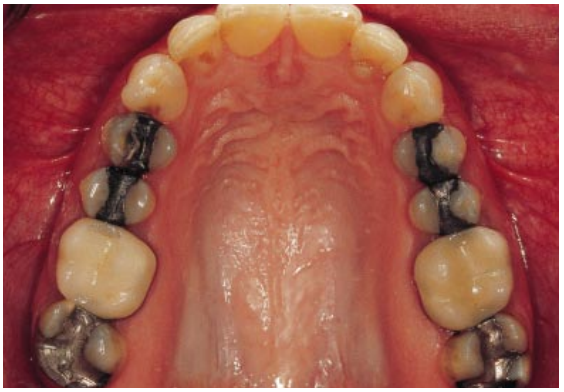
Vs.

Decision Process

1. Diagnostically based.
2. Long-term strategy.
3. Decrease risk/stress.
4. Increase profitability.
5. Increase passion/happiness.

Dr. Kois has developed a sticker system that goes on each patient chart. It simply depicts patient risk in each of the four categories: periodontal, biomechanical, functional and aesthetic. Each category is indicated with green, yellow or red. The sticker is put on the outside of the chart and a copy (in layman's terms) is given to the patient. A patient will not accept a solution to a problem that they do not yet acknowledge. A patient must understand and perceive their problems before any discussion of solutions (treatment) should occur.

Deciding when we can make compromises to please our patients is one of the most difficult dilemmas we face. Never compromise your core values. We can adopt new ways only when



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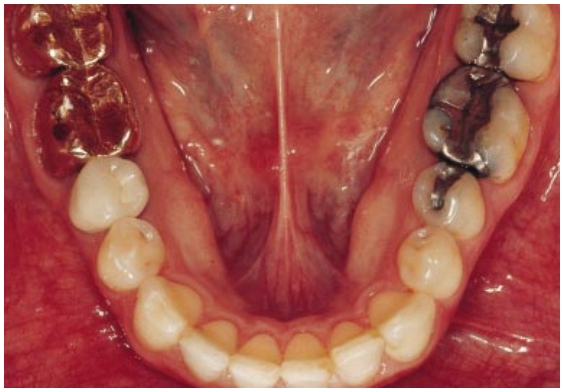

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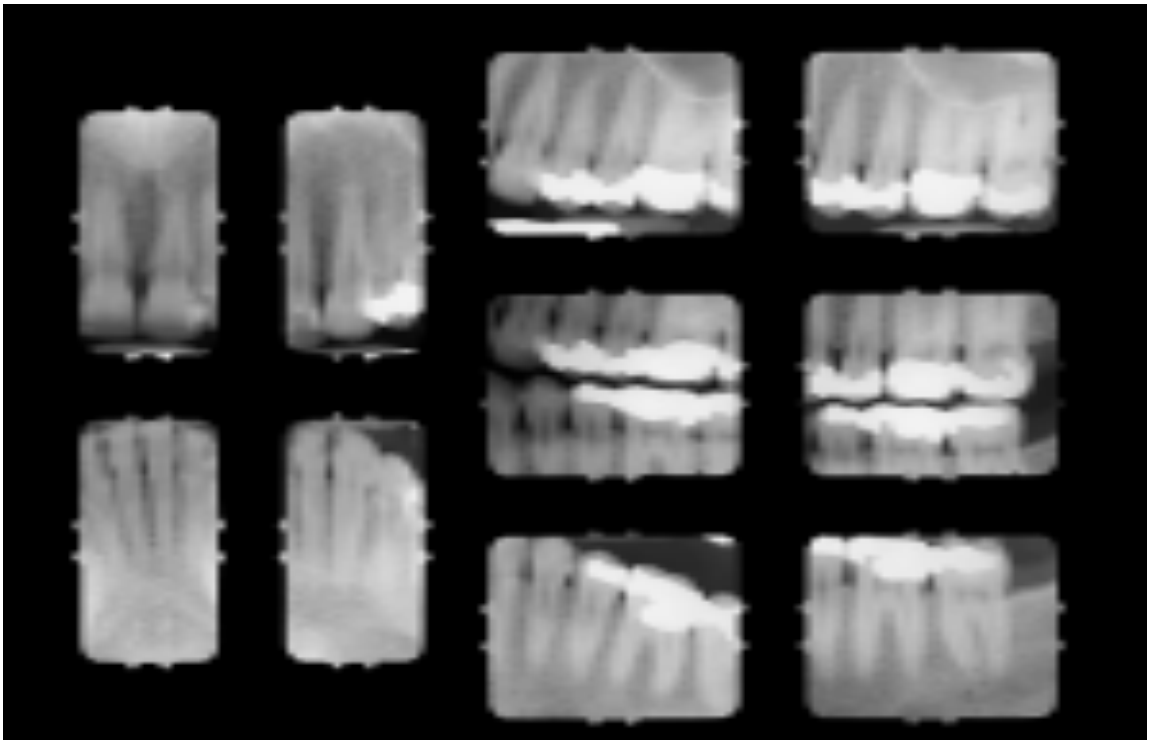


