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Guest Editorial

If You Have It On the Shelf, You Can Deliver It

The discipline of Operative Dentistry has been the basis for my involvement in dental education since the early 1950s. At that time, there seemed to be a clear understanding of the content and importance of the discipline, and Operative Dentistry contained a very specific body of knowledge and skill needed to combat and counteract the results of dental disease and mechanical structure loss in teeth. Those who were comfortable with this skill and knowledge provided patients with the highest form of treatment and counsel.

Historically, the discipline has been maintained as an individual department within the dental education system. However, in the last half-century, this has changed markedly. Today, Operative Dentistry departments have disappeared for the most part, with the discipline now being considered a division within a larger Restorative Department or, in a worst-case scenario, swallowed up and placed under a General Dentistry setting. As long as the details of Operative Dentistry were not disturbed, this did not become a major concern; however, the skills training for Operative Dentistry is being gradually diminished, and faculty with advanced levels of training in the field are becoming a vanishing breed.

The traditional expectation of Operative Dentistry is to possess the level of knowledge and skill needed to provide long-lasting dental restorations, including the nuances of patient acceptance in regard to esthetics. I am not aware of any mandate that suggests that the treating dentist is the only authority on patient esthetics concerns. There are many times when the ball should be placed in the patient's court and, in turn, the patient should help to decide which style of treatment is most appropriate.

An example of this is the patient who presents with a failed (fracture, marginal caries, irreversible pulpitis, etc) all-ceramic crown on a second molar. Frequently, a metallic restoration would have been the appropriate solution, as it requires less tooth reduction, has physical properties that make it more dependable for that location and, for many people, the second molar does not have a meaningful impact in regard to esthetics. When the dentist is asked why the ceramic crown was chosen instead of a metallic one, he or she frequently says that the patient demanded tooth-colored restorations. However, when patients are asked the same question, they often say it was the only treatment option offered by the dentist. Many of our colleagues advertise "metal-free" restorative practices, leaving one to wonder if they truly believe that tooth-colored materials are the only viable alternatives or if they lack the training or understanding to provide other types of treatment.

To help support this line of reasoning, I am reminded of a statement by Peter K Thomas: "If you have it on the shelf, you can deliver it," meaning from an operative perspective, that one has the knowledge, skill and judgment to properly apply all treatment modalities.

Practitioners have expressed concern that patients arrive at their offices only to find that they need molar endodontices. This occurs following placement of large resin restorations with extensive cervical margins placed entirely on dentin/cementum. This is in contrast to the widely published fact that resin attachment to enamel is more reliable than resin attachment to dentin substrate. So, one wonders if something is being overlooked in the teaching program.

I appreciate the effort by Donovan and Simonson to feature the years of clinical work by Richard Tucker. It leaves a message regarding durability and appearance, noting that, in recent years, secondary caries has been receiving attention in our literature. I would be very surprised if this is a compelling problem among the members of the Tucker Academy. My sense is that these clinicians are very careful as to preparation design, condition of the margins prior to an impression and final fit of the cast restoration.

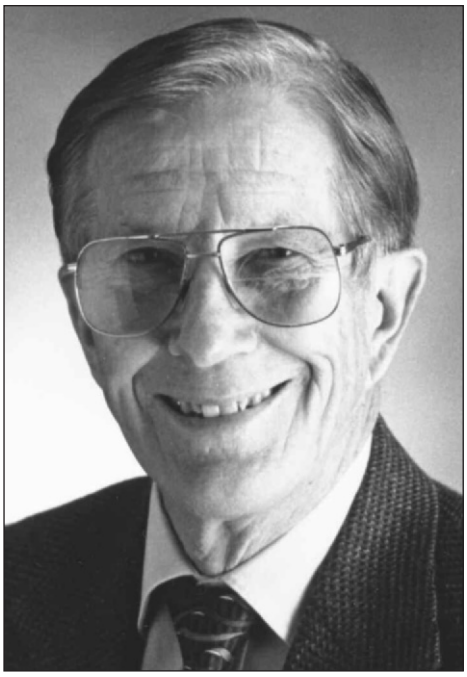
In this regard, clinicians would do well to think on a microscopic level as the cavosurface margins are being prepared for either indirect or direct restorations. All unreliable or decalcified dental tissue should be eliminated to avoid a nidus for future problems. In many cases, margins are best prepared using hand instruments. Unfortunately, this is not as common a practice

today as it once was. In this respect, it appears that there is a greater expectation for convenience than detail, and the techniques to keep restorative hand instruments sharp seem to be almost a lost art.

At the time our Academy was launched in 1972, David Grainger made some pertinent observations. He wondered whether the discipline of Operative Dentistry was suffering from fatigue. At that time, the Consortium of Operative Dentistry Educators (CODE) asked many operative educators to study and validate all elements that comprise Operative Dentistry. If fatigue was worthy of consideration at that time, the past 35 years may make the argument a stronger issue today. Have our educational expectations dimmed over time? Is it possible that the discipline of operative dentistry is being presented by teachers whose level of interest and intensity has waned? Is our current approach to the subject more generalized than specific?

For now, avoid looking at the big Restorative Dentistry picture, which includes large ticket items such as implants and CAD–CAM. Instead, focus your view on the smaller picture—the detrimental results from active caries followed by properly timed surgical intervention. This should lead to consideration of preparation design, including line angles, wall location, the refinement of margins and a solid knowledge of the myriad of materials available for restorations. If this smaller picture is understood and implemented, professional success is a given. This picture has a framework of consistency that should be strongly supported by all who are members of the Operative Academy, those who read *Operative Dentistry* and those who challenge the Operative Board.

The message carried by Operative Dentistry since the days of GV Black has been one of training, knowledge, precision and excellence. This message has been modified with the introduction of different materials, but quality results are still best achieved through careful attention to detail, and this approach must be an integral part of today's dental education in Operative Dentistry.



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Commentary

Dr Melvin R. Lund is a professor emeritus in Operative Dentistry at Indiana University School of Dentistry, where he served as chair of the Department of Operative Dentistry for 14 years. Prior to that, he was a founding faculty member at Loma Linda University School of Dentistry and served as chair of their Department of Restorative Dentistry for 13 years. He has published numerous textbooks and papers and lectured both nationally and internationally during his career and has received many honors and awards for his contributions to our discipline. He continues to teach part-time and is an examiner for the American Board of Operative Dentistry.

Dr Lund has been actively involved in the teaching and practice of Operative Dentistry for more than 60 years and is eminently qualified to address the current state of Operative Dentistry Education and its impact on the future of dental practice. I gladly go on record as sharing his concerns regarding the diminishing role and status of Operative Dentistry in today's curriculum. Everyone associated with the teaching and practice of Operative Dentistry procedures should share these concerns and become actively involved in returning the discipline to its appropriate level of importance.

Michael A Cochran, Editor