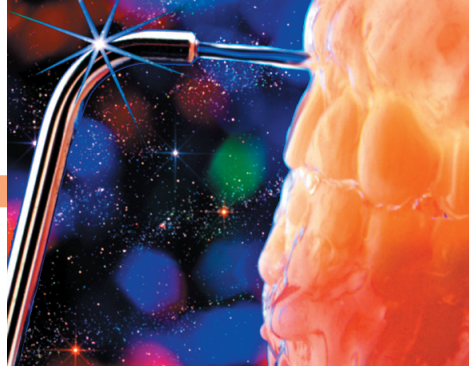

Rough diamonds into gemstones

I live in a small Southern town, and I do my banking at a small community bank. When I pulled into the bank parking lot every other week, I would wave to, and sometimes visit, an old woman who, for years, stood on a corner directly across the street. She was a throat cancer victim and was very thin and frail looking, with a noticeably weathered face. She would stand against a pole in the same spot all day long — rain or shine — and wait for a passerby to give her a dollar or two after leaving the bank. During the hot summer months, the sun would beat down on her wrinkled face, and yet she seemed perfectly content. Sometimes, I sat in the parking lot for a few moments and watched the cars go by, and I often wondered why some people stopped and fussed over her while others just passed her by — possibly regarding her as a bit of an embarrassment. When she died recently, I didn't have to read the local newspaper to find out. The spot where she used to stand for hours on end was filled with farewell messages and bouquets of flowers. It was a very moving sight.

There are many jewels among us who can assist those who wish to challenge and re-invent themselves.

When I think about dental hygiene practitioners, I often scratch my head and wonder why some are "chat and polish" hygienists who just go through the motions day after day (like car drivers who repeatedly passed the old woman without stopping or waving) and others are incredibly driven, compassionate, and professional.

Take, for example, Colleen Rutledge, RDH. Colleen and I first met last year when I joined a speaking and consulting network of which Colleen was already a member. Colleen is a periodontal therapist who is the epitome of a dedicated professional. As a dental practice consultant, public speaker, and practicing periodontal therapist, Colleen exudes a positive karma. She has a natural ability to arouse enthusiasm among hygienists, and she understands what it means to be self-empowered.

I asked her recently to tell me what led her to become passionate about nonsurgical periodontal therapies. She told me, in no uncertain terms, that she was tired of working for dentists who would not invest in her, meaning that she wasn't using state-of-the-art dental hygiene equipment and technologies, and she was tired of working without what she felt she needed to perform her duties to the best of her ability.

Colleen purchased loupes first and then purchased her favorite piezo ultrasonic unit next. Colleen told me something else that really stuck with me, and it relates to other hygienists who are also interested in investing in themselves. A hygienist approached Colleen at a recent public speaking engagement and told Colleen that she wanted to hire her so that she could better herself and become more marketable.

Now that's a 180-degree turn if ever I've seen one! Usually, the hygienist relies on the dentist for continuing education expenses and other advanced training, and there are many dental hygiene clinicians who won't take the initiative to better themselves. Colleen often refers to herself as a "diamond in the rough" that, I believe, now shines like a stunning, multifaceted jewel.

Hygienists who are committed and passionate about periodontal therapy are very different from the "chat and polish" model. These practitioners devour the research literature and love to try new techniques, equipment, and technologies. They value the services they deliver to their clients and don't hesitate to schedule adequate time for oral hygiene instruction or a comprehensive periodontal examination. Dedicated practitioners work only in practices in which they are respected and acknowledged, and ones in which they can grow professionally and treat clients comprehensively.

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What do these professionals know about periodontal diseases that leaves the "chat and polish" hygienists in the dust? Advanced dental hygiene practitioners who specialize in periodontal therapy understand that:

■ **Clients must be susceptible to disease.** This means that these individuals frequently present with multiple etiologies like genetic predisposition, host anatomy, occlusion, and inflammatory response. Susceptibility is often modified by local factors like occlusal trauma, systemic factors such as diabetes, or some other immunocompromised condition. There are also behavioral factors like stress that play a significant role in disease pathogenesis. It's no longer good enough to think in terms of "bacterial load" as being the only etiologic factor.

