



Team Communication

William R. Laney, DMD, MS Editorial Chairman

During the 80's, a decade that saw the revitalization of implant dentistry, the team approach to treatment became commonplace. Increased emphasis on the importance of clean and atraumatic surgery has resulted in more concentration of surgical implant treatment in the practices of oral-maxillofacial surgeons and periodontists. Often the complexities of prosthetic restorations involving alloplast bone-anchored natural tooth or combined support favor treatment in the hands of prosthodontists or restorative dentists with special expertise and skills. The office, operating room, and laboratory staffs of these professionals are generally experienced and well-versed in the clinical procedures and technology required to manage patient conditions ranging from the simple to the very complex.

In the past, both surgical and restorative treatment involving implants has been performed in the offices of individual practitioners. Certainly it can be advantageous for the patient to have all services provided in one office. The practitioner who is experienced and feels confident that all services can be satisfactorily provided in the office without consultation or referral assistance must be uniquely comfortable in controlling his or her own destiny. However, in this setting the opportunity is commonly lost to share expertise, judgment, clinical skills, and experience in planning and providing treatment. While total treatment rendered by the solo practitioner can be as successful as that provided by a professional team, percentage-wise the opportunities for consistently providing quality care for patients with a broad spectrum of treatment situations are probably best found in the group approach.

In the broadest sense, a team concept of treatment includes not only the professionals involved in diagnosis, treatment planning, and delivery of service, but also the patient, research community, and representatives of the dental manufacturing and laboratory industries. Without patient assistance and cooperation, optimal care is not possible. The applications of laboratory research are evident in the daily use of medications, special hardware components and instruments, and basic principles of prosthesis design. Treatment rationale is based upon microscopic findings, observations of biomaterial and physiologic interaction, and the reported impact of function simulated or directly provided by the human subject of laboratory investigation.

In an explosive era of marketing, the implant field has not been overlooked. Recognizing the potential for ever-expanding sales, dental industries have been opportunistic and prompt to respond to the clinical needs of the implant practitioner. A lack of professional *team communication* has created a window of opportunity for

industries, which become acutely aware of the needs of clinicians to correct errors in diagnosis, treatment planning, or surgical placement of implants.

Whether the line of communication involves generalist and specialist, specialist and specialist, or generalist and generalist, the team needs a coordinator. When surgical implant placement is *unilaterally* undertaken without the diagnostic and restorative planning input of the individual ultimately to be responsible for the design and fabrication of the implant-supported prosthesis, the potential for failure or complication increases significantly. Whether this failure to initiate communication or a breakdown in the coordination of team-planned treatment is at fault, completed stage 1 surgical procedures are not readily reversible without additional morbidity, inconvenience, and cost to the patient. Subsequently, there is the prosthetic need to improvise — and enter industry — with a growing armamentarium to satisfy the atypical clinical situation. Unfortunately, the situations have arisen; fortunately, compromised solutions are available for the problems that could have been circumvented with appropriate *team communication*.

A phone call comes from the dental laboratory requesting consultation concerning "a case" that has been sent in for the fabrication of an implant prosthesis. The edentulous mandibular cast has several abutment analogs in the anterior region and the instructions are to "construct a bar-splint and overdenture." It should be so simple, but one of the abutments is severely tipped labially and there is a vertical space problem for accommodation of the splint hardware and prosthesis. The line of communication has been extended beyond what was intended, but the complication could have been circumvented by earlier timely communication.

Reconstructive procedures utilizing implant modalities usually involve a variety of services. A team approach to optimal treatment should incorporate the knowledge and skills of all who would contribute to the patient's care. Since treatment begins and ends with the patient, our collective treatment goal is to provide restorations that are esthetic, functional, comfortable, and cost effective in the attainment of oral health. That admirable goal can be consistently achieved when treatment participants realize the advantages of appropriate communication and take the initiative to see that it is implemented in a timely fashion.