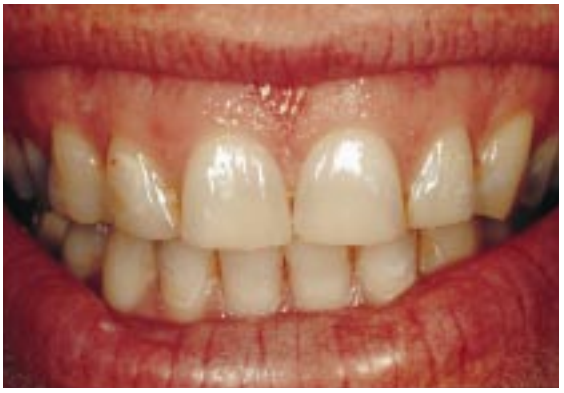
we are confident that we are not diluting the integrity for which we stand.

In optimal dentistry, treatment is based as if all patients were susceptible to disease. However, the reality is that most patients are resistant and most failures are mechanical. Mediocre dentistry is completely dependent on patient resistance factors for a favorable outcome. Some patients can have an ill-fitting stainless steel crown for 25 years and never develop a problem. This is the reason managed care is successful for large groups. Similarly, excellent dentistry is completely dependent on patient resistance factors for a favorable outcome. So what is the real reason for doing excellent dentistry? It is because there is no joy in doing mediocre dentistry. It does not satisfy our core values.

A day in our office can truly change a person's life. Facial symmetry is the bottom line for facial aesthetics. Aesthetics is a matter of perception, not a measure of health. And remember, there is no dentistry better than no dentistry.

The 3 truths of integrity:

1. Integrity is not determined by circumstances.
2. Integrity is not based on credentials.
   a. Credentials can only get you in the door. Integrity keeps you there.



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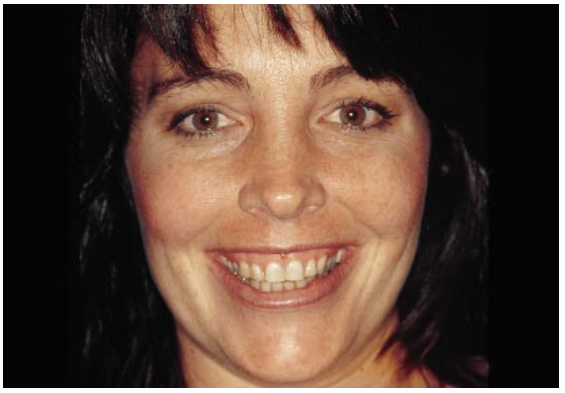

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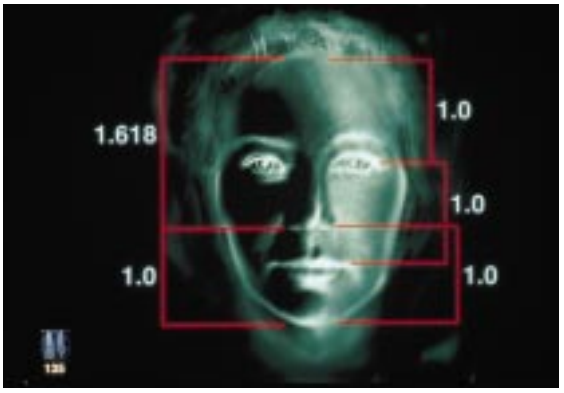

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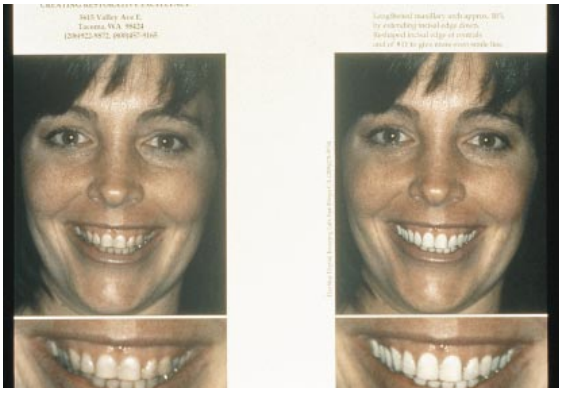