■ **Clients need to manage their own disease.** Once your clients understand that they have a disease of the "bone," you can gently lead your clients to a new level of guided discovery. Instead of the traditional instructor-oriented approach, teach your clients that they can become managers of their own susceptibility.

For example, Sandy Sheffler is a practicing hygienist who likes to perform phase-contrast microscopy so that her clients can visualize the microscopic changes that take place before and after debridement. Slide samples also allow clients to play a more active role in managing their microbial load. In a way, she's like a broker who transfers ownership of an active disease state to the patient. Guided discovery works beautifully if you ask the right questions and invite clients to think and personalize the disease.

By asking your clients the right questions, you transfer ownership of the disease to them. Here's another example to make this important distinction between instructor-oriented and guided discovery a bit clearer. Let's say that you have already viewed the client's full mouth series of radiographs and there is obvious radiographic evidence of grade II and III furcation involvement in the mandibular molar region. Show the client what furcation involvement looks like and include images that reflect different furcation grades. Next, ask the client to study his mandibular molar radiographs with you and ask him to grade the furcations while you record them. A powerful way to get the point across would be to place a plasma screen directly in front of the client so that you could manipulate various radiographic digital images on the TV screen.

■ **It is standard practice to spend adequate time with clients, and the resulting fees must reflect the comprehensiveness of care rendered.** How many times are we guilty of giving away services? A periodontist recently told me that his patients did not value home-care instruction until he started charging for the service.

As frustrating as it might be for patients to come back several times for oral hygiene instruction or for debridement procedures, understand that there is no quick fix for periodontitis. Recognize the value of the services you provide and work in a practice where your dentist-employer appreciates your value.

■ **Complex biofilm is enemy No. 1, and it proceeds from a gram-positive streptococcus-rich biofilm to a structure rich in gram-negative anaerobes.** The microflora that repopulate pockets after debridement may be the result of the maturation of supragingival plaque or incomplete removal of subgingival biofilm. Scientific evidence for the role of calculus in the initiation and progression of periodontitis is inconclusive. Calculus might act as a reservoir for biofilm or its presence subgingivally could possibly trigger an inflammatory response with subsequent infection in susceptible people. Microbiologists theorize that subgingival calculus helps to strengthen the biofilm by interlocking it with the calculus, which creates a more secure matrix that is inpenetraable by irrigation and local anti-infective agents.[1]

■ **Clients who maintain a high standard of self-performed plaque/biofilm control along with routine continuing care can effectively control a majority of gingival and periodontal diseases.** An impressive review of the long-term effects of a 30-year biofilm/plaque control program for over 500 clients in one private practice setting revealed that a dentist/hygienist team can effectively maintain clinical attachment levels and even improve attachment levels interproximally in many patients.[2]

■ **Effective nonsurgical therapy reduces the need for surgery for many patients but enhances the value of surgery for others.** In cases in which nonsurgical therapy fails to achieve the desired clinical outcome, regenerative surgery (guided tissue regeneration and/or bone grafts) may be needed to repair the damage that resulted from periodontal disease.

■ **The oral cavity is a portal of entry by which pathogenic bacteria can gain access to the circulatory system.** In other words, "gum bugs" in infected tissues can hitch a ride to other parts of the body through circulating blood. These bugs that escape can possibly cause disease in other parts of the body in a susceptible host. Many dental hygiene practitioners are excited about developing collaborative, interdisciplinary relationships with other health-care professionals, and these joint arrangements are welcomed by the dental hygiene and other health-care communities.

Over time, I have begun to think of the dental hygiene community as an inner family that helps each member build upon his or her strengths. There are many jewels among us who can assist those who wish to challenge and re-invent themselves. Find a mentor who can impact your career development and personal growth, re-directing your energy. You, too, can become a stunning gem and go far beyond a "diamond in the rough."

References

1 Conversation that took place at the Hinman Dental Convention in Atlanta on March 19, 2005, with with Jim Chandler, president of Vista Research Group in Ashland, Ohio.

2 Axelsson P et al. The long-term effect of a plaque control program on tooth mortality, caries and periodontal disease in adults. J Clin Periodontol 2004; 31: 749-757