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Editorial

Trends

I have been a practicing dentist for over 40 years and have maintained at least a part-time private practice throughout my professional career. I have been involved in dental education and research for more than 30 of those years. I have directed a Graduate Operative Dentistry Master's degree program for more than 20 years and have been editor of an internationally-recognized dental journal for the last 10 years. It has been my job to stay current and conversant in the pertinent dental literature and to attempt to differentiate real evidence from interesting information, as well as to evaluate changes in our restorative materials and techniques. Along with the rest of you, I have watched developing trends in dentistry provide innovative improvements in health care and have also seen the excitement over new products occasionally turn to disappointment over time. However, there are certain trends that I personally find of great concern, and these have to do with three interconnected topics…disease, longevity and balance.

Dental Caries—Do We Really Treat the Disease?

The first trend that worries me is that cariology and preventive dentistry don't seem to get the attention they deserve from the busy practitioner. While I teach restorative dentistry, my first presentation to my graduate residents is to point out that everything they learn about cavity preparation, material selection and placement is essentially to repair existing damage and does not treat the disease that produced the problem. There have been great strides in our understanding of dental caries as an infectious disease. We have excellent models for risk assessment, can effectively monitor the rate of progress of the disease and have methods to stop and even reverse the caries process. Unfortunately, the incorporation of this information into the management of our patients' health care does not get the same emphasis as the latest bleaching technique or the addition of a laser or CAD/CAM system to the practice. The Greek root for the word doctor is "*iatrós*," meaning healer. Should we not be more concerned with maintaining healthy tooth structure and preventing or curing the disease that afflicts our patients rather than focusing exclusively on replacing lost enamel and dentin with our latest dental materials? Do we really require the recognition and financial support of second party payers for diagnostic tests and preventive therapy before we assume our designated role as health care professionals? Are we doing our duty as healers or will we continue to merely follow in the wake of the disease, trying to rebuild damaged dentition?

The Durability of Our Dental Restorations

It is a fact of life, however, that damage to the dentition does occur through disease or trauma and the need for restorative treatment is a major part of dental practice today. When such treatment is necessary, one would assume that the restorations placed would be functional and durable, with a reasonable life expectancy. This brings me to the second disturbing trend that I have observed…the emphasis on the longevity of our dental therapy has been overshadowed by the burgeoning interest in cosmetics and convenience. The replacement rate of dental restorations is really an indictment of our profession. Retrospective studies vary widely in the data presented on restoration longevity, but the trend appears to be a decreasing life expectancy for dental restorations. Why are we seeing restorations placed with newer (and supposedly improved) materials lacking the durability of amalgam, direct gold and cast inlays and onlays, and why are we even seeing a decline in the life expectancy of these restoratives? The primary cause of restoration failure given in most studies is recurrent caries, which segues directly back to our failure to treat the disease. We are quick to point an accusing finger at the material used in the restoration. However, who diagnosed the case, controlled the operating field, prepared the cavity and selected, manipulated, placed and finished the restorative material? We often shift the blame to our patients for lack of home care, but who should bear the responsibility for teaching and explaining the rationale and importance of proper home care and disease prevention? The Latin root for the word doctor is "*doctoris*" (teacher), and it is an agentive noun derived from the verb "*docere*" (to teach). Is not the time spent educating our patients an integral part of health care delivery?

Finding Balance in Dentistry

Finally, our profession is prone to rather wide pendulum swings in perspective and seems to have great difficulty in reaching an acceptable equilibrium (or maybe we just like to argue). It begins in dental education with the ongoing debate on the importance of basic science versus technical training. The polar disagreements state that, without science, a dentist would be nothing but a technician, while, without the technical skills necessary to manipulate our restorative materials, we can diagnose but not treat. Both perspectives are valid within their observational limits, but without combining them equally in our educational system, we are destined to produce a cadre of incomplete dental professionals. The art and science components of dentistry should never be at odds. They are both vital to our mission of preventing and curing dental disease and also providing long-lasting, functional, esthetic, biocompatible restorations to our patients.

In dental practice, we constantly strive for balance between the business (financial) and health care aspects of our profession. Obviously, all of us must earn a living. Many of us are involved in altruistic and/or charitable donations of our time and expertise for the care of underprivileged patients, but we have families to support, debts to pay and practice overhead to cover. We have all spent a great deal of time and money learning our profession, and we want to be able to enjoy an appropriate lifestyle and save for our retirement and our families. However, if our professional balance shifts away from what is best for our patients to what is most profitable, we are abrogating our role as health care providers for our own personal needs. This is a subtler trend than the first two, but equally disturbing. It manifests itself most in the selection of treatment modalities. We preach conservatism, but aggressive (and more costly) procedures are often performed when less invasive treatment would be better. Multiple veneers are frequently done as a routine for even minor diastema closures or the masking of slight discoloration when direct resin bonding, bleaching or microabrasion would offer similar results with less loss of tooth structure. When this is done on patients in their late teens and early twenties, even with good longevity, these restorations will need to be redone two or three times in the patient's lifetime, with continuing loss of tooth structure at each replacement. Additionally, dental laboratories confirm that the use of full-coverage rather than more conservative inlay and onlay restorations has become the norm. Even if the quality of these restorations is excellent, we are certainly not conserving the dental structures we are supposed to be protecting.

We are also lax in apprising our patients of viable treatment alternatives. It is not uncommon for some dentists to state that their patients demand esthetic, tooth-colored restorations, so that metals are no longer used in their practices (I am compelled to add here that the concept of limiting the treatment options available to patients is, in my opinion, an extreme disservice and, in some cases, borders on malpractice). Anecdotally, in both my practice and our graduate clinic, I have asked many new patients who have failed all-ceramic or resin composite restorations on molars why they had requested that type of treatment. The overwhelming response has been "my dentist told me that's what I needed" or "that was my dentist's choice." While we are the health care provider, we should not be the only decision maker in the process, but we should be a teacher and a facilitator. When presented with options and valid information on the advantages and disadvantages of different materials and treatments, most patients make intelligent, informed decisions that are not based entirely on cosmetics.

Trends, by their very definition, come and go, but they can have a lasting effect. We are already seeing, in various surveys, that the respect our profession has enjoyed for so long is declining. In my opinion, it's time for all of us to take a long, honest look in the mirror. If we can truthfully say that we are spending at least as much time fighting dental disease as we are repairing damage, that the restorations we place are as well done as humanly possible, that the materials we select are the most appropriate for each case and that the long-term health of our patients is our first priority, then we can call ourselves health care professionals. If not, then we have failed to fulfill our role as healers and teachers…a downtrend if there ever was one.

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Editor