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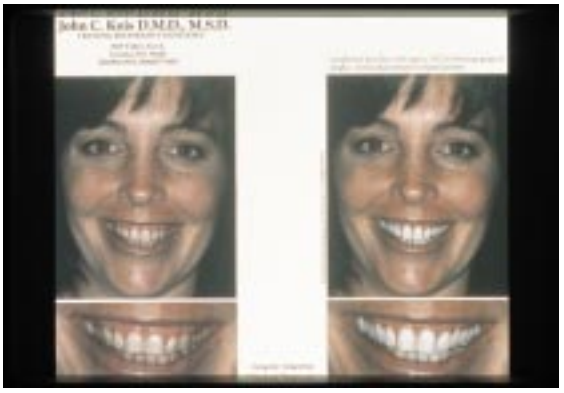

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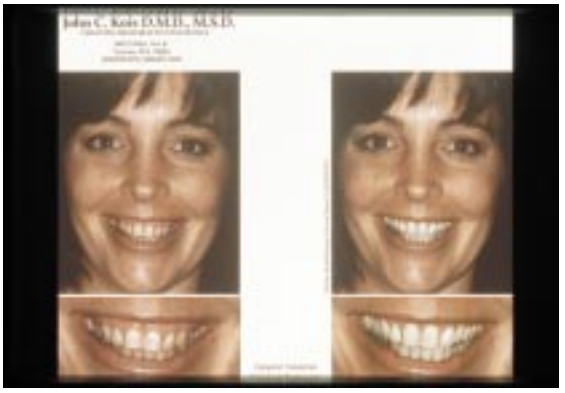


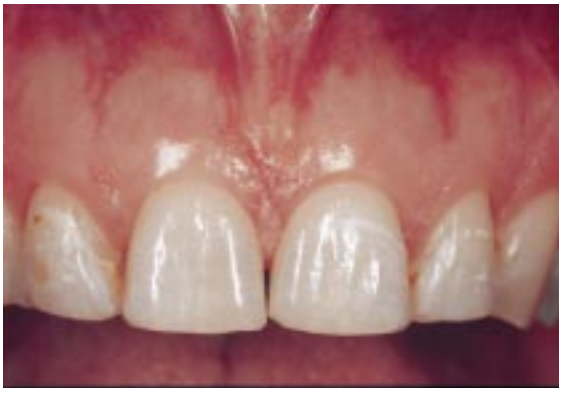
Figure 17

3. Integrity is not to be confused with reputation.
   a. Reputation makes you rich or poor. Integrity makes you happy or miserable.

Watch out for glitzy, glamour models or too much technology in a practice. Put up a picture on the wall of work that you have done. Eventually, those photos become your treatment options or menu.

Beware of putting yourself into a high-risk market such as a dental boutique, smile designer or halitosis clinic. We are looking to create a business that is built to last.

Diagnosis is the key. Only the patient at risk requires treatment. If you knew you had no risk of heart disease, would you really jog every day? High-end dentistry runs the risk of high-end failure. Be sure you are ready for that emotionally before getting too involved.



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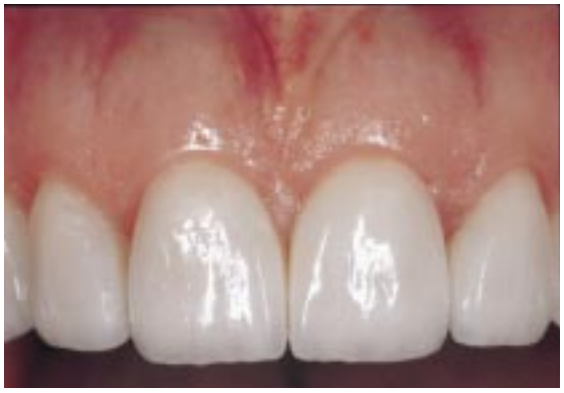

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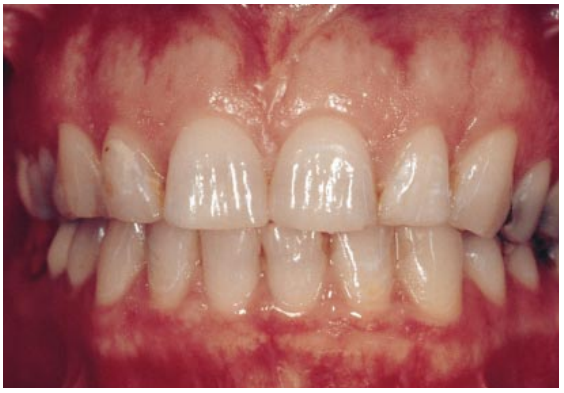

