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THE SPECIALIST

The specialist in prosthodontics does not do the same treatment that the general dentist does.

For each dollar spent, the patient will receive a uniquely different diagnosis, treatment plan and achievement of outcome. The results will be an unnoticeable, pleasing natural appearance, a function that is totally physiologic, and a measurable diminution of future breakdown, unless caused by disease or gross patient neglect. Specialists in prosthodontics have added these values for every dollar spent.

Specialists in prosthodontics can and will serve the needs of the patient with missing oral tissues in a unique and singularly different way. No one else is trained or has the skills to do the same treatments.

Additionally, the specialist in prosthodontics will meet the needs of patients with missing tissues that cannot be restored further by surgery in a uniquely different manner. No one else is trained or has the skills to achieve the same results.

When the specialist in prosthodontics is not consulted or given the opportunity to meet these special needs, the public at large suffers.

The Other End of the Spectrum

Anyone in dentistry reading and understanding the column at left might say "yes, but" who are the other providers of care?

These other providers fit into a wide spectrum of care in prosthodontics. Because of a long history in joint organizations we the specialists have become enmeshed with them. We hardly recognize the variants in treatment they provide. We know little of their failures; we have no opportunity to statistically score their compromises in treatment; and we cannot possibly compile their difficulties in finalizing a satisfactory result. We accept them as they are. It seems there is no one to categorize what they do, and no one to point out the great differences between what they do and what the specialists does in treatment.

A brief example of the other end of the spectrum follows:

The printed program at the monthly meeting of my constituent (ADA) society stated that our speaker was to "focus on fifth generation bonding materials that have simplified dental adhesion and [have] made esthetic procedures predictable." The program's flyer went on to say that these materials further would:

- eliminate post-operative sensitivity
- decrease marginal breakdown
- enhance function and appearance

In addition, the lecturer was to cover reinforced composites combined with ceramic materials -- the materials that are "providing new opportunities for metal-free crowns, inlays and onlays." We were to hear how these new ceromers could be used with confidence for metal-free bridges. As stated, "bonded indirect restorations are rapidly becoming the standard in dentistry."

This speaker was publicized as a post-graduate program lecturer at three different dental schools, past president of a well known academy, and author of textbooks and more than 100 dental articles. Wow!--and oh yes, the 4 hour lecture was co-sponsored by Dentsply Caulk.

The lecture began. The lights were dimmed. Slide after Dentsply slide depicted a cavity preparation requiring no form or shape; the need for a round bur, with no other instrumentation necessary; an ease in etching the enamel; the restorative material squeezed in; and finally, a VCL light-unit applying the final touches. A brief brushing with a bur or stone to remove the excess cured material and WHOA-LA-- a restoration!

Listening carefully -- a light bulb went off -- it suddenly struck me! Is this what general dentistry is becoming or has become? Yes, this is the other end of the spectrum! ❑

Observations

I. These "New Frontiers" in dentistry, as the lecturer had entitled them, have greatly simplified dentistry. So much so that a high-school graduate (maybe even a dropout) can master, repeat master, these miraculous new materials in a matter of months (maybe even weeks!)

And what a blessing! A practicing dentist, no matter how unskilled, can now place restorations predictably, and restore without sensitivity or marginal breakdown. A piece of cake for sure!

Quickly, a new image of dental school formed in my mind! Few skills will be necessary, and the building of anatomic, physiologic and pathologic bases of training and understanding will be complete wastes. Even though we've felt compelled to add a year to

specialty training, one can predict that training in dental school will be shortened to little more than the time needed to become familiar with new materials as they are developed.

We are building "throw- away" dentists! The new frontiers of dentistry are creating success without skill. Learn a material thoroughly and go to work. When another new material and technique comes into play, another new crop of dentists with an understanding in their use will become available. And remember, the sub-professionals in dentistry, our auxiliaries, will quickly want to hop onto the same bandwagon. Throw away the old -- bring on the new!

This is nothing revolutionary. It happens all of the time in the biotech, computer and aerospace worlds. Keeping up with technology is the trick!

And really, with the onslaught of new materials there is some real validity in it -- if only there weren't overriding complications -- such as pulpal involvement, periodontal disease, crucial occlusal problems, edentulous spaces not restored, and mal-positioned teeth and poor jaw relationships. Those very things that the specialist can manage so very well. ❑

A second observation at the other end of the spectrum:

II. How about proprietors leading the way in dentistry? How about the now popular acceptance of lectures and meetings sponsored by interests, strictly commercial? How about these commercial interests being totally involved but not being recognized -- a subliminal sponsorship of sorts?

As specialists we know we have been broadly and thoroughly trained in the basic sciences; and beyond that have covered it all with a large umbrella of knowledge and training in gnathology, dental materials, temporomandibular joint anatomy with its disarrangements, the pathology of the stomatognathic system, and the very complex relationships between anatomy-kinesiology-articulators-and occlusion.

This depth in our training tells us over and over again that there is no one technique or material which fits all. We know that the specialist is not proficient because some device or material is fail-safe. It is a very dangerous road to travel when the specialist or the specialty organization in any way implies that an impression or restorative material, a computer based inlay or crown manufacturing device, an articulator, an implant fixture or any other proprietary item is the reason for success.

Therefore, we should use great caution in succumbing to commercial sponsorships. As specialists we must prevent proprietary involvements. Lectures and the lecturers sponsored by proprietors should be avoided. More so, the specialty should not become involved with, tied to, be a spokesman for, or be "partners with" any proprietor.

It is time to emphasize that the specialist is proficient because of broad knowledge, in-depth training, great experience with many different problems; and that the specialist has a mastery of (not just competence in) the whole art and science of prosthodontics. ❑

The last observation at the other end of the spectrum:

III. Not once did the lecturer say that if extraordinary complications develop, in treatment or with the use of his materials, the patient should be referred to a specialist.

Not once did he say that "resin bonded bridges" -- his terminology-- do fail, and that the subsequent treatment will be complicated and will need the understanding, knowledge and skills of a specialist in prosthodontics.

Not once did he outline the parameters or restrictions in treatment, nor did he explain the limit of those parameters that would trigger a referral to a specialist. The implication was that "all can do all" and that his (Dentsply Caulk) materials and his teaching expertise would result in complete success.

This brings to the forefront the specialty's great ethical obligation to "not offend or disparage" our general dentist colleagues, and we are ever reminded of our obligations to nurture the discipline. But, is there some obligation in reverse? Does the generalist have obligations to refer and submit treatments beyond their capabilities and limitations to the specialist for treatment? If so, are you experiencing it? I doubt it! ❑

And Finally

IV. A view that is purely focused on the far other end of the spectrum neglects the stalwarts occupying its middle. A great bulk of good restorative dentistry is accomplished by good general dentists. They have been dental school trained in prosthodontic subjects and have continued their learning in the discipline. Unfortunately the future bodes badly for this productive segment of prosthodontics. The related subjects in dental school training, if they even exist today, will continue to shrink as predicted -- almost to the point of non-existence. This is a significant problem, but its discussion will have to wait for another time, another day.

This final thought is only to recognize those in the middle of the spectrum, again stressing that they are meeting a great share of the "everyday" dental needs of the population. They do it in a creditable, dependable, accountable and ethical manner for the most part. The treatments they carry out, while necessary on a certain level, should take nothing away from the specialist in prosthodontics who serves another and quite different need. As specialists let's recognize and talk about our significant and necessary contributions in treatment -- continuing to clarify why the public suffers when we don't speak out! ❑

NDW