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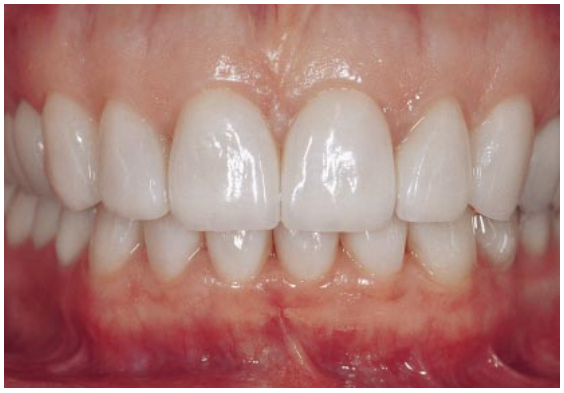

Figure 21

Figure 22

Patients will not accept solutions to problems they do not own. Case presentation is not about winning. It is about knowing the person and their mouth. A certain level of trust must already have been established so the patient realizes you are not selling them a commodity. This is not a mobile dental practice. If the patient does not accept treatment today, I'll still be here in the future when they are ready. Do not assume the patient is an idiot. Make your case by being the first to serve and keep the serve. The first serve sets the rhythm.

Avoid the 3 E's:

1. Ego: the desire to be right.
2. Emotion: the desire to engage in debate.
3. Eloquence: the desire to bowl over the patient with craft and vocabulary.

When presenting a case, sit next to the patient rather then across the desk facing them. Also, present the information in a specific order: periodontal, biomechanical, functional, aesthetics.

Quotes:

"Diagnosis is the key and only the individual patient at risk requires treatment."

"Ideally, treatment provided should decrease risk without incurring additional increases in risk."

Dr. Kois excels in developing systems for all aspects of dental practice. How a patient is managed in his office is a well-defined, reproducible sequence of steps. Implementing systems and the thought processes behind them into one's practice decreases stress, increases joy and provides greater financial return. Each chance to hear Dr. Kois provides several more pieces to the ultimate puzzle we call professional and personal success.

Figure Captions

Fig. 1) Puzzle depicting the four key components in determining an individual treatment plan. Each one is independent, yet constantly dependent on the others.

Fig. 2) Diagnostic Opinion Form.

Figs. 3-5) Three different patients with three distinctly different disease progression models (advanced periodontal disease, severe caries and abnormal attrition). Each patient requires different therapeutic strategies with different risk calculators for treatment outcomes.

Fig. 6) Individual patient risk profile sticker to be used on the patient's chart.

Figs. 7-8) Initial lateral views of a 31 year-old patient. Note previous restorative history resulting in many structurally compromised teeth and defective restorations. Moderate biomechanical risk.

Figs. 9-10) Occlusal views. Note minimal to moderate attrition and evidence of occlusal dysfunction. Moderate functional risk.

Fig. 11) Initial radiographs. Note bone loss (AAP Type II). Resistant to periodontal disease. Low periodontal risk.

Fig. 12) High lip dynamics. Everything shows on smile. High dentofacial risk.

Fig. 13) Initial facial view.

Fig. 14) Goals for facial symmetry. Note racial differences are not a factor.

Fig. 15) Imaged facial photo with teeth lengthened 10% incisally and whiter. Represents higher treatment risk aesthetically.

Fig. 16) Imaged facial photo with teeth lengthened 10% cervically and whiter. Represents higher treatment risks biomechanically and periodontally.

Fig. 17) Imaged facial photo with entire maxilla impacted vertically. Represents increased risk functionally and decreased risk aesthetically.

Fig. 18) Initial anterior view.

Fig. 19) Final anterior view. All laboratory work courtesy of Steve McGowan (Arcus Dental Lab).

Fig. 20) Initial view in occlusion.

Fig. 21) Final view in occlusion.

Fig. 22) Final facial view. Note treatment provided without altering gingival levels or orthognathic surgery. The patient could be treated at different incisal edge positions and at different occlusal vertical dimensions. They all will have successful longevity but will look different with distinctly different risk factors.

John Kois is in the private practice of prosthodontics, Tacoma, WA, is an Assistant Professor in the Department of Restorative Dentistry at the University of Washington, Seattle, WA and is the founder of the Center for Advanced Dental Learning.